



Learning Lessons Briefing

Serious Case Review

In respect of the death of Rebecca Kandare Dob -14.1.14

Background

On Monday 21 March, 2016 Wolverhampton Safeguarding Children Board published the findings of a Serious Case Review into the death of Rebecca Kandare who died in January 2014 aged 8 months, as a result of severe malnourishment, substantial muscle loss, bronchopneumonia and rickets. Her parents, Brian Kandare, 29, and Precious Kandare, 37, of Wednesfield, admitted manslaughter and were jailed for nine and a half years and eight years respectively.

The Serious Case Review looked at the involvement various agencies had with Rebecca and her family in a bid to identify whether anything could have been done differently which may have prevented her death. Each agency identified as having contact with Rebecca and family members provided a report on their involvement and made a number of recommendations for their agency to improve service delivery.

The overview report writer makes a number of recommendations arising from the key themes and main learning points in order to ensure that all relevant interagency learning from the review is addressed.

Please go to www.wolverhamptonsafeguarding.org.uk for the full overview report, the integrated single agency action and the WSCB action plan.

This briefing is to inform how changes can be made within professional practice across all organisations to ensure effective safeguarding for the children of Wolverhampton.

Theme 1

There is a need to improve knowledge and understanding by professionals about the potentially damaging effect on children in relation to the uptake of basic child health services, where parents and carers believe in other forms of healing such as prayers or rituals, which are used to address the origins of the ill health. The beliefs may lead to adverse effects on a child's health and development by withholding treatment.

Recommendations:

Practitioners make themselves aware of practice guidance and support documentation

issued by the WSCB in relation to religious beliefs.

Practitioners demonstrate professional curiosity and are not fearful in asking direct questions in relation to faith and analysing what impact beliefs could have in relation to safeguarding children.

Agencies ensure that recording of religion or faith is standard practice within their organisation. In addition they ensure that cultural beliefs are an intrinsic aspect of assessment and this is monitored through audit.

Agencies ensure that practitioners feel adequately skilled to challenge parental beliefs where these have a detrimental effect on the well-being of the child.

Theme 2

A number of learning points about good practice in assessments, in sharing information and in recording personal information have been highlighted in this Review.

Recommendations:

Agencies should ensure that all front line workers working with children are skilled in assessment, analysis and planning. This should be achieved through workforce development programmes and management oversight of work with families.

Practitioners should take responsibility for ensuring records, including personal characteristics, are accurate and updated when necessary.

All practitioners should ensure they are aware of, and understand policies and procedures in relation to sharing of information where there are safeguarding concerns for a child.

Practitioners should ensure that any information shared as part of protecting a child should be clear, factual and provide an analysis of what impact they believe the information has on the well-being of the child.

Theme 3

The Barnardo Joint Screening meetings should provide a good interagency system to share information and assess the needs and potential risks to children and adult victims relating to domestic violence.

Recommendations:

Agencies ensure that any information shared as an outcome of a Barnardo's Joint Screening meeting is acted upon in a timely manner and supports any future support or assessment.

Theme 4

There is a proliferation of Information systems in the agencies, which have participated in this Review. The ability of professionals to access up to date information about children of all ages is hampered by the range of systems in health and the police in particular.

Recommendations:

Professionals need to be alert to the fact that they must query information held and undertake up to date checks in some cases directly with other professionals particularly where some time has passed as there may be new information held for example in relation to domestic violence.

Where multiple agencies are involved practitioners should, as good practice, convene a Team Around the Family meeting to gain a single version of the 'truth'.

Agencies should review any current systems for recording to assure themselves that the information collected provides sufficient information to alert practitioners of potential indicators of child abuse or neglect.