



**Serious Case Review
Regarding a child to be known as Child J
Review Report and WSCB Response**

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Introduction

- 1.2.1 The Warwickshire Safeguarding Children Board (WSCB) decided to undertake a Serious Case Review (SCR) in respect of a child to be known as Child J in September 2016. They recognised the potential that lessons could be learned from this case about the way that agencies work together to safeguard children in Warwickshire.
- 1.2.2 Child J was a 7-month-old baby when her mother called an ambulance to say the child had got her leg stuck between the bars of the cot. Mother stated that she had pulled Child J's leg out and it started to swell and went floppy. A transverse fracture was later diagnosed. The medical opinion was that it may have been broken deliberately, or that if accidental the force required to break the leg was excessive. Child J was on a child protection plan at the time and had been living in a mother and baby foster placement with her mother until around 6 weeks before this incident.

2 Methodology

- 2.1.1 The Government guidance Working Together 2015 states that SCRs should be conducted in a way that;
- recognises the complex circumstances in which professionals work together to safeguard children; seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
 - seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
 - is transparent about the way data is collected and analysed; and
 - makes use of relevant research and case evidence to inform the findings.

This review has achieved these objectives.

- 2.1.2 Consideration has been given to whether it is necessary to 'identify improvements in the way that agencies work together for the prevention of death, serious injury or harm to children and to consolidate good practice'. The review has also clearly identified 'what lessons are to be learned both within and between agencies and within what timescale they will be acted on and what is expected to change as a result'.¹
- 2.1.3 It was agreed that the review would consider the professional involvement with Child J and her family from the date that agencies were aware of Mother's pregnancy with Child J in around April 2015 until the completion of the investigation into the injury in April 2016.
- 2.1.4 An independent lead reviewer² was appointed who had access to the key single and multi-agency documents in the case. She met with practitioners involved with the family in reflective sessions where the case was discussed, and where there was a focus on the pre-disposing risks and vulnerabilities³ that were known at the time. This was in order to understand the case and to contemplate what was considered at the time. The agencies that had involvement were asked to reflect on the agency specific learning and their reflections are attached as an appendix to this report.

¹ Working Together To Safeguard Children 2015. Department of Education.

² Nicki Pettitt is entirely independent of the WSCB and its partner agencies.

³ Triennial Analysis of Serious Case Reviews 2016, Sidebotham, Brandon et al, Department of Education.

- 2.1.5 The lead reviewer and a representative from the WSCB visited Child J’s mother at home to discuss the SCR and to ask her to reflect on the work undertaken with her and her child during the timeframe of this review. Her views are included in the analysis of this report. Child J’s mother and father will be informed of the conclusions of the review and the WSCB’s response prior to publication.
- 2.1.6 Drafts of this report have been shared with those involved as well as with the Serious Case Review Group of the WSCB to ensure collaboration and ownership.
- 2.1.7 This report has been written in the anticipation that it will be published in full, and contains only the information that is relevant to the learning established during this review.
- 2.1.8 There were no on-going parallel procedures at the time that this review commenced. Both the criminal investigation and child care proceedings had been completed.

3 The Case

3.1.1 For the purpose of this report, the following family members are relevant:

Family member:	To be called:
Mother of Child J	Mother
Father of Child J	Father
Mother’s partner at the time of the incident	Mother’s Partner
Eldest half sibling of Child J	Sibling 1
Youngest half sibling of Child J	Sibling 2
Mother’s previous partner and father of Sibling 1 and Sibling 2	Mother’s previous partner

3.1.2 The family were well known to agencies in Warwickshire at the time that Mother’s pregnancy with Child J was confirmed. Both Sibling 1 and Sibling 2 had been the subject of care proceedings and were adopted in 2012. This followed 6 years of professional involvement with the family due to concerns about the care of the children. The main issues were:

- significant domestic abuse,
- the children’s father’s drinking and drug misuse,
- limited improvements following professional advice and interventions,
- the inability of the couple to remain separated,
- a number of probable non-accidental injuries which were likely to be due to physical abuse, inappropriate handling of the children by both parents, or the children being harmed during assaults on Mother by their father.

3.1.3 The care proceedings undertaken included psychological assessments of the children and of Mother. Mother’s assessment concluded that her own adverse childhood experiences

had an impact on her ability to parent and that she needed therapy. The children were assessed as being damaged by their experiences, and it was stated that their mother did not have the capacity to care for them due to their complex needs.

