Learning Lessons Briefing
Serious Case Review in respect of Child G

BACKGROUND

Child G was 2 years 9 months, when an ambulance was called to the home address and Child G was found to be in cardiac arrest. On examination in hospital, Child G was found to have peritonitis due to a perforated bowel and a complex fracture of the skull, amongst other older injuries. Child G died as a result of these injuries. Child G's Mother's Partner has been found guilty of murder and is serving a custodial sentence; Mother was also convicted of allowing the death of a child.

A Serious Case Review was commissioned by Wolverhampton Safeguarding Children Board (WSCB) to examine the case in detail and to identify important learning that can be shared with relevant agencies.
Please go to www.wolverhamptonsafeguarding.org for the full overview report.

This briefing outlines the key themes identified by the review. We ask that it is shared widely and discussed at team meetings to help professionals understand how to apply the learning in the context of their daily work.

LEARNING THEMES AND WHAT THEY MEAN FOR PROFESSIONAL PRACTICE

Theme 1 – Tenacity and creativity is needed to prevent repeat victimisation from Domestic Abuse.

When Mother's Partner resumed his relationship with Mother again a few months before Child G's murder, the connection with his previous behaviour towards her was not made.

What does this mean for professional practice?

- ***Assessment*** of future risk is better informed if practitioners obtain details of the ***nature*** of historic abuse and ***record the name(s)*** of the alleged perpetrators so they can be more responsive if relationships rekindle
- Promotion of ***"Clare's Law" - Domestic Violence Disclosure Scheme (DVDS)*** with victims of domestic abuse can help to empower them in seeking information in respect of ***future partners*** or those they ***re-enter relationships*** with
- When victims are no longer with an abusive partner, effort needs to be ***sustained*** to help them engage with available support. ***The Freedom Programme*** may be of benefit, but other interventions should be considered if the victim chooses not to engage in the groupwork programme

- When a victim discloses domestic abuse a ***DASH Risk Identification Checklist*** should always be completed. Book yourself on the Domestic Abuse training if you need support to do this.

Theme 2 - No Right to Remain, but no active steps towards removal either.
Practitioners generally had not understood the role of the Croydon No Recourse to Public Funds social worker, nor had they formally checked Mother and children's immigration status.

What does this mean for professional practice?
- Professionals must be able to ***appreciate*** the needs and vulnerabilities of people with ***No Right to Remain/No Recourse to Public Funds (NRPF)*** if they are to better understand the daily lived experience of affected children and families.

- Greater ***publicity and awareness*** of local ***specialist voluntary organisations*** and the value of involving them with NRPF Families is required. Visit the Wolverhampton Information Network for contact details.

Theme 3 - Assessing the implications of religious faith and beliefs
All the adults in this family had strong religious beliefs. Practitioners were aware of Mother's involvement in the Church which, whilst in Wolverhampton has been positive. However, some professionals felt uncertain about how to go about exploring what an individual's faith meant to them, and how this impacted on their lifestyle and parenting.

What does this mean for professional practice?
- Professionals must have the *confidence and knowledge* to make enquiries about ***faith and beliefs*** to enable ***holistic risk assessments*** and effective support for families. Book yourself on the Safeguarding Children from Abuse linked to Faith and Belief if you need support to do this.

Theme 4 – Assessment, planning & recording
Because these children were only regarded as "In Need" by virtue of destitution this was treated with a light touch and no formal "Child in Need Plan" was produced and nor were there any Team Around the Child meetings. Therefore, intervention was not well co-ordinated or systematic enough and led to drift.

What does this mean for professional practice?
- Holistic assessments should include asking ***"who else is involved with you and your family?"*** and recording this in a form that is accessible and easily updateable.
- Find out ***what agencies and support services*** are involved with, or are needed to support the child and family and ensure they are all coming together in a ***multi-agency forum.***
- Transient families are even more vulnerable if accurate and detailed records do not follow them. ***Do you have a full chronology***? Identify any ***gaps in records*** and follow these up – ***Ensure you can tell the child's story.***

Have you attended a Lunch and Learn session to find out more about how learning in this case can be applied to practice? These are running between March and June. For more information visit https://www.wolverhamptonsafeguarding.org.uk/training-and-other-events