Wiltshire Safeguarding Children Board

SERIOUS CASE REVIEW

CHILD K

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INTRODUCTION

Events leading to this Serious Case Review

1. This Serious Case Review concerns a one-year old child who died in 2018. At the time of writing the cause of Child K's death was unknown but the initial post-mortem report had identified injuries including an old skull fracture.

2. The family were well-known to a number of agencies because Child K had been born prematurely with significant health problems; this meant that following his birth, he spent 10 weeks in hospital before being discharged home.

3. When Child K was six months old he was found to have a number of injuries which led to the initiation of Care Proceedings. The application to the Court was later withdrawn on the basis of contradictory medical evidence and Child K returned home, having spent 8 weeks with foster carers.

4. Following the Care Proceedings, Child K's mother was unwilling to work with Children's Social Care who subsequently closed the case; the family continued to receive support from Health Visiting and a local Children's Centre up until Child K's death in the summer of 2018.

Agencies involved with the Family

- GPs
- Midwifery
- Health Visiting
- Primary Care Liaison Service (PCLS) – Adult Mental Health Services
- Hospital Emergency Department
- Hospital Paediatric Department, Bath and Bristol Hospitals
- Neo-natal Intensive Care Unit (NICU) and Outreach Service
- Police
- Children's Social Care (Safeguarding Team, Emergency Duty Service, Legal Services, Fostering Team, Contact Workers)
- Children's Centre
- Family Court

Conducting a Serious Case Review

5. When abuse or neglect of a child is known or suspected and either the child has died or been seriously harmed and there is cause for concern as to the way in which services have worked together to safeguard the child, the Local Safeguarding Children Board (LSCB) has to consider whether a Serious Case Review should be carried out.

6. The Wiltshire Safeguarding Children Board carried out a Rapid Review[1] and decided the criteria were met for a SCR and notification of the decision was made to the National Safeguarding Practice Review Panel[2].

7. The purpose of the Review as defined by Working Together (2015) was:
   - To establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
   - Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result;
   - As a consequence, improve interagency working and better safeguard and promote the welfare of children.[3]

The Process of the Review

8. An Independent Reviewer was commissioned and the process overseen by a Serious Case Review Group[4], this is a sub-group of the Local Safeguarding Board comprised of senior managers and clinicians none of whom had had direct involvement with the case. This group set out the Terms of Reference and agreed the timeframe for the review; from January 2016 to June 2018. This timeframe covers the pregnancy with Child K's sibling (born October 2016) to Child K's death, (June 2018) a period of 20 months.

9. As part of the analysis the Independent Reviewer was asked by the SCR Group to consider the following areas of practice which had been identified by the Rapid Review:
   - Early Help: what can this case tell us about the Early Help system and the attitude of professionals/agencies to Early Help assessments and integrated working?
   - Domestic Abuse: what does this case tell us about our ability to understand the impact of domestic abuse and coercive control on parenting and about our response to women as perpetrators of domestic abuse?
   - How effective are agencies in working with fathers?

[1] Rapid Review – Safeguarding Boards are required to undertake a rapid review into all serious child safeguarding cases within fifteen working days of becoming aware of the incident. Working Together to Safeguard Children, 2018

[2] National Safeguarding Practice Review Panel will be responsible for identifying and reviewing serious child safeguarding cases which the panel believe raise issues and themes that are complex or of national importance. It will look at what could be done differently to improve the protection and welfare of children, and what implications these cases have on current and future policy or practices.

[3] Working Together to Safeguard Children, 2015

[4] See Appendix for a list of SCR Group members

Method

10. The Review must be conducted in line with government guidance, Working Together to Safeguard Children, 2015. In view of the move towards using systemic models and practitioner involvement to promote learning, a model known as a Partnership Learning Review was used.

11. A chronology of events was requested from the agencies who had worked with the family, along with a reflection on their practice in which agencies were encouraged to consider what could be learnt from the case. Two practitioner meetings were held where those who worked with the family came together as a group, to reflect on their practice, to agree who did what and why and contribute to the identification of learning from the case. Consideration was given to the range of factors which can impact on the nature of the work and present barriers to best practice; where relevant, these are reflected in the analysis.

12. The findings are reflected in the Learning Points and Considerations for the Safeguarding Board.

Family Participation in the Review

13. At the time of writing the criminal investigation into Child K's death was still ongoing. The Reviewer was advised not to contact any family members until investigations were complete in order not to compromise any potential legal proceedings. Family members have since been invited to contribute to the review but have been unable to do so to date.

For the purposes of publication events have been summarised and names anonymised.

Members of the family are:

Child K	Subject of the Review
Child KS	Child K's sibling
Ms KM	Child K's mother
Mr KF	Child K's father

