Briefing Paper - Serious Case Review

ADS14 - Polly

September 2017

This Serious Case Review Briefing is designed to help practitioners and their managers understand the key messages from the review undertaken about Polly. This review should be read in conjunction with the full published SCR and or Executive Summary.

Who should read the Serious Case Review?

Any practitioner and manager whose work brings them into contact with children, young people and their families. The messages are also important for those working in adult services (where service users are parents or carers). The term 'children' includes children and young people up to 18 years of age.

Summary

The case showed how difficult it is for agencies to retain a child-centred focus when the needs of a young parent facing domestic abuse continue to dominate. It also showed the importance of obtaining accurate pre-birth assessments especially around assessing the impact of parental mental health and drug use. Other issues included the requirement for outcome-focused children in need plans, which continually adapt to changing circumstances and for professionals to pay more attention to the role male carers are playing in a child's daily life.

Multi agency working

What the SCR identified was the importance of authoritative practice by all professionals involved. They must take any non-engagement by a parent seriously and rather than feel frustrated by it, recognise the impact this has on the child. Home visits should be carefully planned, with purpose and authority.

Across all agencies, practitioners who were involved with the family were inclined to take what M said at face value. An attitude of professional curiosity requiring practitioners to examine the lived experience of Polly was often missing by all agencies. The needs of M overshadowed the needs of Polly frequently.

The review identified six main findings that can be used to inform safeguarding practice improvements:

Finding 1: The Child Protection Plan did not consider whether the mother (M) should be subject to more detailed assessment to fully explore the implications of her mental health needs and drug use on her capacity to parent. Child protection plans are key to ensuring that all aspects of risk are addressed. The danger is that whilst initial assessments pre-birth may appropriately identify the risks, once a child is born, the everyday needs of the adults become the primary focus of the work in the core group. For Polly, the importance of establishing facts about her mother M's psychological functioning was not embedded in the child

protection plan and the relevance of past history, especially if a parent functions better than expected, as in M's case, was lost.
Finding 2: There was not enough evidence of authoritative professional practice that saw Polly as the primary client and this resulted in a fixed view that attachment and parenting continued to be good enough, as risks increased. A significant number of SCR's have over the years found that professionals had an undue sense of optimism about a case, missed the signs of disguised compliance and focused too much on the parent or carer at the expense of the child. There is a risk that whilst collectively working very hard to support a family, challenging and unacceptable behaviour is not always addressed in a meaningful way which highlights what the consequences will be.
Finding 3: There is lack of understanding by professionals about their role and responsibility when a child is subject to a supervision order that can result in a lesser degree of protection than when a child is the subject of a child protection plan. One of the other most significant practice issues that the review has identified was the impact that the supervision order seemed to have on some of the professionals involved. It would seem that the process once the order was made, became less robust. Professionals reflected that they were actually not as clear of their role in relation to the supervision order, as they were when a child protection plan was in place. An additional issue identified was to ensure that professionals are clear that if concerns about the safety or potential harm to the child begin to escalate, then a supervision order does not prevent a parallel process of child protection investigation taking place.
Finding 4: There was little recognition of the role the boyfriend (B2) and father (BF) were playing in Polly's life. This resulted in a lack of professional assessment of both the benefits and risks they posed both to the mother (M) and Polly. M had a number of male friends or partners. Whilst some of these relationships appeared transitory there was too much reliance on M to self-report them. The NSPCC's document "Hidden Men: Learning From Case Reviews" (2015) highlights the very important role men have in children's lives and 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 the children receive from their mothers. There was never a proper assessment of M's new partner or a recognition of the amount of care he was undertaking for Polly. At the same time the birth father who was also having significantly more contact than professionals realised was not being consulted adequately or being informed about issues relating to Polly's care.
Finding 5: Emergency Department and paediatric staff did not sufficiently consider whether child abuse or neglect was a possibility when Polly presented with medical issues during the last few months of her life. Professionals in paediatric and accident and emergency teams have a vital role to play in the identification of some of the most hidden but severe forms of child abuse and neglect. Medical staff, especially those who are less experienced must be mindful of the potential for abuse to have taken place and not be so focused on medical diagnosis so that other explanations are not sought. The taking of a detailed history and consideration of social circumstances when reaching a conclusion about the cause of a medical presentation is crucial. Missed medical appointments for children on a child protection or children in need plan should no longer be recorded

as DNA (did not attend) but always seen in the context of '*was not brought*', to ensure that parental neglect is considered as a factor.
Finding 6: There was insufficient consideration of the importance of the provision of suitable housing for M and the impact of it on Polly. This review has highlighted the need for robust assessments to be undertaken when considering the provision of housing for vulnerable young mothers. During the review it was identified that the accommodation M lived in from 2012 was not suitable once Polly was born. This was especially so once the provision of support had changed. There was a lack of assessment in relation to the safety and welfare of Polly during this time and none of the issues in relation to why M was eventually evicted were addressed before they were rehoused. There was also an over-optimistic view that rehousing would solve long standing problems, when in fact the problems just moved with the family.

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There was good practice identified especially around multi-agency working and the commitment to stay with the case. Once Polly was born there was appropriate identification of the growing risk of domestic abuse when M's relationship with her then partner became increasingly violent, which culminated in care proceedings and the making of a supervision order. However, once Polly was returned back to M's care and she commenced a new relationship, the indicators that risks to Polly were once again increasing, were not fully recognised and the Children in Need plan did not specify clearly enough what good outcomes for Polly would be, hence there was a delay in taking protective action soon enough.

What can the DSCB offer to support?

The report can be found on DSCB website and we recommend that you read it in full.

Visit our website www.derbyshirescb.com for more information and to access the Derbyshire multi agency child protection procedures.

The issues highlighted in this review are not unique to Derbyshire. The references listed below are recommended as essential reading for those providing services to children and their families:

Sidebottom P, Brandon M & Co (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case review 2011 to 2014 DfE.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf

NSPCC (2016) Lessons from SCRs, https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/

NSPCC (2015) Hidden Men: Learning from Case Reviews, https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/hidden-men/