Adam Serious Case Review

Welcome to this briefing to help practitioners and their managers whose work brings them into contact with children/young people and their families, understand the key messages from this Serious Case Review (SCR). Particularly staff within children's centre staff, childminders and those providing contact and supervision of parenting. This SCR was undertaken in 2016 but due to criminal proceedings could not be published until those proceedings were finished. This Briefing was however disseminated to all agencies in November 2017 but did not identify the subject of the SCR. The SCR recognised that the contribution of these frontline workers in cases like this is critical to the safety and welfare of children who are in the care system.

Why was the SCR carried out?

Adam was removed from his mother's care and placed with his father, but then he sustained a serious injury which led to them being placed in care. This SCR considered whether there is a pattern of over-emphasis on the rights to a family life that may be leaving children and young people at risk'.

What are the main areas for practice learning and improvement?

Previous local and national SCRs and this one highlight the importance of maintaining child-centred practice, with a focus on the child and their daily lived experiences. Although there were some exceptions, for example in the observations of the Independent Reviewing Officer (IRO), the child's needs were seen to be of secondary importance. Where assessments of parents/parenting are being undertaken, it is necessary to understand and report on the behaviour of infants/pre-verbal children in interacting with their carers. The assessment by the Independent Social Worker was an exemplar of good practice in this respect.

The decision to place Adam with his father was complicated. There was drift and delay in proceedings, leading to somewhat superficial and rushed assessments. Information regarding father's involvement in previous child protection and domestic abuse incidents was not shared as widely as it should have been. There was a lack of balance in reflecting both risk and protective factors.

The placement of Adam with his father did not go unchallenged. The risks to Adam arose because of the quality of assessment of father and his support network, and in the timely and comprehensive provision of information regarding threshold [for proceedings] to the Court. Supervision and management oversight were, at times, lacking or ineffectual.

Two days prior to Adam's emergency admission to hospital, he was seen to have bruising to his face and a turned-in eye (which had not been noted previously). This was a very concerning presentation. The SCR identified that practitioners did not follow the local procedure on the how to respond to bruises, bites and suspicious/unexplained marks in children.

Finally, there was evidence of a culture of silo-working and tensions in professional relationships, due in part to a perceived hierarchy. The SCR found that those providing universal and specialist services to Adam and his family did not always appreciate the input, or utilise the expertise, of each other.

What areas of good practice have been identified in the case review?

The SCR found evidence that the Bedford Borough Council's Children Services improvement plan is making a difference to some of the issues identified in Adam's care. Improvements seen in the attendance and contribution at Child Protection Conferences timeliness of reports and distribution of minutes.

There is some evidence of improvement in inter-agency working. Nevertheless, there could be room for improvement in the conduct of strategy discussions, which should be face to face, where possible, and reflect the statutory guidance, that:

'A local authority social worker and their manager, health professionals and a police representative should, as a minimum, be involved in the strategy discussion. Other professionals will depend on the nature of the individual case'

(HM Government, 2015:37

You need to know

This SCR highlighted the importance of maintaining child-centred practice, with a focus on the child and their daily lived experiences. Behavioural observation is a vital mechanism for the assessment of pre-verbal children. Good practice was evident in this case, but was not consistent throughout the proceedings, which need to reflect the best interests of the child at all times.

The safe placement of Adam who could not be with his mother was central to this SCR. The decision to place him with his father was complicated by concerns from the parenting assessments, as well as historical information regarding the father's involvement in previous child protection and domestic abuse incidents.

There was some evidence of a culture of silo-working and tensions in professional relationships due in part to a perceived hierarchy.

Sharing the message that escalation and management of concerns is a sign of a well-functioning system, not a failure in professional practice, is critical.

The quality assurance of child protection/legal proceedings now includes expectations of attendance, purpose of meeting and the timeliness of reports and distribution of minutes. ICPCs are held on the same day each week and this aids the planning of attendance (e.g. by the police).

A Bruising Protocol for Immobile Babies and Children is now a 'stand-alone' chapter of the child protection procedures.

Voice of the child

Child-centred approach, focussing on the baby's daily lived experience. If they can't talk then assess/observe the following:

- their bond with their parents/carers;
- how they're dressed;
- their demeanour and behaviour;
- where they are positioned (for example, is the parent keeping them close by or are they being left in another room?);
- experiences of older siblings and any comments they may make about how the baby is being cared for.

Look beyond a baby's basic care needs and consider their emotional, psychological and/or therapeutic needs.

Consider whether parents/carers need to be supervised when spending time with their baby, for example if one parent has a history of violence.

Where can I find out more about good practice in the care of infants who cannot be with their birth mother?

Practitioners will find the following guidance useful: Wilkins W, Farmer, E. (2019) *Reunification: an evidence informed framework for return home practice* London: NSPCC. **https://learning.nspcc.org.uk/research-resources/2015/reunification-practice-framework/**

HM Government (2018) *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*. **http://www.workingtogetheronline.co.uk/chapters/contents.html**

National Collaborating Centre for Women's and Children's Health (2009) *When to Suspect Child Maltreatment*. London: RCOG Press.
NSPCC (2015) *Returning children home from care: learning from case reviews Summary of risk factors and learning for improved practice for reunification* **https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/returning-children-home-from-care/**

Pan Bedfordshire Interagency Child Protection Procedures or
https://bedfordscb.proceduresonline.com/index.htm