SUMMARY OF KEY EVENTS

October 2016	Ms KM suffered with pre-eclampsia. Child KS born prematurely and spent 15 days on the neo-natal unit before going home.
January 2017	Ms KM is assaulted by a former partner (she later disclosed that this had been an eight-year abusive relationship.)
January 2017	Ms KM is pregnant with Child K and requests referral for a termination.
April 2017	Ms KM has decided to continue with the pregnancy and books with midwifery. Ms KM is referred to the Primary Clinical Liaison Service (PCLS) for assessment, she is allegedly depressed and has suicidal thoughts.
June 2017	Ms KM is prescribed anti-depressant medication.
June 2017	7 weeks after booking, Child K is born by C-section, prematurely at 30 weeks and later develops a problem requiring colon surgery. He spends 10 weeks in hospital. (2 hospitals involved.) Ms KM requires post-natal treatment and doesn't see Child K until he is 4 days old. Staff note concerns about Ms KM's and Mr KF's frequency of visiting and lack of telephone contact.
September 2017	Child K is discharged home.
September 2017	Ms KM is reported to be struggling with financial and housing problems, emotional and relationship difficulties. Comments are made about her lack of attachment to Child K.
November 2017	An outreach worker noticed a bruise on Child K's face. Ms KM provided an explanation which is accepted by the worker and discussed with Health Visiting. The protocol on "bruising in pre-mobile babies" is not followed. Ms KM and Mr KF's relationship is said to have ended.
December 2017	Child K is taken for a routine paediatric review where he is noted to have a sub-conjunctival haemorrhage[5], a bruise on his eye-lid and a lesion on the roof of his roof of his mouth. A subsequent skeletal survey reveals a suspected fractured femur. Child Protection Procedures are followed and Care Proceedings initiated, Child K is made subject to an Interim Care Order and placed with foster carers.

[5] Sub-conjunctival haemorrhage is a medical condition that happens when the small blood vessels located just beneath the eye ruptures. Although common in adults, this is rare in children and can be a finding after non-accidental trauma.

February 2018	Ms KM's family members raise concerns about Ms KM's parenting including concerns about her "bonding" with Child K. They allege she leaves him alone at home. Children's Social Care visit and Ms KM denies all the allegations saying they are malicious.
February 2018	An independent doctor reports to the Court that the x-rays have been misinterpreted and there is no fractured femur. The Judge indicates that the application will no longer reach the threshold for an Order and Children's Social Care withdraw the application. Child K returns home with a plan for further assessment and continued involvement with Children's Social Care through the Child in Need process.
March 2018	Ms KM will not cooperate with Children's Social Care or allow them to visit. The planned assessment is completed on this basis and recommends the case is closed and that Health Visiting initiate a CAF as they continue to have a working relationship with Ms KM; however, the Health Visitor reports she is unaware of the plan.
March 2018	Ms KM assaults Mr KF and breaks his nose, he is treated in hospital; a family member informs the police who in turn inform Children's Social Care and Health Visiting. Children's Social Care Emergency Duty Service make a home visit, confirm the children are unharmed and pass the information on to the allocated social worker. Health Visiting make a visit when Ms KM denies the assault happened and says it is the family making malicious allegations.
March 2018	Children's Social Care seek advice from their legal services, further independent medical opinion is sought on the nature of the alleged fractured femur but the doctor consulted feels unable to shed any further light on a difference of medical opinion. Children's Social Care close the case.
April / May 2018	Health Visiting continue to visit and see Child K, the local Children's Centre visit and attempt to work with Ms KM but she is reluctant to take up any offers of help. Child K is not being taken to hospital follow–up appointments.
June 2018	An ambulance is called to Child K's home where he was found to be unresponsive. Investigations into the cause of his death are ongoing.

Child K - Pregnancy and Early Life

14. Ms KM had suffered with pre-eclampsia with her first child, Child KS, who had been born prematurely and spent two weeks on the neo-natal unit before being discharged home. When Child KS was five months old Ms KM discovered she was pregnant again.

15. Ms KM approached her GP requesting a termination and was referred to an appropriate service. However, having later decided to have the baby, Ms KM was booked in with the maternity services when she was 23 weeks pregnant.

Recognition of Vulnerability

16. During the ante-natal booking it became clear to staff that there were factors in Ms KM's history and current circumstances which suggested she was vulnerable. These included:
    - Ms KM's previous obstetric history
    - Her response to being pregnant
    - Her "low mood" (she had been prescribed anti-depressants just before Child K was born)
    - The late booking
    - Relationship problems (she and Mr KF were reported to have ended the relationship)
    - Inadequate housing

17. The maternity team referred Ms KM to the Primary Care Liaison Service [6](PCLS) for a mental health assessment, the assessment recommended Ms KM undertake further work with the IAPT team[7]; Ms KM did not take up this offer of ongoing work.

18. In view of her vulnerability, maternity services referred Ms KM to their specialist 'Lotus Team'. However, before the team were able to begin any effective work, Child K was born by caesarean section at 30.5 weeks. This meant that there were only seven weeks between Ms KM's booking and Child K's premature birth, which allowed limited time to get to know the family.

19. Child K was taken to the neo-natal intensive care unit and Ms KM received treatment on the maternity ward. In the post-birth period Child K had a number of health problems associated with his prematurity which led to him being cared for by two paediatric teams at two different hospitals.

[6] PCLS, Primary Care Liaison Service a mental health liaison service which provides short-term support service to help people with mental health difficulties.

[7] IAPT, The Wiltshire IAPT Service (formerly LIFT Psychology) is a free NHS service which supports people in Wiltshire who are experiencing common mental health difficulties, such as anxiety, depression and stress using CBT techniques. It is a self-referral service.

20. The neo-natal team at the local hospital encouraged Ms KM to visit Child K and to telephone for updates on his progress. They noted it was difficult for her to get to the hospital. She was unable to drive having recently had surgery and had an eight-month-old baby at home.

21. Indications were that Ms KM and Mr KF's relationship was strained and Ms KM told the hospital Mr KF was not to see Child K. During this Review, it was also reported that Ms KM had told Mr KF that Child K had died - her motivation for this was not known.

22. Also noted was the family's housing situation. Ms KM, the two children and three dogs were living in a one bedroomed flat and they also had financial problems exacerbated by Ms KM's extended period of maternity leave.