- 3.1.4 The community midwife made a timely referral to Children's Social Care when she was informed by pregnant Mother that her two older children had been adopted. Mother was also homeless at this time, having been 'sofa-surfing'. Unborn baby Child J was made the subject of a child protection plan when Mother was 5 months pregnant. The social worker involved requested an updated assessment by the psychologist previously involved in the matter and it was then agreed that Mother and Child J would live in a mother and baby foster placement following the birth. Mother had not received the therapy recommended previously, and this was deemed a priority.
- 3.1.5 Child J and Mother lived in the foster placement until Child J was five and a half months old, when they moved into independent accommodation that Mother had been allocated prior to the baby's birth. The view of the professionals involved was that the placement had been successful and that Mother was able to care for Child J. Mother had both pre-birth and post-birth parenting assessments undertaken by an experienced social worker in the Warwickshire Family Support Practice.
- 3.1.6 Child J's parents split up early in the pregnancy. Mother met her new partner a few months before Child J was born. They maintained that they did not live together during the timeframe of this review. Father had supervised contact after Child J was born and agreed to undertake a parenting assessment. Mother's Partner cooperated with assessments following the couple's stated intention to live together at some point.
- 3.1.7 Mother and Child J had been living independently for 6 weeks when Child J was injured.
- 3.1.8 Child J was brought to hospital by ambulance. A fracture was diagnosed the same day and the on-call paediatric registrar view was that it might be non-accidental. The following day Child J was seen by a consultant paediatrician and a strategy meeting was arranged. At the strategy meeting the view of the consultant paediatrician was shared, which was that it was a spiral fracture and most likely accidental. A week later a different consultant paediatrician reviewed the case, along with a paediatric orthopaedic surgeon. She examined Child J and shared her view that the injury was a transverse fracture and that the injury was more likely to be non-accidental. A second strategy meeting was held 12 days after the first and action was taken to protect Child J.
- 3.1.9 Child J's lived experience up until the injury was one of safe and nurturing care and a positive relationship with her primary carer. Child J was a much-wanted child whose Mother was committed to her. She was meeting all of her developmental milestones and was described as happy and contented by Mother and the professionals involved. Child J undoubtedly had a secure attachment to her Mother, who 'adored' her daughter. She spent the first months of her life in a busy home with her mother and the foster family. She had the security of her Mothers care and attention and the support and experience of the foster carer. She attended the children's centre for fun and stimulating groups. When she returned home with her Mother she would have found life quieter, and may have found her Mother more anxious without the advice and support from a 24 hour carer. Those visiting at

the time had no concerns however about how Mother was coping with Child J in the community. They felt confident that Child J was safe and thriving in her mother’s care.

4 Analysis

4.1.1 To analyse the professional involvements and interventions with the family, consideration has firstly been given to the predisposing vulnerabilities and risks in the case. This is followed by the known preventative and protective actions taken by the family and by the agencies involved at the time.

Child J’s predisposing vulnerabilities:
The principle vulnerability was that Child J was a new born baby who was entirely dependent on the care provided by the adult/s responsible for them. It has been established in previous serious case reviews that the frailty of babies is often underestimated by professionals and parents/carers ⁴ .
Child J was pre-verbal and could not tell professionals about her life-experiences.
During the pregnancy, Mother had initially been on anti-depressants and could be expected to have high cortisol levels throughout ⁵ . This can increase the risk of miscarriage or an early birth.

4.1.2 Child J’s vulnerabilities increased because the adults around her had vulnerabilities of their own.

Mother’s predisposing vulnerabilities at the time of the incident:
Mother was a single parent living with a baby who was teething. A degree of isolation was evident as the property was around 10 miles away from the mother and baby foster placement. Mother also felt vulnerable back in her home town, particularly due to her own and her previous partner’s family being local to her address. Mother stated her perception that the foster placement ended abruptly, which left her feeling less supported than she might have hoped.
Mother had an extremely poor experience of being parented.
The on-going relationships between Mother and her own family were poor and stressful. They were unable to support Mother as a parent.
The loss of Mother’s previous children and the psychological impact on her of this.
Previous experience of domestic abuse, and a concern that Mother may be susceptible to abusive relationships.
Mother had been in a long-term violent relationship which she had not left despite engaging in work such as the Freedom Programme ⁶ .

⁴ The Ofsted report: ‘Ages of concern: learning lessons from serious case reviews’ provides a thematic analysis of 482 serious case reviews that Ofsted evaluated between 1 April 2007 and 31 March 2011.

⁵ Cortisol is a stress hormone which may have an impact on the unborn baby.

