CYSUR 1 2021

Concise Child Practice Review

1 Circumstances Resulting in the Review

This is a tragic case which culminated in an unprovoked and violent attack on a young child ("child A") by her mother's partner ("Male B") on 16th July 2020. An ambulance was called to the home the following morning, reporting child A had fallen down the stairs. She was taken to hospital, and clinicians raised concerns about the explanation posed in relation to the injuries. Child A sadly died on 21st July 2020. Her mother was convicted for causing or allowing her child's death, and her partner convicted of murder. The sentencing judge commented that child A's death was the culmination of several months of physical abuse by Male B, and that the mother had prioritised her relationship with Male B over concerns for child A.

2 Background of Family and Male B

Child A and her mother were previously known to the police and children's services due to referrals regarding domestic abuse (concerning multiple previous partners). The first official record of the mother's connection to Male B is in a police report dated 19 June 2020; child A's mother had not disclosed the presence of Male B, or her child's injuries, to professionals. Male B had been open to the community drug and alcohol team within the Local Authority; he had a diagnosis of ADHD and reported to also have Asperger's. Children's services had been involved with his child from a previous relationship in 2014 following concerns regarding his drug misuse and domestic abuse. Male B had been known to Police since 2019 due to domestic incidents between him and his mother.

3 The Assessment Process

It was identified towards the end of the review process that the assessment on the system had not been undertaken by the named social worker, but had been inputted and closed by the team manager when the social worker was on sick leave, as a result of significant service pressures. As such, the assessment was deemed to be of poor quality with several pieces of critical information missing. Key learning has been identified around the need to promote and facilitate safe practice in how assessments are undertaken, recorded and quality assured. Learning was also identified around the need to ensure internal processes for requesting additional staff and resources are clear and understood corporately across all relevant departments.

4 Information Sharing and Professional Curiosity

Information sharing was identified as a key theme across agencies, particularly when concerns fall below the threshold of significant harm. The review highlighted the need for processes to be in place to enable the exchange of key information between agencies prior to a formal strategy meeting.

Missed opportunities were also identified in respect of the health visitor's engagement with the family, which highlighted the importance of rigour, persistence and professional curiosity being exercised by practitioners when access to the home is denied.

5 Identified Good Practice

- Mother was referred by the Health Visitor to the perinatal mental health team for low mood
- The health visitor conducted a visit to discuss a recent domestic incident in person, and thereafter made a referral for a Flying Start nursery placement, which was accepted
- Adult social services completed detailed records regarding Male B, which set out the steps taken and assistance offered, particularly within the community drug and alcohol team
- Joined-up thinking was evidenced between the community drug and alcohol team and housing to support Male B
- There was significant contact with Male B's mother, who provided him with emotional and practical support when she felt able

6 Improving Systems and Practice

- Clear guidance is needed for heads of service when requesting funding, alongside strong links with the council corporate centre
- Training and supervision for assessments to be reviewed, and an audit to be undertaken on current practice in this area
- A policy to be developed regarding sick leave management and case management, to include staff support
- A rapid review template to be developed for serious incidents
- High-quality training and guidance to be made widely available in respect of MARF completion and thresholds
- Consideration to be given to mechanisms which facilitate collaborative decision-making below the threshold of significant harm

7 Improving Systems and Practice

- Agencies to ensure the availability of high-quality training and policies in respect of information sharing, including sharing between practitioners and with non-resident parents
- Information sharing between compulsory education and early years settings to be explored locally alongside national work
- Multi-agency training and managerial support must be robust to support practitioners working with parents and carers who are difficult to engage, and for complex cases
- Police to explore implementation of a flagging mechanism to denote addresses with a wider history of safeguarding concerns
- Importance of being specific when referring to individuals in records to be emphasised via supervision