



SERIOUS CASE REVIEWS

CHILD H

Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children. These processes should be transparent, with findings of reviews shared publicly.

<https://www.cambslscb.co.uk/serious-case-reviews/scr-published-by-cambs-lscb/>

LEARNING

“THINK SIBLING”

WORKING IN PARTNERSHIP WITH FAMILIES

NEED TO CLARIFY STATUS AND OUTCOME OF PROFESSIONAL CONVERSATIONS

THE USE OF VERBAL AGREEMENTS

RECOMMENDATIONS

Recommendation 1

The LSCB's expectations regarding working in partnership with families are reinforced and that agencies are compliant with the LSCB procedures when sharing information.

Recommendation 2

Cafcass to consider how its work on supporting staff to distinguish between coercive and situational couple violence can include consideration of:

- a) the different treatment options
- b) how safe and beneficial contact can be achieved when the child's age means that indirect contact can not be meaningful.

Recommendation 3

LSCB ensures that partners understand the mechanisms of ‘What If’ discussions and checks compliance with the actions agreed

Recommendation 4

CSC consider their procedures in regard to verbal agreement and define their expectations regarding good practice in their use.

Recommendation 5

Education settings review their recording processes and ensure there are not parallel systems which impact on the effectiveness of seeing an holistic picture of the child and their family

Recommendation 6

The LSCB considers how to ensure that the message “Think Sibling” is disseminated.

SERIOUS CASE REVIEW: Child H LESSONS LEARNT

The conclusion of this review is that there is no evidence that the death of H could have been predicted and that the professionals who came in to contact with her and her family could not have anticipated, and therefore prevented, the tragic outcome.

There was nothing in Mother's Boyfriend's antecedents or known behaviours that indicated that he would perpetrate the level of violence that killed H. He had had a troubled childhood and adolescence but it was not exceptional. Many other young people have similar backgrounds but do not commit such violent acts.

Professionals were alert to the changes in the family once he became involved with them and were in the process of acquiring a fuller understanding of his role in the family and its impact on the children's lives when H died. There was nothing to indicate to those professionals that the usual time scales for assessment needed to be accelerated.

Some actions, such as CSC amending their recording guidelines and the GP practice instituting multi-disciplinary team meeting to discuss families "at risk", have already been taken by agencies as a result of the lessons learned from this case.

The Practitioner Event identified other lessons learnt from undertaking the review and which assumed significance from the inter-agency feedback the event allowed, for example, how the ripple effect of agencies concentrating on individuals contributed to the "invisibility" of H.

This reflects the concept that some of the "best learning from serious case reviews may come from the process of carrying out the review" (Brandon et al 2012).



The importance of all professionals considering the whole family system - and to “Think Sibling” - in their work is a key lesson from this case. Where there are concerns for one child in a family, practitioners need to think about whether they give rise to concerns for the other children, in particular for pre-school children who have the potential to be less visible to the professional network. Recording systems can mitigate against seeing the family holistically and this can be further impacted on if there are parallel systems within a single agency.

Unless by doing so, children will be put at further risk of significant harm, agencies need to share their concerns with parents and tell them if a referral to CSC is to be made. CSC need to ensure that their system ensures confirmation with the referrer that the family are aware that the referral is being made and that they behave in a respectful way and communicate their intention to visit the family at home.

The review has identified the need to clarify when there is an apparent misunderstanding about agreed actions following “What If” conversations and in general, the need for agencies to clarify the status and agreed outcomes of conversations

in the context of sharing information and concerns about children.

The use of verbal agreements and whether they serve a useful function is key learning point identified by this review. Verbal agreements are even less enforceable than written agreements and, by their very nature difficult to ensure are consistently understood by the parties and are open to misinterpretation. If they are to be used, it is important that they are proportionate to the family's identified needs; are shared with other people in the family's network; and are reviewed in a timely way and do not run the risk of unintended consequences.

CONCLUSIONS

- FAMILY'S SITUATION WAS NOT UNUSUAL
- PROFESSIONALS WORK WITH MANY FAMILIES WHERE THERE ARE CONCERNS ABOUT THE EFFECT OF A NEW PARTNER
- H'S DEATH WAS NOT PREDICTABLE
- LOW PROBABILITY EVENTS DO OCCUR