⁶ ‘The Freedom Programme is a domestic violence programme which examines the roles played by attitudes and beliefs on the actions of abusive men and the responses of victims and survivors. The aim is to help them to make sense of and understand what has happened to them. The Freedom Programme also describes in detail how children are affected by being exposed to this kind of abuse and very importantly how their lives are improved when the abuse is removed.’ <http://www.freedomprogramme.co.uk/>

Mother had an un-met need / requirement for therapeutic interventions at the time of the pregnancy, which was partially met at the time of the incident.
Mother's previous partner (father of Sibling 1 and 2) was due to be released from prison.
Her history of depression and low self-esteem.
A potentially difficult relationship between Mother and Father, who was inconsistent in his engagement with planned contact with Child J and with parenting assessments.

Father and Mother's Partner's predisposing vulnerabilities:
Little was known about Father's vulnerabilities; however he was often described as angry with professionals and Mother.
Concerns emerged about Mother's Partner's anxiety and mental health.
Mother's Partner disclosed being a victim of domestic abuse in a previous relationship.

4.1.3 It is recognised that the adults predisposing vulnerabilities are likely to be predisposing risks to the child. A number of risks were identified in the reflective meetings with staff.

The other risks in the case:
The likelihood that Mother had caused harm to her previous children (which had been formally stated in a court finding).
Mother's inability to protect her children in the past.
Relatively little was known by partner agencies about either Father or Mother's Partner, despite good efforts to engage and assess both of the significant males in Child J's family. Engaging fathers or male partners has been the subject of focus in a large number of previous serious case reviews ⁷ . Where they are either not engaged or where their role in the family is not understood leaves professionals not knowing to what extent they may be a risk or protective factor within a family.
Child J had gone from living in a foster placement where Mother had 24 hour access to a responsible and knowledgeable carer to living alone with her Mother in the community.
Mother had fairly recently engaged with therapy to confront her own abusive childhood experiences. The psychological assessment undertaken and updated prior to Child J's birth raised issues with Mother's ability to parent; with Mother's unregulated emotions; with some inconsistencies in Mother's responses; and with Mother's ability to present in a socially desirable manner.
Mother had been offered an appointment for counselling prior to her pregnancy with Child J, following the adoption of her older children. She had not attended however and she was discharged from the service.
Father did not consistently cooperate with parenting assessments and work offered to him, and often missed contact with Child J.

⁷ <https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/hidden-men/>

It had not yet been established if Mother had the capacity to change in the long-term or if she could continue to appropriately parent this baby when they were living alone in the community. The assessments that had been undertaken were positive yet acknowledged that risk could not be totally eliminated.

The background information available regarding Mother’s care of Sibling 1 and Sibling 2 included information provided by Mother’s extended family about Mother physically harming the children and from professionals involved at the time who described Mother as ‘rough handling’ the children.

Mother had to move back to her own accommodation, which was in the area where her extended family lives, despite wishing to remain near to the mother and baby foster placement. This was because of housing policy, processes, and practice.

Following the injuries, the first medical opinion diagnosed a spiral fracture⁸ and that it was most likely an accidental injury. This left Child J in a potentially vulnerable situation, having unsupervised contact with her Mother and Mother’s partner in the hospital. It was almost two weeks later that a further strategy meeting was held and another medical opinion was available. The injury was identified as a transverse fracture⁹ and the consultant paediatrician shared their opinion that the bone had either been broken deliberately or ‘the force required to do it would be such that anybody would recognise that this was going to cause harm’.¹⁰

4.1.4 There were strengths and evidence of protective actions from the family when considering the case:

Protective actions – family
Mother alerted the midwife to the previous issues at an early stage. She was thought to be honest and open about the family history.
Mother engaged with everything required by professionals during her pregnancy and afterwards.
Mother agreed to live in a mother and baby foster home and was said to have engaged very well with the opportunities this provided to her and Child J. The foster carer had no concerns.
Mother was assertive with Father and made the decision to cease contact due to his lack of engagement.
Mother stated both at the time and during this review that she knew she had let her older children down and she showed insight into her poor parenting. However she stated to this review that she was not aware of the professional concerns about her rough handling and physical harm of her older children, other than from malicious reports by her family. To her knowledge this had not been part of the risk/parenting assessment in regards to Child J.
Mother’s partner appeared to be committed to the relationship and the baby, undertaking

⁸ A spiral fracture of the bone is generally caused by force along with a twist. The break is helical.

⁹ A fracture where the bone is completely broken in a manner that is perpendicular to the way the bone runs.

¹⁰ From Consultant’s letter.

parenting work, cooperating with the child protection plan and with the on-going mother and baby placement.

Mother was committed to keeping a distance from the members of her wider family who could potentially be a risk to Child J.

Although this was not yet tested, Mother had been clear that she would have no contact with her previous partner on his release from prison.