Maternal Ambivalence

23. The implications of Ms KM's late booking, feelings about the pregnancy and response to Child K indicate maternal ambivalence described in the triennial analysis of Serious Case Reviews, "Pathways to Harm, Pathways to Protection,"[8] It states:

> "*One potential indicator of parental risk identified in this triennial review was a sense, in a few cases, of maternal ambivalence towards her child. This could present as an unwanted pregnancy, or ambivalent feelings about being pregnant; and result in late antenatal booking, or non-engagement with antenatal services. Later presentations included an apparent lack of joy or warmth in relation to their baby.*"

The report makes the following learning point:

LEARNING POINT:

- A parent who presents as ambivalent about their pregnancy, or who does not seem to be engaging with parenthood provides an opportunity to explore with that parent their feelings towards the child and any risks that this might pose.

[8] Pathways to Harm, Pathways to Protection: a triennial analysis of serious case reviews 2011 to 2014, Final report May 2016, Peter Sidebotham et al

LEARNING THEME 1 - Early Help, Assessment and Planning

24. Working Together to Safeguard Children 2018 states:

> *"Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life…"*
>
> *"Where a child and family would benefit from co-ordinated support from more than one organisation or agency (e.g. education, health, housing, police) there should be an inter-agency assessment."*

25. In Wiltshire, the CAF Early Help Assessment provides a framework for working in an integrated and coordinated way at Early Help level.

26. An assessment enables a shared understanding of a family's needs and strengths to inform an outcome focused plan. The assessment should be evidence based and clear about the action to be taken and services to be provided to prevent needs escalating. Team around the child, known as TAC meetings, should take place to bring together those agencies working to support the child and the family. Within this framework information can be shared and progress towards improved outcomes for the child monitored.

27. Despite the recognition of Ms KM's multiple needs, none of the professionals working with the family considered initiating a CAF and convening a TAC meeting. Discussions in the Practitioner Event, and from the agencies own reflection on their practice, have identified that this was a lost opportunity.

What did Happen and Why

28. There was good communication in the handover between midwifery and Health Visiting and the neo-natal unit provided a follow-up outreach service visiting Child K at home. PCLS had carried out an assessment and Ms K had applied to be re-housed and was expecting to move into a larger property in the near future.

29. For the professionals working with the family, the combination of these actions meant that they considered that everything that could be done for the family was being done; the issues had been identified and services were being provided. Therefore no one in the professional network considered the fact that a coordinated Early Help Assessment was necessary and would provide a framework for integrated working and information sharing.

30. Consideration should have been given to initiating a CAF Early Help Assessment on Child K. The focus of help was on the immediate presenting problems and a CAF would have enabled a more structured assessment of the emerging needs, for professionals to share their thoughts in a more considered way and for a plan to be

put in place which could be reviewed. The assessment may well have helped keep Child K at the centre and at the fore-front of professional's minds.

31. More thought should have been given at this early stage to the implications of Ms KM's response to being pregnant, Child K's premature birth and hospitalisation and the concerns about Ms KM's visiting frequency. It became clear, as time went on, that Ms KM was signposted to numerous agencies for help and support and although this reassured professionals, Ms KM did not engage with any of the services offered. Had a CAF been in place, the implications of this lack of engagement for the care of Child K might have been considered and better understood by all agencies.

32. Lack of an effective CAF Early Help Assessment has been identified before as an issue for Wiltshire (for example see SCR Baby J, 2016). In 2015 Ofsted carried out a thematic inspection of the effectiveness of Early Help which drew on evidence from 12 local authorities; this demonstrates that there are common challenges for LSCBs in evaluating the effectiveness of Early Help and the quality of Early Help assessments.

What Needs to be done

33. The Ofsted report reinforces the message that Early Help can prevent the escalation of difficulties which in turn can lead to a deteriorating family situation and children being more at risk of suffering harm. This is acknowledged and accepted in Wiltshire and there is work taking place within the Families and Children's Transformation Programme (FACT) to improve Early Help assessment and planning, oversight and quality. [9] However, whilst this work is being progressed key messages about the importance of Early Help assessments, clear outcome focussed planning and regular review should be reinforced.

CONSIDERATIONS FOR THE WSCB

- Discussions from the Practitioner Event suggest that the Early Help assessment process in Wiltshire is not yet embedded. If Early Help is to be effective, all agencies will need to be fully engaged with this assessment and integrated framework for working.

- Where there are examples of good practice these should be shared as exemplars to assist practitioners in their understanding of the process of Early Help.

[9] See http://www.wiltshire.gov.uk/children-young-people-fact-overview

LEARNING THEME 2 - The Significance of Bruising in Non-Mobile Babies

34. When Child K had been at home for four weeks the outreach worker noticed a small bruise on his forehead; Ms KM was asked about the bruise and gave the explanation that a toy had been thrown by an older child. This explanation was accepted by the worker.

35. Bruising in babies who are not crawling, cruising or walking (non-mobile) is rare and there is wealth of research about its significance as a potential indicator of child abuse. The NICE guidance "When to Suspect Child Maltreatment"[10] states that *"bruising in any child not independently mobile should prompt suspicion of maltreatment."*

36. Subsequently most Local Safeguarding Boards in the UK have a multi-agency protocol which defines what action is to be taken if a non-mobile baby or child (for example a non-mobile child with a disability) is found to have a bruise or injury.

