7 Minute Briefing Child Practice Review: N40 - **Historical Child Practice Review**

The scope of the Review was from August 2013 – 27th August 2016.

7. Learning Learning Opportunity

a) Assessment Skills Observation of parenting should be a central part of assessing and working with families.

b) Reporting concerns. Staff who witness children being assaulted must immediately report this to the Local Authority and police.

c) Strategy meetings should be considered when there are multiple separate child protection issues in a short period of time

d) Review Case Conferences. Police should attend review child protection conference when there is an active child protection police investigation

e) Care and Support Plans
Ensure a single plan covers all areas of concerns, actions, what matters to the family/ young person, safety and actions. Any changes and reviews of the plan should be multiagency and include the family and all necessary professionals.

1. Background

The child subject to this Review was the fourth child to mother and father, referred to as child D
The children's mother and father had a history of mental health issues.

This Review was commissioned following a referral from Probation Services identifying Child D had suffered two separate fractures while in the mother's care in Summer 2016 which were considered to be non-accidental in nature. Having been victim to these injuries child D was removed from mother's care and placed in foster care. Child C now resides with father and children A and B reside with extended family and are subject to Care Orders

Child A, B and C were subject to child protection from the Summer 2014 under the categories of neglect. Child D's name was put on the child protection register at birth under the category of physical abuse. At this time child C lived with father.

Key Learning Themes

Communication and Information Sharing

- Confusion about confidentiality, specifically in respect of both parents' mental ill health and treatment. As a result the impact of both parents' mental ill health on their parenting was not fully considered by the LA SPOC initially.
- Health visiting notes were not routinely shared each time this family moved and concerns were not shared fully as a result..
- GP records were not used to form part of consideration by health visitors when meeting with the family and reviewing support. This meant the impact in respect of parents' mental ill health on their ability to parent was not fully considered.
- Mother was not in agreement with the birth plan for Child D. No formal meeting was held to review this even though the LA were in PLO.
- There were a number of incidents of the older siblings having sustained various injuries. A number of these had not been reported by school staff as mother's explanations were accepted. Therefore, the extent of these injuries were not fully considered by the Local Authority as they did not have the full information.

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Perceptions of Parenting

Intervention with mother was in respect of her struggling to manage children's behaviour and her own parenting ability. There was however, very little observation of mother actually parenting, playing and managing the children.

It was highlighted that no practitioners spent any time observing mother with the children during visits to understand how she was caring, playing and responding to them. It was clear that any observations that were done were only recorded when there were concerns.

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Postnatal Depression

All mothers should have a postnatal depression assessment/ scoring. However, during the pregnancy and post birth of Child D there was no evidence that mother was ever considered as suffering from post-natal depression.

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Child Protection

Health professionals during an attempted home visit found one of the children home alone but did not immediately contact the police or social services

Within the timeline at the end of March 2015, the managers of both the fostering and the locality team became aware of concerns that the kinship carers (at this point a kinship assessment was being undertaken), may have been smacking the older siblings in their care. These concerns were not addressed immediately and there was about a month period before they met with the kinship carers to discuss these concerns.

The child protection plans were not circulated to the core group, did not reflect the worries, actions or clear outcomes.

In early 2015 there were two separate safeguarding concerns in a short space of time, whilst the children were on the CP register and PLO, there were ongoing concerns about the welfare of child A and B and mother was pregnant with child D . One was a scratch mark to child A's neck which mother stated was caused by paternal grandmother, and was later deemed as a NAI by medical staff and the second was an incident where school staff witnessed mother kicking child B in the thigh.

There was a delay in school reporting this information to the local authority and by the point the referral was made the local authority child B had left the school and gone home.

Better planning and information sharing between all key agencies could have been achieved through a contemporaneous Strategy Meetings. Instead ,this was dealt with at the review conference, which the police did not attend (thought there was on going CP investigation).

Neglect of Neglect

The home circumstances in respect of day to day life for the older siblings hadn't got any worse or any better which led to stasis. Concerns in neglect cases don't have to get worse to mean that the impact on the children is increasing, rather the continuation of being neglected in itself can increase the harm to a child's welfare/wellbeing.

mother's interaction with the children was of concern at times, this included how she spoke to them and managed their behaviour. However, this did not lead social workers to question what impact her care could have on all of her children, including Child D.

The child protection plan created a narrative where practitioners may have been more focused on the older siblings' behaviour and not on how they were being parented by mother. Child D returned home despite practitioners identifying that it was at that time not appropriate for the siblings to be in mother's care due to her parenting.