When Child J was in hospital following her injury, there were nothing but positive reports from nursing staff regarding the care Mother provided to Child J and the relationship between mother and child.

4.1.5 Pathways to prevention and protection ‘revolve around the professional curiosity and robust assessment of the above features to increase understanding of what the pathways to harm may be’. The protective actions by statutory and other agencies were extensive in this case. They were:

Protective actions – agencies

There was early consideration of the pregnancy and timely decision making.

A pre-birth initial child protection conference (ICPC) was held and the decision was made to make Child J the subject of a child protection plan at birth. The decision to have an early conference was good in regards to the obvious need for Mother’s cooperation with any plan to be tested. However the conference was held before access was available to all of the historic information held by Children’s Social Care, as the paper files had been archived. It was within the closed case files that more detailed information about the rough handling and possible physical abuse of the older children by Mother was recorded. When this information is missing from decision making at an ICPC, the assessments and plans that follow can be based on and continue with incomplete or inaccurate information. The issue of access to information is explored later in the report.

Pre-birth and post-birth assessments were undertaken. The social worker involved no longer works in the area but agreed to be interviewed by the lead reviewer by telephone. She shared that the focus of the assessments was Mother’s parenting with consideration of her history of mental health issues and domestically abusive relationships, attachment, and Mother’s general parenting skills. A concern that Mother may physically harm Child J was not stated initially, but she became aware of information about the historic concerns of physical abuse regarding Sibling 1 and 2 during the assessment. There were no specific questions asked or focus on this during the assessment however. There were no indications that Mother may physically harm Child J. With hindsight the assessing social worker believes there was a lot of pressure on Mother to always do the right thing, and that in the heat of the moment when Child J’s leg got caught, Mother probably panicked and did the wrong thing.

A mother and baby foster care placement was provided which was extended to allow Mother to engage with therapy. Mother described a perceived ‘abrupt’ end to the placement due to the foster carers going on holiday however. Learning has been identified regarding this later in the report.

Regular core groups were held and were largely well-attended.
Good communication was evident between the professionals involved. Of particular note was the information shared between the allocated social worker and the assessing social worker, the foster carer and her supervisor, and between the midwives and health visitors in the case, including when the family moved.
There was early involvement of a health visitor, prior to Child J's birth.
Targeted services were provided to Child J and Mother at the local children's centres, including in another local authority area when Child J and her mother lived in the foster placement. Transport was provided when required.
Good support and supervision was provided to the mother and baby foster carer.
Good case recording was evident across agencies.
Specialist parenting assessments were available. They were started in a timely way, and were largely comprehensive.
Children's Social Care agreed a budget for Mother to receive psychological therapy when other options for providing this work had not been successful. There was delay in being able to offer the work however due to the difficulty in finding an appropriate service through the available resources. Mother told this review she had gone 'round in circles'.
The placement and the move home provided Mother with a good balance between support and testing, although Mother told this review that she felt the final move home had been rushed.
Robust strategy meetings were held when the injury was discussed, where the chair pushed the paediatrician who attended the first meeting to be clear about what the likelihood was that the injury was non-accidental.
Swift protective actions were taken to protect Child J after the injuries were identified as likely to be non-accidental. This included supervised contact between Child J and her mother.
The key professionals were consistently involved throughout the period being considered by this review, including the social worker and the CP conference chair. The health professionals changed as Mother and Child J lived in two different geographical areas, but information sharing at the handover was good when Mother and Child J moved.
The work undertaken with Child J and Mother, and with Father and Mother's Partner, was collaborative, both between agencies and with the family. Brandon et al stated in their 2010 review of serious case reviews that there is a 'need for practitioners and managers to be curious, to be sceptical, to think critically and systematically but to act compassionately.' This happened.
All of the professionals involved confirmed that they had received good and challenging supervision and management support in this case. The social worker specifically

<p>considered in her supervision whether Mother's compliance was real or disguised. The Victoria Climbié enquiry¹¹ highlighted that professionals must maintain a 'healthy scepticism' and 'respectful uncertainty' to see beyond what is being presented by parents. This was evident in this case.</p>

<p>No other contextual/capacity issues were identified in the case.</p>

4.1.6 The following areas require further analysis:

The importance of historic information:

- 4.1.7 It was the view of those involved at the time that the risk of any harm coming to Child J in both the short term and in the long term had been identified. It was the aim of the child protection plan to reduce or minimise the risk. To a large extent this was achieved. The plan included the provision of a mother and baby placement and parenting and psychological assessments, which Mother fully cooperated with. There was however a limited understanding regarding Mother's role in the physical abuse suffered by Sibling 1 and Sibling 2. While all of those involved with the family were aware of the previous concerns, they felt that reports of her being rough with the children were largely hearsay evidence from unreliable sources, namely Mother's extended family.
- 4.1.8 On closer inspection there was evidence available within the older children's records, stating that when 10-month-old Sibling 2 was an inpatient in hospital, staff had concerns about Mother's rough handling of him. The information from the hospital and shared with Children's Social Care also stated that Mother was not consistently meeting his needs, was prop feeding him, and did not follow professional advice. The information was recorded in the day to day social work case records of the older siblings, but was not highlighted in the conclusions of an assessment completed in 2010. This means the information was not seen to be as significant as it should have been, as the previous assessment provided most of the information that the concerns for unborn Child J were based on.
- 4.1.9 The concerns identified by the hospital were part of a history where a number of injuries had been seen on the children which were largely unexplained, or reportedly due to them being in the way of a domestic violence incident. Around this time Mother's extended family stated she was physically abusive to the children, but they were felt to be unreliable sources of concerns. In the coming months, Mother refused to separate from the children's father and the children had a number of other small injuries. The children later came into care at their mother's request (S20 accommodation) and care proceedings were started about 6 months later.
- 4.1.10 The lack of a robust investigation at the time of the physical harm to siblings 1 and 2 did not help those involved in 2015 to be clear what the concerns and risks were. The fact that Mother had acknowledged she could not cope with Sibling 1 and Sibling 2, and had initially placed her children into care at her own request, was often stated by Mother to be a protective step. This then became the accepted history, with slightly less emphasis being placed on both her lack of care and protection of the children prior to this, and the evidence of significant harm found by the court during the care proceedings that followed.

¹¹ Laming, Lord (2003) The Victoria Climbié inquiry. Report of an inquiry by Lord Laming. Cm 5730, London: TSO.

4.1.11 When considering why this was the case, it was noted that although respectfully uncertain about her compliance, the professionals involved all came round to thinking she was genuine in wanting to change. Her insight into her previous relationship and the impact on the children was good, and the assessments considered the historic issues as well as her current circumstances. The combination of liking Mother and respecting her commitment to change, and the very negative perception held by professionals of her birth family were likely to have been contributory factors in professionals not adequately recognising the role Mother played in the physical harm of her older children, and the limited assessment of the potential risk of physical harm to Child J. There was also a pattern emerging of not going back to the history, but starting with the current presenting issues.

4.1.12 Those involved in the review had case examples where concerning information was shared by one parent about the other in a way that was seen to be vindictive, after a couple separated, and the information was later found to be true. In one recent case in Warwickshire a complaint made by a non resident father was upheld at Stage 2¹². His child protection referral had been dismissed as malicious because he was clearly being vindictive. However it was later discovered that there were concerns about the mother's life-style, as he had claimed.

Learning: When either current or historical concerns have been reported by others it is important to think separately about whether the information is given in good or bad faith, and whether it might be accurate. It is possible both for good faith information to be inaccurate (mistaken for example) and bad faith information to be partially or completely accurate (for example real concerns reported following a falling out)¹³.

4.1.13 The CP conferences were held on time and included most of the key professionals working with the family, and family members. The conferences, the child protection plans made, and the core group functioning both in meetings and between meetings appear to have been good in this case. The mother and baby placement, the parenting assessments and the therapeutic input with Mother ensured a balance between assessment and interventions. Mother told this review that she felt supported by the interventions such as the parenting assessment because it was thorough and gave her a lot of feedback.

4.1.14 At the CP conference held following Child J's injury, which came after the start of care proceedings, some concern was recorded from the conference chair regarding the previous sharing of information available from the sibling's history, particularly in regard to Mother's role in the physical harm to those children. However the conference chair told this review that it is a difficult decision when deciding whether to delay a conference while waiting for historic information. In her experience there is rarely the capacity to read every case file, and her confidence in the assessment process made it the right decision to go ahead in this case. With hindsight she noted that had there been more information available, Child J may have been placed onto a CP plan under the joint categories of risk of emotional harm and physical harm.

¹² When a Local Authority has been unable to resolve a complaint at Stage 1 the complainant has the right to request their complaint is considered at Stage 2, by an independent investigator.

¹³ Writing Analytical Assessments in Social Work, Chris Dyke. 2016.