37. The reason for adhering to the Bruising and injuries in Non-mobile Babies and Children Protocol is that it prevents any one professional having to assess the bruise and the subsequent risk in isolation. In Wiltshire, the protocol in place at the time of these events "Bruising and Injuries to non-mobile children: actual or suspected injuries or bruising in children who are not independently mobile" stated that:

> "any *bruising, fractures, bleeding and other injuries such as burns should be taken as a matter of enquiry and potential abuse unless otherwise evidenced"* and that ...
>
> *"Any other obvious explanations for the injury or bruising should not automatically be referred but a consultation with the safeguarding advisor should take place and the detail of what has been observed and discussed should be recorded, dated, timed and signed in the child's individual record held by the agency."*

38. This protocol has since been reviewed and replaced with a new version which begins with a much clearer statement "*all bruises or injuries to non-mobile babies or children must be reported by phoning the MASH."*

[10]NICE guidance Child maltreatment: when to suspect maltreatment in under 18s, Clinical guideline [CG89] Published date: July 2009 Last updated: October 2017. https://www.nice.org.uk/guidance/cg89

LEARNING POINT:

- Although most practitioners are familiar with the injury and bruising protocol, human factors, for example a tendency to want to believe parents, can distract staff. Adhering to the protocol ensures focus on the child is not lost and ensures the incident is properly assessed, recorded and forms part of the chronology of events.

CONSIDERATIONS FOR THE WSCB

- The updated Bruising and Injury in Non-mobile Babies and Children Protocol is clearer about what action must be taken if a pre-mobile baby has a bruise or injury; however, this case demonstrates that human factors can distract staff. Exploration of these factors with staff will help ensure compliance and all agencies need regular reminding about the importance of following the protocol.

LEARNING THEME 3 - Child Protection Investigation and Care Proceedings

39. In December 2017, two weeks before Christmas, Child K was taken for a routine paediatric appointment where the examining doctor noticed three unusual presentations, a bruise to the eye-lid, a sub-conjunctival haemorrhage and a lesion on the roof of Child K's mouth. A skeletal survey was carried out and the results were reviewed by two radiologists who concluded Child K had an avulsion fracture in the right femoral area. [11] This type of injury is highly indicative of non-accidental injury.

40. A strategy meeting was convened promptly and Section 47[12] enquiries began. Child K was placed with foster carers, an application was made to the Family Court and an Interim Care Order (ICO) was granted. Supervised contact was arranged for Child K's parents. A Looked after Child (LAC) Review was held within accepted timescales.

[11] Avulsion fractures are caused by trauma. They usually happen when a bone is moving one way, and a tendon or ligament is suddenly pulled the opposite way.
As the bone fractures, the tendon or ligament that attaches to part of the bone pulls this bone fragment away from the rest of the bone.

[12] Section 47 Child Protection Enquiries: Section 47 of the Children Act 1989 places a duty on local authorities to investigate and make inquiries into the circumstances of children considered to be at risk of 'significant harm' and, where these inquiries indicate the need, to decide what to do.

41. In line with usual court procedures, a Children's Guardian was appointed who met Child K and his parents, observed some contact and made a home visit. Children's Social Care prepared a report for the court.

A Cluster of Medical Presentations

42. Studies about child deaths from non-accidental injuries show that these children often have a history of minor injuries prior to a very serious injury or death. Known as sentinel events or sentinel injuries, in one study these injuries were present in 25% of children subsequently diagnosed as abused.[13]

43. Injuries in babies and infants who are not crawling, cruising or walking (non-mobile) are rare and there is a wealth of research about their significance as potential indicators of child abuse. For example, the NICE guideline 'When to Suspect Child Maltreatment'[14] uses the terms "injuries and presentations" and prompts health practitioners to consider the possibility of maltreatment in forming a diagnosis, or as part of differential diagnosis.[15]

44. For Child K there were three unusual presentations, one of which was a sub-conjunctival haemorrhage. These are caused when blood vessels on the surface of the eye are broken and whilst common in adults, are rare in babies. If there is no obvious explanation for sub-conjunctival haemorrhages in babies, for example whooping cough, they are an indicator of possible child abuse.

45. An example from the literature states:

> *"sub-conjunctival haemorrhages in infants and children can be a finding after non-accidental trauma. We describe 14 children with sub-conjunctival haemorrhages on physical examination who were subsequently diagnosed by a child protection team with physical abuse. Although infrequent, sub-conjunctival haemorrhage may be related to abuse. Non-accidental trauma should be on the differential diagnosis of sub-conjunctival haemorrhage in children, and consultation with a child abuse paediatrics specialist should be considered."*[16]

46. For this reason, hospital safeguarding protocols often list sub-conjunctival haemorrhage as a "red flag" presentation which should be referred to the safeguarding team.

47. The presentations were discussed with Child K's mother who could not offer any explanation and Child K was then seen by different paediatric consultants, each with

13 Sheets LK et al paediatrics 2013:131(4)
14 See: http://guidance.nice.org.uk/CG89
15 A differential diagnosis is considering which of several possibilities might be producing the symptoms
16 Sub-conjunctival Haemorrhages in Infants and Children: A Sign of Non accidental Trauma, Paediatric emergency care 29(2):222-6 · February 2013, Catherine A Deridder et al

specialist knowledge of the specific injury. The report written following the examination concluded that:

> *"the combination of an unexplained bruise, a sub-conjunctival haemorrhage, mouth lesion and unexplained fracture is highly suspicious of non-accidental injury."*[17]

48. A Case Management Hearing (CMH) was held at the Court six weeks after the ICO had been granted. During the hearing the Judge drew attention to a perceived lack of clarity about the alleged fractured femur. The Court ordered that further evidence was required about the nature of the fracture and an independent expert radiologist was instructed to review the x-rays. This radiologist reported that, in his opinion, there had been "*no metaphyseal fracture of (Child K's) femur...*"

49. Following the radiologist report, Children's Social Care had to consider whether, in the absence of a fracture, they had sufficient evidence of harm to meet the threshold for Care Proceedings. Children's Social Care took advice from their legal team and withdrew the application**.** [18] The other unusual presentations, the cluster of injuries, were not considered sufficient to meet the threshold for Care Proceedings.

