GLOUCESTERSHIRE CHILDREN'S SOCIAL WORK ACADEMY

Serious Case Review (SCR) Briefing

Practice Briefings

Liam

Gloucestershire Safeguarding Children Executive

Liam was one month old when he died unexpectedly; he was born to a mother who was being supported by a range of services due to a 'chaotic' lifestyle. Both he and his half sibling were subject to a child protection plan for neglect. The mother's first child had also been subject to a child protection plan for neglect and emotional harm, at the age of three she became the subject of a Special Guardianship Order.

The SCR Findings

1. Understanding and responding to neglect

All agencies must consider the overall impact of neglect and possible trauma response in the child. Agencies must consider and challenge all marks, injuries and bruises seen on a child as possible evidence of neglect. Agencies must not only consider neglect in terms of whether it is "wilful", but also consider other parental factors as evidence of chronic neglect.

"... when incidents were reported in isolation their consideration and response was based on it being an isolated episode rather than a cumulative chronology over time detailing the number, frequency, type and explanation of these injuries."

2. Pre Birth assessment and planning

Agencies supporting the family should all be involved in completing a robust pre-birth assessment prior to the birth that includes consideration and assessment of family history. This will support and inform decision making regarding the possible level of risk and support required.

3. Recording practice and information management

All agencies must ensure that information in assessments is not simply "copied forward" from previous entries, therefore not reflecting an accurate record of the current circumstances.

Agencies must ensure that referral outcomes and minutes of meetings are present on the agency record. This will support informed decision making and allow timely escalation and challenge. Individual agencies should ensure record keeping and information management systems within their organisations are robust and routinely implemented and that any deficit in the information is addressed by practitioners with appropriate management oversight.

"Record keeping was not of sufficient content or quality to know what was happening for the family, what risks were identified and the rationale for any decisions or actions to be taken ... records were not always clear regarding the work to be undertaken and whether the desired outcomes of assessment and plans had been achieved"

4. Resolving professional disputes and escalation

Appraisal in this SCR confirmed findings already known within the county, from previous reviews, regarding the lack of a culture of respectful professional challenge within individual agencies and within the multi agency arena.

Effective professional challenge and resolving professional disputes continues to be an area of problematic multi-agency practice

Useful links:

1. https://www.gscb.org.uk/media/2095279/escalation-of-professional-concerns-guidance-february-2020-amended.pdf
2. https://www.gscb.org.uk/media/2097927/gloucestershire-revised-loi-guidance-v6-feb-2020.pdf
3. https://www.proceduresonline.com/swcpp/

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5. Professionalism over optimism and professional curiosity

It is commendable that workers were able to establish a relationship-based intervention with Nicole and they all wanted her to do well. However, it can be suggested that this resulted in an overly optimistic view of her ability and motivation to change and to prioritise the needs of Emma, Logan and Liam.

There was a lack of professional curiosity within many key practice episodes with little exploration of Nicole's motivation to change, especially given that she did not hold the same concerns as professionals nor recognise her lifestyle or parenting behaviours over time as problematic.

6. Working with substance misuse and maternal mental health

Agencies must give enough consideration to how mental health issues combined with substance misuse is likely to impact on parenting capacity and whether the threshold for likelihood of significant harm was met.

Practitioners across agencies should be equipped to robustly assess the significance of substance misuse and poor maternal mental health and its impact on parenting capability and put in place an appropriate plan of support and intervention.

This review found that despite the long history of maternal substance misuse and fluctuating maternal mental health there was a lack of professional recognition and response.

7. Provision of safer sleeping advice

Safer sleeping advice is routinely provided by midwives and other health professionals at key points within pregnancy and neonatal care. Where a child is subject to a child protection plan and there are concerns regarding co-sleeping it would be helpful that the advice is tailored to the child's specific circumstances and written as an expectation in the plan.

8. Voice of the child and lived experience

Agencies should ensure that they do not place too much emphasis on self-reporting from parents and carers, rather than a wider assessment of 'a day in the life of' the children according to their age and stage of development.

The voice of the children was not always heard or responded to and while plans made and services provided may have benefitted them, this was not always designed into assessment or delivery plans that were child focussed and that considered all unmet need.

9. Understanding thresholds, Levels of Intervention and Child Protection processes

Agencies reported that they could benefit from improved understanding about the Levels of Intervention document and application of thresholds and there are several examples in this review where the threshold for child protection processes were not correctly applied or not correctly followed at times.

Useful links:

1. https://www.gscb.org.uk/media/2095279/escalation-of-professional-concerns-guidance-february-2020-amended.pdf
2. https://www.gscb.org.uk/media/2097927/gloucestershire-revised-loi-guidance-v6-feb-2020.pdf
3. https://www.proceduresonline.com/swcpp/