4.1.15 The information available to the initial conference was largely a summary of the conclusions of the assessments undertaken during the care proceedings on the older siblings. These focused on the risk posed by Mother and the children's father as a couple. The need to demonstrate that the threshold for significant harm was met for the children led to the conclusions focusing on the risk posed by the more dangerous adult – the children's father. This SCR has established that the assessments undertaken in the previous care proceedings provided an incomplete analysis of the risk posed by Mother, as it wasn't necessary for the purpose of demonstrating that the children had suffered and continued to be at risk of significant harm. This led to a lack of focus on the need to support Mother with physically handling Child J, particularly when she was feeling stressed and isolated.

Learning: A thorough knowledge of the case history is essential; particularly in cases where there has been extensive involvement including care proceedings on previous children and a new baby is expected. Professionals should:

- **Look at previous assessments with a critical eye and identify poor practice in the past, for example where injuries have not been investigated as they would be currently.**
- **Be aware of the purpose of earlier assessments, and therefore the possible limitations of these for the current purpose.**

Responding to injuries:

4.1.16 The initial view that the fracture was a spiral fracture is likely to be due to the interpretation of the x-ray. The trained eye of the Orthopaedic Consultant who saw it later was that the fracture was transverse, not spiral. The X rays are always looked at initially by Emergency Department (ED) staff and then formally reported by an x-ray specialist and reviewed by an Orthopaedic Consultant. The first strategy meeting was held after the x-rays were seen by ED staff.

4.1.17 There were some difficulties in establishing an opinion on the likelihood of the injury being non-accidental at the first strategy meeting. This was because the consultant paediatrician who saw the child in the ED was unable to attend and a middle-grade doctor represented them at the meeting. When challenged on the medical information, the doctor in attendance had no option but to continue stating the consultant's view, i.e. that the injury was likely to have been as Mother stated and an accident. There was an acknowledgement that medical uncertainty exists in cases such as this, but the consultant's opinion was a dominating force in the meeting, despite them not being present. The belief at the time that the injury was a spiral fracture added to the paediatrician's assertions that the injury was most likely to be accidental. Although the paediatrician involved in the later strategy meeting informed this review that they would be inclined to worry about either type of fracture in light of the context of the history given.

4.1.18 The delay in confirming the type of fracture, and the absence of the consultant at the first strategy meeting, delayed the protective and investigative processes from taking place. A further strategy meeting was held two weeks later after another consultant paediatrician had reviewed the case and was clear that the degree of force required to cause the injury (now confirmed as a transverse fracture) was excessive. Care proceedings were then initiated.

4.1.19 WSCB have undertaken two SCRs recently that have led to the identification of systemic issues around how medical advice is used in assessing levels of harm and risk to children. It is rare that medical information provides complete certainty, and those investigating child protection concerns, such as social workers and police officers, need to be given advice that helps them understand the range of possible interpretations, and their likelihoods. A model is being developed where paediatricians are expected to be more explicit about the likelihood that an injury may be non-accidental, indicating that they are satisfied beyond reasonable doubt (the criminal threshold), on the balance of probabilities (the civil threshold used in care proceedings) or that they are unable to rule it out, meaning that immediate protective action may be required and that s.47 enquiries should continue to seek further clarity. Alongside this, a training issue has been identified where paediatricians must be clear about the expectation that they hear information at strategy meetings as well as delivering it.¹⁴

Learning: For strategy meetings to make the right decisions, the appropriate medical/health information must be available. This should include the extent to which non-accidental injury can or cannot be ruled out.

Professional continuity:

4.1.20 There was good practice identified regarding the transfer of information and engagement with the child protection plan when Mother and Child J were living in another local authority area. Although the family centre worker in the other local authority area hadn't seen any of the assessments or background information setting out the reasons why Child J needed a CP plan and a mother and baby placement, even though she was in the core group.

Learning: When new professionals become involved, it is helpful for the Initial Child Protection Conference minutes and the social workers report to be shared with / requested by those joining the core group to ensure they are aware of the concerns that led to the plan being made.

4.1.21 Local services were available for the family despite Child J being on a CP plan in Warwickshire and placed in a Warwickshire placement. Mother spoke positively of the support she received in both areas.

4.1.22 An issue was identified when Mother stated her wish to remain living close to her foster placement however. No housing was available unless Mother was able to arrange her own mutual exchange. The previous threat of domestic abuse was not recent enough to assist in re-housing away from Mother's home town. The social worker reported that she spent a lot of time and energy trying to establish if a house move was possible for Mother and Child J. The limits to the amount of time housing staff have to enable them to be members of a core group meant that there was not one person the social worker or Mother could speak to about the issue. During the reflective session professionals considered that a Skype/video call system would help improve 'attendance' at key meetings for those whose input would be helpful.

¹⁴ The hospital in question undertook an internal review following this incident that identified this learning.