50. Children's Social Care in their written report for this Review say that "the collective medical view at this time became that Child K's cluster of injuries were not of significant concern."

51. Enquiries conducted during this Review have not been able to ascertain how injuries considered by doctors to be "*highly suspicious of non-accidental injury*" became "*not of significant concern*."

52. It seems likely that the focus of the Court became the fractured femur and the need to seek further medical opinion and consideration of the other issues was overlooked. It is also possible that the language used by professionals has different meanings for different agencies, for example a presentation which is "not of concern" to a doctor may have a different meaning for a social worker.

Challenging Medical Opinion

53. It is very difficult for non-medical professionals to question or challenge medical opinion whether it is definitive, as in this case, or in other cases, when it fails to reach a conclusion. Neither Children's Social Care nor Cafcass formally questioned the difference of opinion between the radiologists about the nature of the alleged fracture or discussed the significance of the cluster of presentations.

[17] From Report of Community Paediatrician, Dec 2018

[18] Threshold criteria as defined by section 31 of the Children Act 1989 are the facts that a local authority have to prove if they want the court to make an order. If the facts are not found, the threshold is not met and the Judge cannot make any public law orders, then the Care Proceedings will come to an end.

54. Children's Social Care did try to obtain another medical opinion about the potential fracture but the doctor was not able to comment beyond the fact that there had been a difference of opinion about the diagnosis.

55. Previous SCRs have commented on the hierarchy of evidence, demonstrating that in the professional hierarchy, doctors are more likely to be believed than other professionals and their diagnosis can significantly influence the nature and outcome of an investigation. There are a number of reasons for this, for example different professional understanding about the nature of "evidence," the natural human optimism in wanting to believe the best of people and the difficulties of achieving medical representation in multi-agency meetings.[19]

56. In this case, despite the general understanding among all professionals of significant injuries in babies and the added implications of there being a cluster of injuries, there was no challenge to the medical opinion on the fracture diagnosis or other presentations. Because of the difficulties in questioning medical opinion, some LSCBs have developed guidelines for staff. [20]

LEARNING POINTS:

- The presence of a number of apparently minor injuries to a baby can be considered sentinel injuries and may be an indication that the child is at risk of harm.
- Medical evidence is a crucial part of risk assessment. It is important that other agencies are clear about the meaning and significance of medical evidence and seek clarification when necessary.
- Ensuring health staff are aware of the family history, background and contextual information may influence the medical opinion provided.
- Focussing on the child's experience, particularly when there are a number of unusual presentations, can help practitioners frame questions and encourage discussion between all the agencies which contribute to assessment of risk.

19 Scie have produced a fact sheet, Practice issues from Serious Case Reviews Confusion about interpretation of medical information on cause of injury.
20 See for example Wakefield LSCB, Guidance on Challenging Medical Opinion in Section 47 Cases

CONSIDERATIONS FOR THE WSCB

- The Safeguarding Board should satisfy itself that all agencies are confident to question medical opinion which is provided as part of Section 47 enquiries in a helpful and professional manner and that medical practitioners are open to challenge.

Referral

57. Towards the end of the Care Proceedings, Children's Social Care received information, from members of Ms KM's extended family which reported that that Ms KM:

> "*had not bonded with Child K, had expressed the view that she "hates" Child K and wished he had died instead of the family dog, that she leaves Child K alone and uses cannabis and has fluctuating moods and aggression.*"

58. Children's Social Care and the Child's Guardian interviewed Ms KM together and she denied all the allegations suggesting the intention was malicious. The referrer was interviewed and as there was no evidence, no further action was taken. Mr KF was not spoken to; the tendency to overlook the role and responsibilities of fathers is discussed later in this report.

LEARNING POINTS:

- In order to form a view about the significance of referral information it is essential that it is considered within the family context, the chronology of events and what is already known; if referral information cannot be substantiated this doesn't mean it's not true and the significance of the information may need to be reviewed again in future assessments.

- Child K's early history suggested that there were indicators of potential attachment difficulties. Practitioners should be alert to the significance of parental attachment and include their observations in assessments.

Outcome of the Care Proceedings

59. At the end of February 2018, when the application to court was withdrawn, Child K returned home; he was aged 8 months and been living with foster carers for 11 weeks.

60. The Children's Guardian did not challenge the decision to withdraw but made it clear that, in her view, Children's Social Care should remain involved with the family "to offer support and monitor the situation." A plan was draw up with Ms KM which stated that a parenting assessment would be completed and that Children's Social Care would remain involved with the family, working within the Child in Need Framework[21].

61. Once Child K was at home, Ms KM indicated that she had been extremely upset by recent events and despite numerous attempts by the social worker to arrange a visit, she would not agree to any ongoing work.

62. In view of the difficulty engaging Ms KM, Children's Social Care decided that the best way forward in the circumstances was to withdraw and to ask the Health Visitor, who was described as having a good relationship with Ms KM, to start a CAF; this would still enable multi-agency assessment, a plan and reviews to be put into place. However, this decision was not communicated clearly to the Health Visitor and the CAF never got started; the Health Visitor was surprised to find Child K at home when she visited.

