Implications for Practice

- All agencies must use the escalation policy and ensure that their concerns are properly recorded
- When threshold is met, Initial Child Protection Conferences must be held without delay and risk discussed thoroughly with the involvement of all
  partners
- All plans including CLA plans must be reviewed following a relevant change in circumstances and the impact of this change on risk considered
- Assessments must be based on information available from all partners involved and the outcomes and recommendations shared with these partners following completion
- All care options must be considered and contingency planning undertaken and a full understanding of risk considered based on thorough assessments.
- Any bruising on non-mobile babies must be dealt with in accordance with the policy
- All agencies should consider disguised compliance when working with families.

Peterborough Safeguarding Children Board

An overview report is available to download from the Peterborough Safeguarding Children Board website alternatively contact

PSCB@peterborough.gov.uk

Keeping Children Safe Together

Peterborough Safeguarding Children Board

Highlighting lessons from

Serious Case Reviews

Child J

Outline

The case involved the abuse and neglect of a 5 month old child by his father.

The child's parents were both known to a number of universal and specialist services throughout their lives. They were "*not below the radar of services*".

Mother had 2 previous children removed due to her capacity to care for them. She was also known to have a learning disability and a significant hearing impairment.

Child J was born in June 2013 and removed at birth and placed into foster care.

Father put himself forward as a suitable carer for J and a number of assessments were undertaken.

In October 2013 the court placed Child J with his father on a full-time basis. This was supported by a package of visits and interventions.

J had sustained a number of non-accidental injuries

Father had been the victim of physical abuse as a child. He had some special needs, suffered from ADHD, depression and suicidal thoughts. He left home at 16 and spent time sleeping rough and in hostels. He had a number of minor convictions for burglary and drunken disorder.

The parents met when both were residents in the same supported hostel accommodation.

Within a month of Child J residing with his father — J had sustained a number of non-accidental injuries.

Child J was removed from his fathers care in November 2013 and returned to his original foster carers.

Father was subsequently charged with neglect and received a community sentence.

Learning from the Review

- It is considered good practice that Child J was placed with foster carers who had looked after his half-siblings
- It is considered good practice that the midwifery service challenged the hospital discharge plan
- It is considered good practice that the GPs fully undressed Child J and as a consequence observed additional injuries
- There was "**a premature intention to place Child J with his father on a permanent basis and the role of optimism**". Plans were predicated on an insufficient understanding of risk and a tendency to be over optimistic. There appears to be no point at which a reflection was taken of all that was known.
- **"Lack of compliance with procedures"**

  There were a number of instances where Child Protection procedures were not followed including failure to follow the Bruising in Pre-mobile Babies procedure.
- **"Disguised Compliance"**

  Professionals should always be alert to the possibility that families will appear compliant with plans but in fact be avoiding doing so
- **"Holistic Assessments"**

  There was an unacceptable evaluation of risk. This resulted in the information being placed before the court to enable them to decide where J should live was incomplete.
- **"Information Sharing"**

  Information appears to have been confined to communication between Children Social Care, The Guardian and Support Services