7 minute briefing
Child Z Serious Case Review (SCR)
November 2021

GREENWICH
Safeguarding Children
PARTNERSHIP

Background

Child Z was born at 24 weeks with extremely low birth weight and respiratory distress. Child Z had significant health and developmental problems.

Child Z lived with two siblings, Ms A (mother) and Mr B (father). She was the 10th of 11 children born to Ms A and Mr B's 4th child.

Child Z was dependent on two complementary forms of feeding, which increased her vulnerability. Ms A and Mr B were taught how to safely administer feeds. Hospital staff were largely unaware how mentally unwell Ms A was.

Child Z was awarded a substantial care package to help with overnight feeds, which was not accepted, as Ms A did not want carers in the house overnight.

Children's Social Care (CSC) were involved with Ms A's older children. Concerns about capacity to parent, mental health, overuse of prescribed medication and historically substance misuse. Mr B was assessed as a Protective Factor.

What happened

Child Z died at home in April 2018, aged 2 years and four months; neglect was believed to be a contributory factor.

Referrals were made to CSC; mostly about neglect. Two Initial Child Protection Conferences (ICPC) took place (July 2017 & Jan 2018). At the second ICPC the majority agreed to no CP Plan; the Chair overturned this.

The parents made a complaint and access to the children / home became limited. March 2018 Child Z was stepped down from a CP Plan. **Two weeks later Child Z died.** The paramedics and police who attended, indicated the home was in a neglectful state, unsuitable for any of the children.

In Oct / Nov 2021 both parents were convicted of Neglect and sentenced by the Criminal court. They were not given a custodial sentence to prevent their two other children from experiencing any further trauma.

Further reading

GSCP and SAB See the adult see the child guidance www.stastcgreenwich.org.uk.

Myth of indivisible men - Safeguarding children under 1

GSCP Learning and Development Programme

Findings

Children's voices not heard above their parents'. Mental health Services paid little attention to safeguarding of the children.

Professionals did not recognise the link between mental health and parenting.

Professional Curiosity, i.e., understand what being a mum meant to Ms A.

Across all agencies there was poor use of history and a lack of analysis.

Lack of knowledge about neglect.

Lack of descriptive language reduced effective communication, i.e. when describing a situation or individual's presentation.

Information sharing about the outcomes of complaints made by the parents, caused challenges within multi-agency working.

Recommendations and Actions

Guidance on seeking & recording children's views.

Awareness training re mental health diagnoses.

Staff to be sighted on neglect through training, assessment tools and guidance.

Review systems and processes for complex cases.

Ensure relevant information and outcomes from complaints is shared with partner agencies when children are subject of CP plans.

All agencies to hold a summary of historical information on record.

Maternity services ensure pregnant women with a diagnosis, receive services to meet their and their unborn child's needs. Refusal of a service must be considered from the view of the unborn child.

Revise escalation policies to include guidance on dispute resolution.

Key Learning

Lack of a **multi-agency approach** meant opportunities to develop trusting relationships with professionals, who would be involved long term, were missed. **Relationships** are key to delivering effective interventions.

Over reliance on self-report, means that information can be missed and that support is not provided by the most appropriate service.

Professionals 'felt sorry' for Ms A and Mr B, as a result excused neglect of Child C and D's health needs.

Professionals were mindful not to discriminate against Ms A because she had mental health issues.

Rejection of Child Z's care package was seen as parental choice rather than neglectful or putting the children at risk.

Key Learning continued

The timing of the referral for additional support was significant. Ms A and Mr B viewed this referral as a criticism, rather than necessary support for Child Z's health needs.

Non-attendance at appointments was excused owing to the parent's health and capacity, with insufficient thought to the impact on the children.

The couple's history and previous experience of Children's Services had created trust issues.

Insufficient focus on the children and over reliance on Mr B to keep them all safe. There is little evidence that professionals included Mr B in assessments.