7 - minute Learning Summary

Serious Case Review – Grace and Georgina

Case Summary

Georgina was brought to hospital in February 2018 by Ms G. Georgina was 10 months old and severely infected with Chicken Pox. A chest x-ray showed a healing rib fracture, further fractures were identified, all the injuries were suspected to be non-accidental.

The review period for this Serious Case Review begins in January 2013 and ends in February 2018. In January 2013 Ms G was 15 years old and living with her mother and stepfather. Ms G's lived experience was one punctuated with frequent domestic abuse incidences between family members.

Ms G was in a violent relationship when she was 15 and her partner was 19 years old. In 2013 she became pregnant with Grace. Ms G was physically harmed by her stepfather during her pregnancy, she was treated in hospital and a referral was made to Children Social Care (CSC). CSC began working with Ms G as a Child in Need (CIN). Mr G, Grace's father committed a serious assault on Ms G and was given a custodial sentence. Ms G applied for a Non-Molestation order. A safety plan was put in place stipulating no contact between Grace and her father without a Social Worker being present. Following his sentence Grace's father was understood to be living in Wales.

In March 2014 a Pre-Birth Conference was initiated regarding Grace (unborn) as Grace's father was due to be released from prison. A Multi Agency Risk Assessment Conference (MARAC) was also held in relation to the risks posed by Grace's father. Grace remained on the Child Protection plan until March 2015. Supported by the Health Visitor, Ms G attended a series of courses on parental mental health, victims of domestic abuse and parenting. In March 2015 Ms G was offered her own accommodation and the case was closed. This was due to Ms G seeking the Non-Molestation order and proactively seeking courses re domestic abuse and parenting. This was later discovered to be disguised compliance, with only partial attendance.

In August 2015, Ms G, reported that Grace's father had visited the family home to see his daughter before moving to Wales. He was arrested for breaching the Non-Molestation order. Grace's father disclosed to the Social Worker he had been living with the family since his release from prison 1 year earlier. In July 2016, Ms G reported that she was pregnant with Georgina and that the father was not interested. During the same period, CSC received an anonymous referral relating to Grace being hurt, verbally abused and poorly supervised by Ms G.

Despite this information in the January 2017 Pre-birth Child Protection Plan for Georgina, a greater proportion of the risks were attributed to the dangers from Grace's father, than to mother's parenting. In Sept 2017 the CP Plan was stepped down to a CIN plan. During the 3-month period before the case was closed at the end of 2017, issues of concern had been recorded by the nursery (voluntary organisation) and the GP, however, were not shared with CSC. There was also no risk assessment conducted by the Welsh Probation Services despite having knowledge that he had a partner and child.

Care proceedings were initiated, protective action was taken. Fact finding attributed the cause of the injuries to Ms G. Both parents had adverse childhood experiences. As a child Ms G was subject to a CIN Plan when living with her mother and stepfather. She had a diagnosis of ADHD and partial deafness with a GP referral to CAMHs. Grace's father's medical records showed a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and mental health problems.

Recommendations from the SCR

1. That Wandsworth Safeguarding Children Partnership (WSCP) share this review with the Cwm Taf Morgannwg Safeguarding Children board in order for any relevant actions to be considered.
2. The WSCP to consider the most effective means of promoting and supporting professionals' practice skills and knowledge across the multi-agency partnership when working with parents whose capacity or willingness to make changes for their children is under question, or who appear to be resistant to change. This should include ensuring that practice remains child and outcome focused.
3. WSCP to consider developing a programme to raise awareness and to refresh understanding of the risk to infants of physical abuse for children at all levels of intervention.
4. WSCP consider the degree to which the reality that children can be harmed in different ways and by more than one perpetrator is understood within the multiagency partnership and what actions can be taken to develop best practice.
5. WSCP review the way that the category of Emotional Abuse is used for children subject to Child Protection Plans.

What did we learn ……..

Education, training and research

In the care proceedings following the injuries to Georgina it became apparent that there was a diagnosis of ADHD for both parents in their early childhood. Mother was also deaf and father had mental health issues.

Wandsworth Safeguarding Children Partnership (WSCP) will ensure that training and learning events will encompass

- Education, early screening and an understanding of the impact of neurodevelopmental disorders on parenting capacity.
- Impact of domestic abuse on parenting capacity, research on the impact of DA on victims will also need to be explored and potential vulnerabilities when conducting parenting capacity assessments. (Social Care Training)
- Complexity of assessing risk when one parent is also a victim and the importance of measuring progress and impact.
- LfE to explore relevance of including family history in the assessment and planning process and the importance of chronologies and case analysis in management of risk.

Probation Checks

The checks that should have been completed regarding Mr G were not conducted. Mr G was discharged from prison and no contact was made with Wandsworth Children's Social Care. Despite Ms G and the children's situation being known there was no liaison between Cwm Taf Morgannwg and Wandsworth Probation Services.

Supervision of Mr G by the Community Rehabilitation Company fell significantly below the expected standards. There were long periods without any contact with his Offender Manager with no resulting enforcement of the order; significant gaps in the records; no evidence of any direct work with Mr G about the nature of his offending; no risk assessment when Mr G committed a further alcohol related offence or in the context of Mr G having a partner who was pregnant; and no liaison with other agencies.

An initial Offender Assessment System (OASY')S assessment was undertaken and assessed him as low risk to children and a medium risk to his current or previous partner. However, there is no evidence from the record of how that risk was being managed.

Multi-agency

Training is required for multi agency practitioners that will draw on their professional curiosity when assessing parents with adverse childhood experiences. Practitioners need to hold multiple possibilities in mind. Hypothesis may be right, challenged or changed, however more importantly, they need to be critically reflected on.

Multi agency response and work to support the step down process needs to be improved. In particular, understanding and application of thresholds, quality of information sharing and communication between multi agency partners, including the voluntary sector who provided child care.

The review highlighted how disguised compliance/ engagement may have influenced:

Children's Social Care

Children's Social Care decision making re stepping down was greatly influenced by the reported attendance on parenting and domestic abuse courses by Ms G. The case was stepped down without knowledge of the how this impacted on the outcomes of the care provided to the children.

Health Visiting

The Health visitors and the GP decision making when acting as the lead professionals. If there had been regular liaison between the GP and HV about the impact and outcome of Ms G's attendance to courses and how the course outcomes impacted on the care of the children the case may not have been closed or stepped down with only Health visiting services involved as the lead service.

General Practitioners

On two occasions the GP did not escalate any concerns when Georgina was presented with bruises.

The children had previously been on Child Protection and Child in Need plans therefore professional curiosity should have made the GP ask for further information.

Vulnerability of parents

The vulnerability of the victim parent in domestic abuse and what this might mean for the care of the children, was not sufficiently explored.

The multi-agency partnership has noted this is a complex issue which needs to be reflected on in depth to consider what training and development would lead to practice improvement.

To inform any expected changes in behavior and practice we need a fuller exploration and understanding of the impact of adverse childhood experiences on parenting capacity.