It must be acknowledged that even if the work undertaken had been significantly different there would be no guarantee that the incident where Child L was injured would have been avoided. There was limited information held by any agency to indicate that mother's partner posed a risk and the review has not been able to identify any information that could have been accessed that would have shown that he was unsuitable to be living in the household. It is possible that if an effective assessment had been undertaken investigating the concerns raised by father that this would have identified further information about Partner 1 but it is equally possible that this would not have provided any additional knowledge. It is therefore not clear how this injury could have been prevented.

Key recommendations

Surrey Adult Social Care Services should amend their protocols regarding occupational therapy assessments to ensure that they are all sent to the relevant GP.

The SSCB & Surrey Adult Safeguarding Board review the extent to which current training for staff in Adult services provides sufficient clarity about the nature of Children in Need and the thresholds for child protection referrals.

The SSCB ensures that the findings of this serious case review regarding the practice of the Contact Centre are addressed in their on-going review of the functioning of the Contact Centre. The SSCB to ensure that there is a full report provided to the Board about how the service is to be improved to ensure that the problems identified in this review are not repeated.

That the SSCB ensures that the recommendations in all of the completed IMRs are implemented by regular review of individual action plans.

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surrey safeguarding CHILDREN BOARD

LEARNING FROM A SERIOUS CASE REVIEW

Child L

www.surreycc.gov.uk/safeguarding

The SSCB conducted a serious case review as a result of events in 2010 when Child L sustained serious injuries. The SCR covered the work of the agencies in Surrey, one other local authority and one other police service.

Synopsis

Child L was born to white British parents who were not married to each other. Mother had three older children living in a neighbouring area. Child L's parents relationship was always troubled; there were a number of disputes about custody and contact. These disputes involved a range of agencies including the police, courts and social work services.

Despite the difficulties between the parents, the care provided to Child L was good and generally there were no concerns about development. However mother developed serious health problems when Child L was quite young. Mother was housebound for a period and needed professional assistance in order to maintain her independence and capacity to care for Child L.

Relations between Child L's parents continued to be poor and mother moved for a period with child L to live in a neighboring authority. Child L's school attendance throughout this period was not good which may have been because of health problems but may have also been affected by the parent's disputes and mother's disability. Child L's parents separated and mother began a relationship with Partner 1 who moved in to live. The only professionals in contact with the family at this time were school staff and the GP. There was no direct contact by any agency with mothers new partner.

In 2010 there was an incident at the family home that involved Child L, mother and mother's partner. As a result Child L sustained serious injuries, which were inflicted by Partner 1.

Key Themes and Practice Implications

Importance of multi-agency working at the earliest stage. Agencies had separate, different information about Child L and the family but no agency had the full picture. There was no holistic assessment of risk and separate agencies responded reactively to each situation rather than the whole context. There was no evidence of any agency considering the use of the common assessment framework (CAF), which could provide a structure for early joint intervention with families.

Lack of awareness about the impact that physical and mental health problems can have upon parenting capacity. There were a number of occasions when professionals seemed unaware of mother's disability despite seeing her in a wheelchair and her mental health problems were only acknowledged in full by the GP who did not appear to consider the effect of them on her availability to act as a full-time parent for Child L. It is essential that all agencies ensure a consistent focus on the child. This applies fully to those agencies whose primary client is an adult and it is crucial that those agencies consider whether their service users are parents or care for children when designing and delivering their services. The responsibility for protecting children lies with everyone.

Lack of attention by agencies to the men in the family There was evidence of fixed views about Childs L's father who may have been treated differently because he was identified as a perpetrator of domestic abuse which directly affected the credibility of his legitimate concerns about Child L's care. Apart from Child L's mother's allegations, there is little information in agency records that describes his relationship with Child L and what care he provided**.** There was no information held by any agency about mother's most recent partner although he had been resident in the house for a year Child L's father raised significant concerns with a range of agencies about mother's previous partner and her most recent one. These concerns included domestic abuse and poor temper control with regard to her previous partner and alcohol abuse by her most recent one. On no occasion did any agency respond to these concerns. This review has identified a pattern previously recorded in serious case reviews of agencies failing to take account of the role of male carers within the family process.

Complexity of working with families where there is significant marital discord and where domestic abuse is a possibility. Communication between the Family Courts and Cafcass was not effective however a number of other agencies were aware of the marital disputes and that applications had been made to the court. There was no attempt by these agencies to contact Cafcass. The key issue in this is the need for professionals to ensure that the focus on the child is not lost and that regardless of the motivation for allegations being made all child protection concerns must be fully assessed.

There is little evidence that any professionals considered Child L separately from the parents; Child L was in effect 'the invisible child'.