4.1.23 There was also some lack of understanding and sharing of information about which part of the housing service should be involved in the case at later stages. The core group record states that housing officers had sent apologies, however there is no evidence on housing records that invitations were sent to anyone in the housing department.

4.1.24 In regards the housing issue identified in this case, the review considered the possibility of families in these circumstances being treated in the same way that care leavers are, and a question has been identified for consideration by the WSCB in this report.

Learning: There are no specific requirements in housing legislation for flexibility in the provision of housing across Local Authority areas unless the tenant is a care leaver or a recent victim of domestic abuse. However s.27 of the 1989 Children Act¹⁵ sets out a general duty for local authorities and others to co-operate in child protection cases which could be used as the legal framework for requesting, and responding flexibly, to requests to house families in other LA areas.

4.1.25 The engagement with Mother undertaken as part of this review also identified her perception that the placement had ended abruptly. It appears that the support offered from the foster carer following the placement was informal and on a 'if you need me' basis. With the carer going on holiday immediately after the move, there was a gap in the support available to Mother from someone she knew and trusted.

4.1.26 The impact on Child J and Mother of moving from 24 hour support to living alone in the community was significant. It appears that the system does not allow foster carers to formally continue to support families after the end of a placement. This is due to the financial implications and the sufficiency of placements, which are much in demand.

Learning: Consideration should be given to what formalised support is required and available from the previous placement/foster carer in the days and weeks following the move out of a mother and baby foster placement. This should be agreed by and communicated to all parties.

5 Conclusions

5.1.1 As stated in the 2016 Triennial Analysis of SCRs, for many of the children who are the subject of an SCR, 'the harms they suffered occurred not because of, but in spite of, all the work that professionals were doing to support and protect them.' This was true for Child J. There was no doubt that there was a lot of conscientious practice across agencies in this case, and that a great deal of consideration had been given to the decision to allow Mother to care for Child J following the removal of her older children. Child J was thriving in her mother's care, and Mother worked exceptionally well with professionals and in her therapy. Those involved were confident in her ability to safely care for Child J, with on-going support from the team around the child.

¹⁵ Section 27 imposes a duty on other local authorities, local authority housing services and health bodies to cooperate with a local authority in the exercise of that authority's duties under Part 3 of the Act which relate to local authority support for children and families. Where it appears to a local authority that any authority or body mentioned in section 27(3) could, by taking any specified action, help in the exercise of any of their functions under Part 3 of the Act, they may request the help of that other authority or body, specifying the action in question. An authority or body whose help is so requested must comply with the request if it is compatible with their own statutory or other duties and obligations and does not unduly prejudice the discharge of any of their functions.

- 5.1.2 This review acknowledges that there were risks taken in allowing Mother to care for Child J. The risks needed to be balanced with the harm that could be done to the child by removing them. This was evidenced by Child J's reaction to being separated from Mother after the injury. Child J had a positive attachment and Mother showed she had the skills and commitment to care for Child J. Child protection work is about balancing risks, not eliminating them.
- 5.1.3 Despite this balance, Child J was physically harmed while in her Mother's care and was then removed from her which was distressing and difficult for a baby who had such a positive attachment to her Mother. A more thorough appraisal of these risks at the start of the work may have allowed a more proactive and focused approach to working with Mother to explore issues of physical handling, and to enable an appropriate and supportive approach.
- 5.1.4 There had been information available about the role Mother played in the inadequate care of Sibling 1 and Sibling 2, but the case had latterly been predominantly seen by those involved as one where domestic abuse was the main risk and where Mother had a been a victim who had chosen to stay with her partner over continuing to care for the children. The physical risk she posed to the children had not been highlighted as significant when the decisions were being made for Child J, and there had not been a transparent focus on preventing physical harm during the work undertaken with Mother prior to Child J's injuries. If the risk of rough handling and getting cross with the child was better understood the assessments and plans may have been slightly different.

6 Learning and recommendations

- 6.1.1 The main issues that have been identified as learning from this case have been identified within the analysis section above. The WSCB SCR Group, along with the lead reviewer, have considered the learning and have identified questions and recommendations for the WSCB.
- 6.1.2 The Triennial Review states that 'good quality SCRs should incorporate particular characteristics. These include lessons learned which are clearly linked to the findings of the review; findings and questions for the LSCB, to promote deeper reflection on the lessons of the review, and leading to a response and action plan developed by the Board to address that learning; specific recommendations where there is a clear case for change, again with a response and action plan developed by the Board; and a strategy for dissemination and learning of the lessons that will reach relevant practitioners and managers within the Board's constituent agencies'.
- 6.1.3 The questions and recommendations for the WSCB are directly linked to the learning and are:

Learning point 1:

When either current or historical concerns have been reported by others it is important to think separately about whether the information is given in good or bad faith, and whether it might be accurate. It is possible both for good faith information to be inaccurate (mistaken for example) and bad faith information to be partially or completely accurate. (For example real concerns reported following a falling out.)