Impact of the Withdrawal from Court

63. The withdrawal of the application to the Court had a significant impact on the future direction of work.

64. The decision to withdraw the application was primarily based on the medical opinion and Children's Social Care's assessment of the family, which had not identified any risk of harm to Child K other than the risk of injury. The "Analysis of the Evidence of Parenting Capacity" in the report to the Court emphasises that the family were not known to Children's Social Care prior to these events and states that:

> "*the issue of parenting capacity in relation to the safety (of Child K) pertains solely to the parents inability to provide an explanation for significant injuries...*"

[21] Child in Need Framework - Section 17 of the Children Act 1989 states that it is the general duty of every local authority to safeguard and promote the welfare of children within their area who are in need; and so far as it is consistent with that duty, to promote the upbringing of such children by their families. Working with Children's Social Care within this framework is entirely voluntary for families.

65. Once the risk of injury had been dismissed, Children's Social Care considered they had no basis for statutory involvement and therefore no choice except to withdraw the application.

Impact on the Workers

66. Withdrawal of the application to the Court had a significant impact on the confidence of the social workers who reported that they were left feeling they had "got it wrong." This lack of confidence in the process was compounded by Ms KM's angry response, in particular that she had been denied spending Christmas with Child K. The workers became distracted by their sympathy for Ms KM and the focus on Child K was lost.

67. When Ms KM refused to work with Children's Social Care they felt they had run out of options; on reflection, they have concluded that the decision to step-down the case from the highest level of intervention, removal of a child and court proceedings, to working through the to the lowest level, the CAF process, should have been scrutinised by managers more robustly.

68. Even though Children's Social Care did not "get it wrong", the Section 47 investigations, the application to the court and the protection of Child K were all carried out properly and efficiently, the focus on process, the difficulties in engaging Ms KM in ongoing work and the reluctance to cause Ms KM any further distress deflected from consideration of Child K and his needs and experience.

69. Although Children's Social Care completed the planned assessment there was insufficient thought about the impact of the events on Child K, his return home after yet another period of separation from his family and what this might mean for him.[22]

70. As a result of this case, procedures have been changed so any decision to withdraw from Care Proceedings must be agreed by the Head of Service and a meeting held to discuss any case closed as a result of parental non-engagement.

[22] Since this case, for Children's Social Care reflective supervision has changed and the pro-forma for safeguarding supervisors now includes risk and impact analysis as standard headings.

LEARNING POINTS:

- Withdrawal of Care Proceedings is a rare and unusual event and supervision should address the feelings of practitioners in all agencies and how these might impact on their judgement and the risk of over-identifying with parents.

- Reflective supervision, reviewing the case, looking at the events holistically the background and impact of the separation and asking questions such as "what do we know about this baby, about his relationship with his parents?" and specifically addressing the question "how concerned are we about the risk of harm" would bring the focus back to the child.

The Value of Multi Agency Assessment

71. A Strategy Meeting or multi–agency discussion at the point of withdrawal of the Care Proceedings would have enabled practitioners to come together to discuss Child K and whether there was a need for further protective action, despite the lack of medical evidence to support the threshold for care proceedings. This would have enabled further discussion about the medical presentations and to consider the implications for Child K if his mother could not be engaged in further work. Although it is common practice for Children's Social Care to take the lead in preparing evidence for court, this does not preclude other agencies from remaining involved in risk assessment and intervention or providing information to the court.

72. When Child K was placed in foster care a LAC Review was held. However, there was a misunderstanding among the practitioners at the Practitioner Event that in order to hold an Initial Child Protection Conference (ICPC) there must be an indication of "ongoing risk" to the child. As Child K was looked after and there was no "ongoing risk" there was no Child Protection Conference; this view does not accurately reflect the procedures which are more permissive and indicate that a decision should be reached and the reasons for not holding an ICPC recorded.

73. The local Child Protection Procedures state:

> *"Children who are already looked after will not usually be the subject of Child Protection Conferences, though they may be the subject of a s47 enquiry. The circumstances in which a child who is looked after may be considered for a Child Protection Conference or may be subject to a Child Protection Plan can vary..."*

74. Also, when a child who has been subject to a Care Order returns home, the procedures state that:

> *"the members of the LAC Review must decide and record whether an Initial Child Protection Conference should be convened prior to the change. If it is proposed that a child subject to a care order should be returned to their birth family / returned home, the members of the statutory looked after child case review must decide and record whether an initial child protection conference should be convened prior to the change. .."*

This discussion would be initiated by the Independent Reviewing Officer. (IRO)

75. None of the practitioners involved with this case were aware of expected practice and the assumption made by agencies at the time was, that the Child Protection Process had been exhausted and there was nothing to be gained by going down that route again.

76. Even if, after careful consideration, the decision had been taken not to hold a Strategy discussion or ICPC, a professionals meeting would have provided an opportunity to re-assess the family situation and discuss the risk assessment and make a plan. This would have avoided the pitfall of others in the professional network being unaware of Child K's return home, enabled reflection on events and to take a step back from feeling sympathy for Ms KM and focus on Child K's experience.

LEARNING POINTS:

- Child Protection Conferences and Child Protection Plans exist to manage risk to children placed at home with their parents/carers. Care Proceedings are initiated when that risk cannot be managed safely enough. When Care Proceedings are withdrawn it is essential to consider risk in a multi-agency forum.

