Serious Case Review
Briefing Note for Agencies in relation to Child J

NOTTINGHAM CITY Safeguarding Children BOARD

1. Introduction

This briefing note was completed by the Nottingham City Safeguarding Children Board (NCSCB) in response to learning from a Serious Case Review. The aim of the briefing is to share key learning across the NCSCB partnership to inform frontline practitioners of the issues identified by the review and learning that can be applied to improve practice.

2. How this document can be used

- Please read this document carefully and consider the learning in respect of current families you are working with.
- Keep this document in a handy place to support easy reference in future work.
- Take this document to team meetings and share with colleagues.
- Use this document in supervisions for reference and to support case management / reflective practice.

3. Case Summary

Child J was seven years old when she died as a result of an injury to her brain. She was found dead at the home where she lived with her Aunt under a Special Guardianship Order (SGO).

Child J had complex health needs and had experienced early trauma. When she was four years old, Child J was placed with a foster carer. A permanent placement was sought for her and a SGO was granted to her Aunt.

Child J was the victim of sustained serious physical and emotional abuse by her Aunt. There were a number of concerns about injuries that Child J had sustained, and of Aunt's treatment of her. Aunt was able to deflect these concerns by claiming that Child J was badly behaved, difficult to care for and self-harmed. Aunt also appeared to some professionals as a loving carer, concerned for Child J's wellbeing.

4. Key Learning

The key learning points from the Serious Case Review are grouped into themes below.

<u>Child focussed practice</u>

- Practitioners must be child centred in their practice, avoid focusing too much on the needs of the parents or carers, and maintain focus on the lived experience of children.
- Remember the importance of talking to others involved with a child as this allows us to check our shared understanding of a case.
- Children should be helped to understand the reasons for being in care; this can be addressed through appropriate life story/direct work
- A bite-sized learning sheet on child focussed practice can be found here

<u>Understanding self-harm in primary age children</u>

- Practitioners need to be aware that self-harm in primary school age children is uncommon.
- Consideration should be given to potential emotional well-being or safeguarding concerns where a primary school age child is described as, self-harming.
- Practitioners must give due consideration to the early trauma that a child may have experienced, and understand that children's prior experiences shape how they behave.
- Bite-sized learning sheets on self-harm in primary age children and early trauma can be found here

<u>Working effectively with children with continence issues</u>

- Practitioners must be mindful that having control over continence is a developmental skill, and like other skills, children will attain it at different ages
- When supporting the child and their family, the emphasis must be on normalisation, no blame, no shame and strictly no punishments
- Refer to best practice guidance, such as the NICE guidelines, and the bite-sized learning sheet on working effectively with child continence issues which can be found here

Confirmatory bias

- Practitioners must be aware of the influence of fixed views and confirmatory bias. Confirmatory bias is the tendency for people to selectively search for and interpret information that supports or confirms already held beliefs and theories.
- Self-reflection and reflective supervision are an essential way for practitioners to critically analyse their practice and consider the range of factors that might influence or affect their decision-making.
- When there are major differences in professional opinion in a network of practitioners that are responsible for meeting the needs of a child, this often indicates that no one agency has fully understood the child's situation - everyone should step back and reconsider a new approach
- A bite-sized learning sheet on confirmatory bias can be found here

Disciplinary approaches and assessing potential non-accidental injury

- Be aware that there are a limited number of causes for a child sustaining an injury and it is essential to consider all possible causes and seek evidence to exclude them.
- Practitioners must maintain professional curiosity and not immediately accept the explanation given by a parent or carer.
- Clinicians completing child protection medicals should ensure that they obtain full psycho-social history and history of previous concerns/injuries
- Distinguish between what is discipline and what is child abuse. Discipline must be age-appropriate, reasonable and support the child to understand what is expected of them.
- Terms such as 'physical chastisement' and 'unreasonable punishment' confuse understanding of what the child is experiencing, these should be challenged and clarification sought so that there is a shared understanding of what life is like for the child.
- Be cautious of putting more emphasis on a child retracting a disclosure, than on the disclosure itself
- These topics are described in greater detail in bite-size learning sheets which can be found here

The importance of the multi-agency professional network

- Schools play an important role in safeguarding children and should be actively involved in all multi-agency activity.
- The critical importance of keeping clear and accurate written records, using these records to share information effectively (including referrals), promptly, in writing, and following up on responses.
- Those responsible for conducting enquiries about concerns must always speak directly to the individual who initially raised the concern (even if they did not make the referral) to ensure clarity and accuracy.
- The importance of effective plans, assessments and multi-agency processes in keeping children safe and facilitating case reflection.
- Avoid placing too much emphasis on engagement with parents/ carers which can lead to a lack of challenge and collusion, ultimately leaving children at risk
- Meetings should have a clear purpose, include all the practitioners involved in the child's network, be fully recorded and provide a structure for identifying actions and measuring progress

Emerging themes

- Be mindful that covert electronic recording of meetings and conversations may be taking place, which could later be produced as evidence in court, a complaint or some other more public forum. Where practitioners communicate professionally this should not be an issue

6. Useful links

- Multi agency Safeguarding Procedures -http://nottinghamshirescb.proceduresonline.com/
- Bite-size learning sheets on practice issued identified in the Child J Serious Case Review - http://www.nottinghamcity.gov.uk/children-and-families/safeguarding-children-board/learning-from-practice/#bitesize