Case Overview

This short briefing summarises the findings and lessons from a Serious Case Review (SCR) into the death of Child D (Jamie).

The briefing focusses mainly on the lessons agencies can learn from this case. It also encourages you to reflect, think and learn, and take forward actions for service improvement.

A Serious Case Review takes place “where abuse of a child is known or suspected; and either –
(i) the child has died; or
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child”.

There may be additional recommendations for your agency and your role. Please ask your manager or contact your representative on the Kent Safeguarding Children Board to find out more.

You can read the full report at www.KSCB.org.uk

Child D’s Story

Jamie was the youngest of eight siblings, seven of whom were under 11 and lived in the same, overcrowded home. Initially this was with Jamie’s Mother and Father, but in August 2015, shortly before Jamie was born, Mother and Father separated, and Mother started a new relationship.

This was a large family of young children living in cramped conditions. The children sustained unexplained injuries, thought to be from lack of supervision or because of unaddressed safety risks. These injuries were not always attended to appropriately. Although there were appropriate questions as to whether such injuries may have resulted from physical abuse, this was not substantiated; they were seen to probably arise from neglect of supervision or caused by the children themselves. Health or developmental needs, health appointments or immunisations were not attended to. The children were, at times, unkempt, dirty, inappropriately or poorly dressed, smelly and had untreated head-lice; these were denied by the parents, or claims were made that they had been attended to, when they had not been.

There were concerns about domestic abuse (initiated by both parents). Its emotional impact on the children was denied, despite evidence that the children were aware of it and upset by it. There were also suggestions of alcohol or drug use, including alleged dealing, these were also denied.

Mother’s engagement and cooperation with agencies was minimal. Father avoided attempts to involve him in work on improving parenting, although he did at times care for the children. The monitoring of the concerns noted the lack of progress and were stepped up to consider court action to safeguard the children in the spring of 2015 when Mother was pregnant with Jamie. There were questions about Mother’s ability to sustain changes; at times she seemed to be compliant and at
times she was thought to lie. Towards the end of 2015, the Core Group noted good progress against the Plan, however, it did not properly review the need to plan for the assessment of the involvement of the Lodger or the Mother’s Partner. The latter was being seen as being a positive influence. SCS ended the court action given the improvements noted by the Core Group, which agreed with this decision.

From September 2015, Mother’s Partner and a Lodger were resident in the home, although Mother initially denied this. During this period there was also disclosure by one of the children about possible inappropriate sexual behaviour between the children, although this was not followed up.

Following the commencement of relationship with the new Partner, agencies noted some improvements in the children’s school attendance and care, sufficient for SCS to cease the pre-court proceedings, in the autumn. However, the Partner was not assessed as a carer/parent, although he was frequently involved in the children’s care and at times, had sole care of some of them. The Lodger’s full history was not fully explored.

In December, it was noted that Jamie’s youngest sibling, a toddler, had an increasing number of bruises and there were still questions about the adequacy of the supervision of the children. At a Child Protection Review Conference in February 2016, it was agreed that all the children, except this sibling, should cease to be subject of Child Protection Plans and should be stepped-down to Children in Need, based on perceived improvements in the children’s care. The single sibling was maintained on a Child Protection Plan because of continued concern about the unexplained minor injuries.

In April, the serious, non-accidental and fatal injury to Jamie occurred and his older siblings were taken by court order into interim care. The post-mortem revealed Jamie had suffered significant injuries in at least five different events over a ten-week period up to his death. The cause of death was ascertained to be as a result of a serious head injury caused by shaking. The majority of injuries were assessed by expert pathologists and a specialist paediatrician to have occurred in the few days prior to the fatal shaking or at the same time.

The Police investigated Jamie’s death. As a result, both Jamie’s Mother and her Partner were convicted of causing or allowing the death of a child and possession of a class B drug (amphetamine). They were sentenced to eight years and thirteen and a half years imprisonment, respectively.

### Theme 1 – Working with Neglectful Families

**Findings:**
- This was a big family with several children with different needs, and at-times, a volatile parental relationship and later, the addition of new, unassessed adults
- Workers did not recognise that they were working with ‘disguised compliance’ and the long-term neglect was not addressed
- There was not enough challenge and scepticism about Mother’s capacity to change and sustain change. She was challenged and made occasional improvements, but these were often short-lived and appeared more as reluctant compliance than insight-based change based in realising the impact of the neglect and domestic violence on the children

**Lessons to be learned:**
- The need for the continuing assessment of the parents’ capacity to change and sustain
change in cases of chronic neglect

- The adequacy of a child’s physical home circumstances is an important factor in neglect and this must be fully considered within a safeguarding assessment
- Ensuring that holistic assessments of children who have experienced long-term neglect, include emotional neglect and insecure or disorganised attachment
- The need to keep an open mind in neglectful families of the possibility that any injuries may not be as a result of neglect or caused by children themselves, but may result from physical abuse or mishandling by adults, especially for babies and toddlers

Reflective Question(s)

- How do you assess the parent’s capacity (and willingness) to change?
- How do you ensure that any changes made are sustained?
- What do you, as part of your ongoing assessment of neglectful families, consider to be the causes of physical injuries to young children?

