

SUMMARY OF FINDINGS

The conclusion of this review is that Child K died from an overwhelming infection which he may have succumbed to regardless of the care he had received. However the underlying dehydration and malnutrition that the post mortem revealed contributed to his vulnerability to, and lack of resilience to recover from, the infection. Professionals, as well as his Mother had had concerns about his weight and nutrition during the last six months of his life.

RECOMMENDATIONS

Recommendation 1: Cambridgeshire Community Services NHS Trust review and then re-launch the Health Visitors' weighing protocol.

Recommendation 2: Arrangements should be reviewed to ensure that there is sufficient streamlining between with Early Help, Early Support and CSC services so that plans can seamlessly transfer between the various MOSI levels

Recommendation 3: The LSCB should assure itself that the role of lead professional in Early Support arrangements is clearly defined, understood and supported

Recommendation 4: CSC ensure that the changed remit of the Disabled Children's Service is embedded and that the system for sharing their specialist knowledge to support social workers across CSC is defined and understood.

Recommendation 5: The CSC reviews the current systems for the provision of legal advice.

Recommendation 6: LSCB assures itself that it can be confident that it has robust data about the safeguarding of disabled children

Recommendation 7: LSCB reviews the training provided on neglect and disability to assure itself that it provides sufficient focus on identifying risk when a child has a chronic health condition and that all relevant staff have received recent training.



SERIOUS CASE REVIEWS

Child K

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.

<http://www.cambridgeshire.gov.uk/lscb/reviews>

SERIOUS CASE REVIEW: CHILD K.

This SCR is about a two year old boy with severe disabilities who died from an overwhelming infection in the context of longer term failure to thrive and lack of nourishment. He had been made subject to a child protection plan shortly before his death. His primary carer at the time of his death received a caution for cruelty.

The SCR found that whilst the infection was not preventable the underlying malnutrition and dehydration might have been. The child lived in a home where a vulnerable young mother was having to meet the complex, unremitting and highly demanding needs of a very disabled child. In the context of ensuring the medical and care needs of the child were being met the professionals involved did not always retain an effective focus on the risk he was facing.

Alongside the identification of some good practice, the SCR makes a number of recommendations to support increased consistency and clarity in the management of risk to children with severe disabilities.

While some of the professionals involved were sympathetic to Mother's situation, it is not clear that they were sufficiently curious about her history and life experiences and therefore did not recognise the significance of her vulnerabilities and the consequent impact on her care of the children. The support that was provided to her was focussed on her compliance with professional advice. There was not sufficient focus on risk. Risk is more difficult to identify when it has a chronic component and when practitioners are seeing the child regularly there is a risk of them becoming desensitised to it. A recent study into neglect has also identified that practitioners become de-sensitised to children's difficulties through habituation when undertaking medium- to long-term work (Farmer and Lutman 2012). Risk from neglect is also more difficult to identify and focus on when there is ambiguity about how much the child's disability is a factor.



LESSONS LEARNT

The review has considered whether Child K's situation should have prompted a response under s47 sooner than it did. The conclusion is that it is not the designation that counts - child protection 'rarely comes labelled as such' (Laming 2009) - but it is the action and intervention that matters. Decision making must be based on an assessment of cumulative risk and harm as well as need. CSC's responses to referrals need to take account of the repetition of previous concerns and the cumulative impact on the children. Child protection processes and CSC involvement of themselves do not protect children. In addition the right people need to be involved .

Whilst CSC have the ultimate responsibility for the assessment of risk and ensuring safeguarding the expertise and knowledge of health professionals was needed to inform the multi-agency assessment of risk. Professionals need to take responsibility for addressing concerns through their own safeguarding systems and escalate their concerns if they feel that they are not being responded to appropriately.

The lives of children with disabilities and their families are complicated enough as it is. Systems that are there to support them need to

be transparent and easily accessed and understood as possible. Despite individual practitioners' best efforts there was not a seamless transfer of plans

of how Child K's and the family's needs were to be met between CSC and Early Support. The specialist knowledge of the social workers in the Disabled Children's Service could have provided a clearer understanding of the risks Child K was exposed to but despite the redesign of the Disabled Children's Service, and Child K clearly meeting the threshold for allocation to their services, their involvement with him was limited and the system for co-working and offering support to mainstream services was not effective.

The review identified learning about the need for professionals to be clear about the purpose of letters they send and of their expectations of the recipients, especially when copying others in. Similarly, agencies need to have robust systems for the receipt and consideration of the content of letters sent. Another learning point relating to communication practice was identified in relation to the need to make a record of conversations and advice given when a professional is contacted outside working hours.