Lancashire Safeguarding Children Board Learning Brief: For Practitioners

Child KG Serious Case Review – September 2016

Lancashire LSCB has recently completed a Serious Case Review (SCR) about a child under the age of ten known as Child KG.

Child KG had experienced a very happy, stimulating childhood and had a stable family life up until the first incident, when a parent tried to kill them and had planned to kill themselves afterwards. Seven months later, the parent again tried to kill Child KG and again had planned suicide afterwards. Child KG survived both of these incidents and did not suffer any life threatening physical injuries.

The review found that the first incident was sudden and could not have been predicted or prevented. However, during the seven months prior to the second event, risk factors were present (most significantly, the parent's continued unstable mental health, self-harm and suicide attempts) that might have alerted professionals to the potential risk of the second event. The second event in 2015 was considered to be potentially both predictable and preventable.

The key themes in the review were: the management of parental mental ill health; the child being seen as protective factor for the parent; professional bias as a risk factor; and practice issues related to following standard processes correctly. These are discussed in more detail below.

Mental Health
The professionals who worked with the parent concentrated on managing the parent's mental health, but did not connect this to risks to the child. For example, when the parent expressed suicidal thoughts, these were not seen as potentially dangerous to the child even though this was the context of the first attempted murder.
The expert Psychiatric Consultant advising the panel said that **"if professionals do not know what risk a mental health patient poses to those around them then it should be assumed that the risk is always high."**

Child as a protective factor
The child was seen as a positive factor in supporting the parent's mental health (a protective factor), but no assessment was made as to the potential impact and risk to the child of having contact with the parent. The fact that this parent's mental health was likely to make them a significant risk to the child was not sufficiently considered. Contact was seen in the best interest of the parent, but it was not assessed from the child's perspective.

Professional Bias as a risk factor
This case has identified that professional bias may have contributed to the ineffective management of the case during the multiagency child protection /child in need interventions. For example, the difference in approach between adult focussed and child focussed staff suggests that adult focussed staff did not see themselves as responsible for safeguarding children. Similarly, child focussed staff were not fully aware of the potential dangers presented by this parent, and also allowed their perception of the family as professional people themselves to influence the way they implemented child protection systems. Multiagency

professionals did not challenge the decision to work the case under the child in need framework rather than under child protection proceedings.

Key Learning Points from the Review

The review highlighted areas of learning for practitioners. These are as follows:

1. Every professional should understand the importance of screening for domestic abuse disclosure when working with adults with mental health issues and be able to manage the risk.

2. If working with anyone with suicidal thoughts or you are undertaking a mental health consultation, clarity should be ascertained as to whether they have actual plans for suicide and/ or they have experienced thoughts about harm to others. If appropriate, a risk assessment should be completed.
   If you do not have the expertise, find someone who does to consult with!

3. If a child is being affected as a result of the family being under stress and there is no improvement, you should always consider a CAF.

4. Make sure that you stay objective and use the proper systems and processes regardless of a family's social standing or profession.

5. Beware of relying on written agreements with families! A piece of paper alone cannot secure a child's safety - ever.

6. Where children need a child protection medical examination ensure this is completed by appropriately qualified paediatrician.

7. Beware of the risk of missing information if you do not invite all the relevant professionals to strategy discussions or meetings.

8. Where cases involve mental health issues make sure you understand potential risks to others. If you don't know the risk, the default is to assume it is 'high' until proven otherwise.

9. Make sure that your risk management plan is clear so everyone understands what is supposed to happen - including the families. SMART plans are a good start.

10. Make sure you get supervision to check your thinking and plans. This is important for everyone but this case highlighted the issue for inexperienced staff in particular.

11. Specialist adult mental health and the child protection staff must both prioritise the safety of the child and should have joint safeguarding plans for the child.

NB: Please see the 'learning brief for agencies' for key agency learning identified.

Finding Out More about Serious Case Reviews:

Lancashire Safeguarding Children Board continues to run Briefing Sessions about the findings from Serious Case Reviews and they are updated on a regular basis. There will be more about the learning from Serious Case Reviews completed in Lancashire and helpful practical advice to take back into your practice. Check the LSCB website for upcoming dates and for copies of future SCR briefings.

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