# Briefing in a minute

## Child J Serious Case Review

July 2016

A Serious Case Review (SCR) is undertaken when a child dies or is seriously injured and abuse or neglect are suspected (Working Together 2015).

Newcastle Safeguarding Children Board (NSCB) initiated a SCR in May 2014 following the unexpected death of J when she was 15 weeks old. She and her siblings had been subjects of Child Protection Plans for neglect for five months. An initial post-mortem concluded that her death was caused by a head injury. Further tests confirmed that this was likely to have been as a result of shaking.

J's mother and her partner were convicted of causing or allowing J's death in December 2015 and given custodial sentences.

NSCB published the full review report and its response on the 13th June 2016; these documents are available on its website https://www.nscb.org.uk/Serious%20Case%20Review

### Findings from the SCR

The Review Team agreed 12 Findings: 9 for Children's Social Care (CSC); 3 for health and 1 for police and the courts:

- 1 - Practitioner Tools: chronologies
- 4 - Management Systems: invites to conferences; administration of core groups; bail conditions and checks; medical diagnosis of types of injury
- 1 - Human Bias: prioritisation neglect cases
- 2 - Response to Incidents: – child death review process; response to open cases in CSC
- 1 - Long Term Work with Families: the current system encouraging more superficial Child and Family Assessments
- 3 – Communication and Collaboration: Contracts of expectations; definition of family; attendance at Child Protection Conferences

## Learning from the SCR:

- Risk in neglect cases is not always obvious until symptoms become more serious therefore requires the system to be more vigilant
  Neglect can also be [mistakenly] perceived as more benign than other forms of abuse and judged as less of a priority
- There is a tension between the need for practitioners to be ultra-alert to neglect and the constant demands placed on their time and attention by other cases
- Practitioner vigilance is also affected by the way in which routine tools of the trade [computer systems etc.] are set up or relate to each other
- Families who have inhabited the system for decades/generations are evidence that the 'system' designed to support them to overcome difficulties has not worked well enough. They are likely to develop strategies, which present a challenge to being able to work together constructively
- Practitioners are facing an impossible task if their work does not build in enough time for reflection
- Processes designed to help shape thinking and professional judgement [assessment] can become rushed and lose much of their original purpose, particularly in cases of neglect, which are not incident driven

## Disseminating the learning

- Multi-agency Learning from Practice events have been arranged during 2016 to disseminate learning across the children's workforce. To book on an event follow the link below

  http://www.nscb.org.uk/sites/default/files/Learning%20from%20practice%20flyer%202016.pdf

- In addition single agency staff briefings held by NSCB member organisations will also be provided
- .Bespoke briefings are also available on request, contact Sue Kirkley, NSCB Co-coordinator susan.kirkley@newcastle.gov.uk