- It is unhelpful to decide whether to initiate a Strategy Discussion and the Child Protection process based on an assumption of the outcome. This risks the process becoming more important than the purpose of the meetings and an opportunity for a multi- agency discussion being lost.

- The IRO plays an important part in ensuring plans for children are independently scrutinised, this is particularly important when there is a sudden and unplanned change.

CONSIDERATIONS FOR THE WSCB

- The WSCB should reassure itself that all agencies are aware that anyone of them may request a Strategy Meeting if they have concerns about a child.

- None of the staff at the Practitioner Event were aware of the role and responsibilities of the IRO and members of the LAC meeting defined in the procedures and to be followed when a child returns home. This guidance needs to be shared and embedded in practice.

LEARNING THEME 4 - Domestic Abuse

77. There was another opportunity for a Strategy Discussion, consideration of Section 47 enquiries and the possibility of a Child Protection Conference when, two weeks after Child K returned home from foster care, there was a domestic incident; Ms KM punched Mr KF and broke his nose, the injury required hospital treatment.

78. The assault, which was reported to the police by a family member, led to the police informing Children's Social Care and a home visit being carried out by the Emergency Duty Service (EDS). Child K was observed by the workers during the visit, who noted there were "no concerns about his presentation," they told Ms KM they would pass on the details of the incident to her allocated social worker.

79. At this time, the allocated social worker was still attempting to persuade Ms KM to cooperate with the plan for the assessment agreed after the Care Proceedings, but without success.

80. Two days after the domestic assault the Health Visitor made a previously arranged home visit during which Ms KM implied it had not happened and that the report was made with malicious intent.

81. Health Visiting and Children's Social care were aware that Ms KM had been the victim of domestic abuse in a long-standing previous relationship and allegedly in her current on/off relationship with Child K's father. Despite this history there is little evidence that the impact of Ms KM's experience on her parenting capacity was fully considered and whether, for example, it impacted on her relationship with Child K; for example, there is no evidence that the circumstances of the pregnancy Child K's birth were ever explored with her. Ms KM was signposted to a local domestic abuse service but she didn't take up this option.

82. The police completed a report known as a PPD1 which is used to inform other agencies of the incident and this was sent to Children's Social Care. The PPD1 assessed the risk as "standard," a significant mitigating factor being that the couple were no longer living together, this was despite the fact that the assault had occurred after they had allegedly separated. The police did attempt to contact Mr KF but he "didn't answer his phone" and this was not pursued as the risk wasn't seen as serious enough to warrant follow up.

83. Shortly after this incident Children's Social Care assessment was completed and signed off by a manager and the case closed.

84. In summary, the reasons the assault did not lead to a strategy discussion included:

- The initial visit was made out of hours and Ms KM would not engage in discussion with the EDS;
- The incident was not followed up by Children's Social Care because Ms KM would not see the social worker;

- Mr KF was not spoken to about the incident;
- Children's Social Care assessment did not consider the implications of Ms KM's history of domestic abuse or the context of the assault which took place shortly after Care Proceedings.

85. Also, during the Review practitioners reflected on the question of whether the response to the domestic assault would have been different if it had been Mr KF who had assaulted Ms KM and whether gender issues influenced risk assessment. The conclusion was that it is probable that gender was a factor, and that practitioners were unclear whether Ms KM was a victim or perpetrator of violence.

86. The intention was that following Children's Services closing the case, a CAF would be led by the Health Visitor but the Health Visitor was not aware of this.

LEARNING POINTS:

- It is still less common for a recognised perpetrator of domestic abuse to be female. However it is important to remember that living with domestic abuse is always harmful to children; it is acknowledged as a form of child maltreatment regardless of the gender of the perpetrator.

- When new information comes to light, for example domestic abuse, the significance of the event should be considered in the light of what is already known about the family, the background and the chronology.

- When assessments are signed off by managers, and particularly when a case is to be stepped-down or closed, there needs to be a level of scrutiny which reassures practitioners that their analysis is comprehensive, evidence based and retains a focus on the child.

LEARNING THEME 5 - Hidden Men

87. Mr KF was not spoken to about the domestic assault and throughout this case there is little information, from all the agencies involved with the family, about Mr KF, his relationship with Child K and his role in Child K's care.

88. During the practitioner event, participants suggested that there are some barriers which make engaging with men harder, for example visits routinely made between 9 and 5 when fathers might be at work and computer recording systems which don't include space for information about fathers.

89. Lack of engagement with fathers or significant men is a common theme in Serious Case Reviews, in 2015 the NSPCC published a report called Hidden Men which states:

> *"Men play a very important role in children's lives and have a great influence on the children they care for. Despite this, they can be ignored by professionals who sometimes focus almost exclusively on the quality of care children receive from their mothers / female carers."* [23]

90. Although there may be some practical challenges, in this case there appeared to be a general lack of curiosity about Mr KF, the parent's relationship and especially what this meant for Child K, for example reports refer to "the parents' care" even when they were no longer together.

LEARNING POINTS:

- Practitioners from all agencies should always consider including in reports and assessments clear and discreet information about fathers or significant male figures.

- Recording should include:
  - the nature of parental relationships;
  - the relationship with the child;
  - the part men play in the care of the child;
  - any observations about parenting capacity.

[23] *Hidden Men: Learning from Serious Case Reviews, NSPCC 2015, updated 2018*

SUMMARY

91. Child K was a year old when he died in the summer of 2018. Although, at the time of writing, the cause of his death was not known and may never be clear, he was found to have a number of injuries including bruises, scratches and a fractured skull.

