Lancashire Safeguarding Children Board Learning Brief: For Organisations

Child KG Serious Case Review – September 2016

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

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

Critical reflection on the information prior to the first event highlighted there were no indicators of significant dangers. The event was sudden and could not have been predicted or prevented. However, during the intervening seven months prior to the second incident, many risk factors were highlighted (most significantly, the parent's continued poor mental health and suicide/self-harm attempts) that should have alerted professionals to the potential risk of a repeat incident being high. There were also issues in relation to partnership working, the completion of risk assessments and information was not effectively compiled, shared or used to manage risk. The second incident in 2015 was potentially predictable and preventable.

The key themes in the review were: mental health; child 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 the parent's mental health, but did not sufficiently connect this to the 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 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 positive for 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 dangerous to the child was not considered. Contact was seen in the best interest of the parent, but it was not assessed from the child's perspective.

Professional Bias & Practice Issues
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 Constabulary agreed to cancel a child protection

medical examination with a paediatrician (Children's Social Care was informed) as Child KG's parent would not provide consent. Child KG's parent preferred the GP to undertake the assessment in an attempt to minimise distress to their child and there were no physical signs of harm requiring hospital attendance. Child protection procedures were not followed in cancelling this paediatric medical appointment.

The review identified that the approach was possibly influenced by perceptions and assumptions regarding the parents' social class, professional status, high academic qualifications and the attitude of Child KG's parent towards them. This was not challenged. It is critical that robust supervision and challenge is embedded into practice to avoid professional biases impacting on practice and provides the opportunity for reflective practice.

Key Learning Points from the Review

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

1. The parent provided different perspectives of their mental state & self-harm to different GPs, followed by concerns expressed by close family members which included requests for specialist intervention. None of this triggered any action; consultation with specialists was available and may have supported the management of this case.
   Learning Point Identified: Consultation with Specialist Mental Health Services should be made available for all cases that are not improving and consultation should not only be available for cases categorised as high risk.

2. Child KG's parent had completed a patient health questionnaire (PHQ9), a self-assessment to detect depression, the score was high and identified self-harming thoughts. The self-assessment was not consistent with information shared in the counselling sessions. It was not reviewed or followed up within general practice which may have resulted in further exploration of risk.
   Learning Point Identified: PHQ9 self- assessment forms should always be reviewed or followed up within the General Practice. This should be shared with primary care services across Lancashire.

3. The consideration/ instigation of the CAF was not in professionals' mindset despite the stress this family was under whilst balancing the needs of Child KG whilst his parent's mental health showed no improvement prior to the first event.
   Learning Point Identified: There should always be consideration of the instigation of the CAF in these situations and the rationale for decision documented.

4. This case has identified that professional biases may have contributed to the ineffective management of the case during the multiagency child protection /child in need interventions. This learning point is discussed under the section 'professional bias & practice issues' which starts on page 1.

5. This case demonstrates potential inconsistency in practice at the point of a child protection referral with some referrers being advised to duplicate their referral to the Constabulary and Children's Social Care.
   Learning Point Identified: Multi-agency safeguarding procedures must be followed and do not advise that practitioners duplicate their referrals.

6. The Constabulary were not provided with an understandable expert opinion (mental health services) regarding Child KG's mother's fitness to be interviewed despite repeated requests this contributed to a delay in the criminal proceedings.

Learning Point Identified: Specialist Mental Health Services should offer expertise to the Constabulary in criminal investigations to ensure the mentally ill service user is able to be interviewed at the earliest point without compromising their health status.

7. This child did not have a child protection medical examination by an appropriately qualified Paediatrician despite the life threatening assault and this is not expected practice. This learning point is discussed under the section 'professional bias & practice issues' which starts on page 1.

8. The review found case management oversight through effective, reflective safeguarding supervision was not sufficiently robust leaving an inexperienced front line practitioner isolated in practice when making key safeguarding decisions. Child KG's parent had made a number of emotional abuse disclosures* to mental health and social care practitioners that did not trigger a domestic abuse assessment, referral to specialist services or contribute to care planning. The focus of attention was on the clinical management of Child KG's parent's mental health rather than a holistic perspective of contributing factors and risks to Child KG.

Learning Point Identified: all agencies should review the effectiveness of their learning opportunities and strengthen the opportunities to interrogate professional belief systems in respect of domestic abuse within supervision and safeguarding practice.

9. Specialist adult mental health and the child protection services should have been able to unify practice effectively to manage the risk jointly for Child KG and their parent.

i. A Psychologist assessed child KG's parent and a report was written providing clear predictors of risk yet its content was either not known or not understood by some multi-agency professionals.
ii. The management of bail conditions and contact arrangements between Child KG and his parent were unclear and confused.
iii. Partnership meetings were not as effective as they could have been resulting in limitations of multiagency involvement, silo working and poor information sharing leading to ineffective assessment and management of risk.

Learning Point Identified:

i. In future practice risk predictors identified during a psychologist's assessment in respect of mentally ill adults, involved in child safeguarding proceedings, should always be shared in a meaningful form with multi-agency partners and families.
ii. The Lancashire Constabulary have made recommendations regarding the management of bail conditions as a result of this case.
iii. When adult Mental Health Services and Children's Social Care are jointly involved in complex cases consideration should be given to the feasibility of a single process to combine the functions of both the care planning approach meeting and the child in need meeting to more effectively share, assess and manage the information.

10. The availability of psychological trauma services for Child KG post the initial incident was uncertain leading to some confusion for the family and professionals. This will be fed into the review of the CAMHS service specification.

* The review did not seek to make a finding on the disclosures of emotional abuse but understand how multi-agency practitioners managed the disclosures

Good Practice

Child KG's parent and teachers report that Child KG responded positively to the wishes and feelings work provided by the family support worker, employed by Children's Social Care. They have commended this work saying how much Child KG looked forward to these sessions. It was further noted within the review that this was a useful way of hearing the 'voice of the child'.

Multi-Agency Recommendations:

Following a serious case review the LSCB are provided with recommendations to implement and undertake work with partner agencies to improve practice. The recommendations for the LSCB as a result of the child KG SCR are as follows:

The LSCB should;

1. Be assured that the content of single and multiagency learning, supervision and development opportunities strengthens professionals understanding of the negative impacts of professional biases and beliefs in safeguarding practice.
2. Review its current procedures to strengthen the understanding around the child as a protective factor, risk of filicide, and harm to others when mentally ill adults have child care responsibilities. Awareness raising of the issue should be increased within the workforce.
3. Be assured that partner agencies have responded to the relevant learning points contained within the overview report.

N.B. there are single agency action plans to address all the learning points identified within this briefing and the briefing for practitioners along with the multi-agency recommendations above. If you require more detail about this please contact your agency safeguarding lead in the first instance.

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 newsletters.

Contact the LSCB:

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