The SCR Concluded

Whilst it would be very challenging to state with any conviction that Child T's death was either predictable or preventable, there were certainly numerous missed opportunities when interventions should have been more rigorous and incisive on clear occasions when there were concerns about his safety at home. Additionally there were some occasions when initiatives were not taken to assess the levels of risk to the child when there was a procedural requirement to have done so.

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HIGHLIGHTING LESSONS LEARNED FROM CHILD T SERIOUS CASE REVIEW

SYNOPSIS

Child T, a five year old boy, died tragically in 2011 as a result of an incident at home. He and his eight year old sister moved to Peterborough with their mother in July 2009. Mother's new partner moved in with them in early 2010.

Although the mother and her partner said the incident that subsequently led to his death was an accident, the post-mortem identified that the injuries were likely to have been caused by blunt trauma to the head and abdomen. As a result Child T's death became a murder enquiry and both the mother and her partner were arrested as part of those enquiries and charged as follows:
Mother's partner—murder and three counts of causing cruelty
Mother: - causing or allowing the death of a child and three counts of causing cruelty.

Whilst neither child had been subject to a child protection plan here in Peterborough or the previous location, some concerns had arisen when Child T had sustained injuries that had required hospital treatment. Mother's partner had been convicted of offences related to domestic violence in a previous relationship and was subject to a court order to attend a domestic violence treatment programme with the local Probation Trust at the time of living with the mother and her children. He was also known to be violent to the mother on at least one occasion whilst they lived together.

LESSONS LEARNED

Lessons that apply to all agencies

1. If concerns about domestic abuse are not consistently viewed as child protection issues, then this will inevitably mean that children are not protected from either emotional or physical harm.

2. To make assumptions about actions or decisions of other professionals, without checking these out or seeking evidence to support them, is dangerous to child protection practice which could leave children unprotected,

3. When inter-agency responses to child protection concerns become confused or tense , then to revert back to clarification of the formal child protection procedures, or to seek intervention from managers and clarify that roles have not become confused, could be useful ways to help restore harmony and objectivity to the process.

4. There were four Strategy Meetings/discussions held as part of the management of this case and whilst some were useful and helped to direct appropriate initial actions others appeared confused in terms of their purpose and timings, with inconsistency about minutes being produced. There was some confusion about whether one of the meetings was a Strategy Meeting or a Discharge Planning meeting at the time that the subject was in hospital with a broken leg. The need to ensure that Strategy Meetings meet procedural requirements was the subject of a recommendation for an earlier SCR in Peterborough and so this was a reminder that work to improve these processes still remained.

What are the practice implications for me?

1. Direct work with children, particularly when undertaken with them on their own can be a most effective tool in terms of assessment of risk. However, professionals need to be cautious about using this in isolation or give it prominence in the support of the analysis of risk without it being balanced by a broader analysis of family functioning.

2. To focus on concerns or incidents in isolation and not make use of background information or consideration of patterns of previous care or other incidents will mean that any assessment of risk to a child will be significantly compromised.

3. The failure to involve male partners or significant males in respect of interventions with a family will seriously compromise the quality of any assessments undertaken In terms of the recognition of any possible risks to the safety of the children in the same household and the degree to which planned future interventions will be effective.

4. It is rare for there to be certainty about whether injuries to a child have been the result of abuse or not, especially in the first few days of the injury occurring. Any inconclusive medical opinion which nevertheless raises child protection concerns. needs to be considered alongside wider urgent assessment of the family’s circumstances rather that expecting medical opinion to always provide a clear lead in respect of what professional interventions need to take place.