Theme 2 – Responding to new adults and that regularly visit the home

Findings:

- Mother’s wish to conceal the relationship with the man who would become like a step-father to the children, meant it was initially difficult to establish who he was and what his role was. Mother agreed that he would not be left alone with the children, but there was evidence that he was and that he very quickly played quite a big role in their care, and certainly did in the latter months of the pregnancy with Jamie
- The Partner was an unknown quantity and should have been joined to the pre-birth parenting assessment being undertaken for unborn Jamie and the ongoing child protection reviews for the older children. There was no separate assessment of his intellectual capacity, his personal motivation or his views about entering a relationship with Mother and ostensibly taking on a role of caring for seven children. His presence was accepted
- No assessment was undertaken of the Lodger or of the prior relationship between Mother and Lodger, or Lodger and Mother’s Partner; explanations were taken at face value. The Lodger was known to be a strong and intimidating woman; her influence or possible control over Mother was not considered. No direct work was done with the Lodger

Lessons to be learned:

- The importance of undertaking full assessments of all new adults in the household, regardless of their standing of ‘Parental Responsibility’
- The importance of engaging Parents and other adults, especially new adults who join households where children are already subject to safeguarding concerns
- Importance of maintaining a dynamic Genogram to reflect relationship changes.

Reflective Question(s)

- How do you identify new adults who have a significant involvement with children within families?
- How do you engage with these adults in the household and how do you assess them to establish their relationships and role within the family?
# Theme 3 – Children’s attendance at appointments

**Findings:**
- It was evident in this case that the children ‘Did Not Attend’ (DNA) a number of health appointments
- The missing of appointments was not fully considered as part of the longer-term neglect picture

**Lessons to be learned:**
- The need to understand the implications for children missing health appointments / assessments or specialist services assessments as ‘Did Not Attends’ and how this term puts the focus on the child as opposed to the parent / carer
- Where a child is not attending appointments, the term Did Not Attend does not reflect the reality of the actual circumstances. ‘Was not brought’ to appointments better describes the position
  - This 2 minute video asks you to re-think ‘did not attend’ notifications. (Shared with permissions of Nottinghamshire LSCB) [https://vimeo.com/196256529](https://vimeo.com/196256529)

**Reflective Question(s)**
- How do you follow up children who are not brought to appointments?
- At what point would you consider this to be ‘neglectful’?

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# Theme 4 – Working together

**Findings:**
- The case was time-consuming and required a high number of visits and co-ordination. There was no overall planning of the contacts from different agencies to the family, this meant that sometimes, Mother had or was being asked to have several contacts in one day or week.

**Lessons to be learned:**
- The need to develop confidence in multi-agency staff to undertake appropriate interdisciplinary challenge and escalation
- Recognising how the term ‘single agency assessments’ might exclude other partners from contributing to the assessment process
- There needs to be greater coordination of agency working for visits and contacts

**Reflective Question(s)**
- If you are aware of other agencies working with a family, how might you consider a more joined up approach to joint contacts and visits?
- Do you feel confident in professionally challenging partner agencies? If not, what do you do when there are professional disagreements?
## Theme 5 – Working with children where the Parents have additional needs

### Findings:
- Within the history of this family, there were known incidences of domestic abuse, with both Mother and Father as victims and perpetrators. Some of the incidents of domestic abuse appear to have alcohol and drug use as a significant dynamic within them.
- At times, the children spoke out to draw attention to what was happening to them and at times they appeared to communicate through acting out.
- It is not clear how much thought was given to Mother’s own history of attachments and negative relationships to know whether her own inherent attachment-style was disorganised.

### Lessons to be learned:
- When working with adults who may be domestically abusive, there is a need to confront the reality of the impact on children of living in a violent world
- Understanding how to work with drug and alcohol using parents, including where the level of use does not evidence dependency
- The importance of focussing on the child’s experience and life, including their emotional experience

### Reflective Question(s)
- How do you ensure that you keep the child in focus when working with adults with their own needs?
- How do you assess adults whose substance use is not deemed to be a dependency?
- How do you identify key aspects of parents’ histories that may impact on how they parent their children?