Question to the WSCB:

How can the WSCB ensure that the processes used to consider allegations and information shared enable professionals to robustly consider both the source and the likely validity of the information?

Learning point 2:

A thorough knowledge of the case history is essential; particularly in cases where there has been extensive involvement including care proceedings on previous children and a new baby is expected. Professionals should:

- Look at previous assessments with a critical eye and identify poor practice in the past, for example where injuries have not been investigated as they would be currently.
- Be aware of the purpose of earlier assessments, and therefore the possible limitations of these for the current purpose.

Recommendation:

WSCB to request that Warwickshire County Council Children's Social Care and Legal Services review their practice at the end of care proceedings to ensure that any issues identified during proceedings, but not used to meet the threshold for significant harm, are clearly noted and available to those involved when a later referral is received.

Learning Point 3:

For strategy meetings to make the right decisions, the appropriate medical/health information must be available. This should include the extent to which non-accidental injury can or cannot be ruled out.

Recommendation:

The WSCB to request that the 3 hospital trusts review their arrangements for ensuring that the appropriate medical/health advice is available to strategy meetings.

Learning Point 4:

When new professionals become involved, it is helpful for the Initial Child Protection Conference minutes and the social workers report to be shared with / requested by those joining the core group to ensure they are aware of the concerns that led to the plan being made.

Recommendation:

The WSCB to request that Warwickshire County Council considers how it can ensure that any new professionals working with a family are made aware of the case history and reasons for decision making.

Learning Point 5:

There are no specific requirements in housing legislation for flexibility in the provision of housing across Local Authority areas unless the tenant is a care leaver or a recent victim of domestic abuse. However s.27 of the 1989 Children Act sets out a general duty for local authorities and others to co-operate in child protection cases which could be used as the legal framework for requesting, and responding flexibly, to requests to house families in other LA areas.

Question to the WSCB:

The WSCB, and the partner agencies that provide housing, to consider their systems and how flexible reciprocal arrangements could be in place to allow families with child protection concerns and housing needs to be able to move to another part of the area, in line with s.27 of the 1989 Children Act .

Learning Point 6:

Consideration should be given to what formalised support is required and available from the previous placement/foster carer in the days and weeks following the move out of a mother and baby foster placement. This should be agreed by and communicated to all parties.

Recommendation:

The WSCB to request assurance from partner agencies about the support that is available, including from the previous placement, to families moving on from a mother and baby foster home.

WSCB response to the Serious Case Review

The case of child J, the seven month old baby who is the subject of this Serious Case Review, is an important case that brings out both positives and negatives in relation to the care the child received, and highlights important lessons for Warwickshire Safeguarding Children Board and its partner agencies. On one level – as demonstrated by the Serious Case Review – child J was a healthy, thriving infant whose lived experience ‘was one of safe and nurturing care and a positive relationship with her primary caregiver’; she experienced both love and commitment from her mother, and the nurturing support of an experienced foster carer; and the professionals who were working with child J and her mother demonstrated a high level of support and diligence in the care they provided.

Nevertheless, in spite of all these positives, child J suffered a serious injury while in the care of her mother, and that injury occurred while she was the subject of a child protection plan designed to keep her safe from harm.

It is from that perspective, and in the context of a long-standing involvement of a range of professionals with the family, that WSCB commissioned this Serious Case Review and welcomes its findings.

The process of undertaking this SCR and the learning arising from it has been an invaluable experience for all involved. The model of ‘Pathways to harm; pathways to protection’ set forth in the recent Triennial Review of Serious Case Reviews¹⁶ and used as the analytic framework for this review has lent itself to a depth of learning that is clearly rooted in the case and has been able to identify pertinent learning for the Board and its partners. As a Board we are extremely grateful to Nicki Pettitt, the lead reviewer, to the members of the review team, to Child J’s mother, and to all those practitioners who contributed to the review.

WSCB fully endorses the six learning points identified in the review and the four specific recommendations arising from these. The Board has discussed the two questions put to it at an extraordinary meeting on 17.5.17. An action plan is being drawn up to progress the learning from this review.

¹⁶ Sidebotham P., Brandon M., et al. (2016) *Pathways to harm, pathways to protection: a triennial analysis of Serious Case Reviews 2011-2014*. DfE RR545. London: Department for Education. ISBN: 978-1-78105-601-1