92. Looking back, Child K spent almost half of his life living apart from family, either in hospital or with foster carers, and it is likely that this influenced the nature of his relationships. After his death, it also became known that he had been left alone on the day of his death, for a number of hours, on a particularly hot day.

93. However, this was not the whole story of Child K's life, and to some of the practitioners who knew him, his death came as a huge shock. One worker, who saw Child K shortly before his death, described him as sitting on the floor, playing happily with his mother, looking well. They discussed how well Child K was doing despite his difficult start, and were looking forward to watching him develop in the future.

94. For the practitioners, this highlighted just how challenging it can be to see beyond first impressions and to keep an open mind, to work together and value different professional perspectives, to continually assess, analyse and make sense of complex information. It is vital not to become distracted by procedures and processes and keep the focus on the child at all times.

SUMMARY OF LEARNING

a. A parent who presents as ambivalent about their pregnancy, or who does not seem to be engaging with parenthood provides an opportunity to explore with that parent, their feelings towards the child and any risks that this might pose.

b. Although most practitioners are familiar with the bruising protocol, human factors, for example a tendency to want to believe parents, can distract staff. Adhering to the protocol ensures focus on the child is not lost and ensures the incident is properly assessed, recorded and forms part of the chronology of events.

c. The presence of a number of apparently minor injuries to a baby can be considered sentinel injuries and may be an indication that the child is at risk of harm.

d. Medical evidence is a crucial part of risk assessment, it is important that other agencies are clear about the meaning and significance of medical evidence and seek clarification when necessary.

e. Ensuring health staff are aware of the family history, background and contextual information may influence the medical opinion provided.

f. Focussing on the child's experience, particularly when there are a number of unusual presentations, can help practitioners frame questions and encourage discussion between all the agencies which contribute to assessment of risk.

g. Practitioners should be aware of the role of the Named Professionals and the support and advice they can give in Child Protection cases.

h. By the conclusion of this Review ongoing investigations had found that at least some of the referral information was true and Child K was left alone. Child K's early history also suggested that there were indicators of potential attachment difficulties.

i. In order to form a view about the significance of referral information it is essential that it is considered within the family context, the chronology of events and what is already known; if referral information cannot be substantiated this doesn't mean it's not true and the significance of the information may need to be reviewed again in future assessments.

j. Withdrawal of Care Proceedings is a rare and unusual event and supervision should address the feelings of practitioners in all agencies and how these might impact on their judgement and the risk of over-identifying with parents.

k. Reflective supervision, reviewing the case, looking at the events holistically the background and impact of the separation and asking questions such as "what do

we know about this baby, about his relationship with his parents?" and specifically addressing the question "how concerned are we about the risk of harm" would bring the focus back to the child.

l. It is unhelpful to decide whether to initiate a Strategy Discussion and the Child Protection process based on an assumption of the outcome. This risks the process becoming more important than the purpose of the meetings and an opportunity for a multi- agency discussion being lost.

m. The IRO pays an important part in ensuring plans for children are independently scrutinised, this is particularly important when there is a sudden and unplanned change.

n. It is still less common for a recognised perpetrator of domestic abuse to be female however it is important to remember that living with domestic abuse is always harmful to children; it is acknowledged as a form of child maltreatment regardless of the gender of the perpetrator.

o. When new information comes to light, for example domestic abuse, the significance of the event should be considered in the light of what is already known about the family, the background and the chronology.

p. When assessments are signed off by managers, and particularly when a case is to be stepped-down or closed, there needs to be a level of scrutiny which reassures practitioners that their analysis is comprehensive, evidence based and retains a focus on the child.

q. Practitioners from all agencies should consider including in reports and assessments clear and discreet information about fathers or significant male figures.

r. Recording should include:
    - the nature of parental relationships;
    - the father's relationship with the child;
    - the part the father plays in the care of the child;
    - observations about parenting capacity.

CONSIDERATIONS FOR THE WSCB

1) Discussions from the Practitioner Event suggest that the Early Help assessment process in Wiltshire is not yet embedded. If Early Help is to be effective, all agencies will need to be fully engaged with this assessment and integrated framework for working.

2) Where there are examples of good practice these should be shared as exemplars to assist practitioners in their understanding of the process of Early Help.

3) The updated Bruising and Injury in Non-mobile Babies and Children Protocol is clearer about what action must be taken if a pre-mobile baby has a bruise or injury; however, this case demonstrates that human factors can distract staff. Exploration of these factors with staff will help ensure compliance and all agencies need regular reminding about the importance of following the protocol.

4) The Safeguarding Board should satisfy itself that all agencies are confident to question medical opinion which is provided as part of Section 47 enquiries in a helpful and professional manner and that medical practitioners are open to challenge.

5) Safeguarding Board should reassure itself that all agencies are aware that anyone of them may request a Strategy Meeting if they have concerns about a child.

6) None of the staff at the Practitioner Event were aware of the role and responsibilities of the IRO and members of the LAC meeting defined in the procedures and to be followed when a child returns home. This guidance needs to be shared and embedded in practice.

APPENDIX

MEMBERS OF THE SCR REVIEW GROUP

Wiltshire CCG	Designated Doctor, Chair
Wiltshire Council, Children's Services	Head of Support and Safeguarding
Wiltshire Police	Public Protection Strategic Manager
Wiltshire Council, Children's Services	Head of Service Quality Assurance and Principal Social Worker
Wiltshire CCG	Designated Nurse, Safeguarding Children
Wiltshire Safeguarding Children Board	Quality Assurance Lead