MSCP SCR Briefing sheet

Serious Case Review George – March 2020

Until September 2019 Local Safeguarding Children Boards undertook Serious Case Reviews (SCRs) when a child dies or has been seriously harmed, and abuse and/or neglect are suspected or known to be a factor, and/or there are concerns about how local agencies worked together. The purpose of such reviews is to learn lessons and improve practice. These reviews have been replaced by local Child Safeguarding Practice Reviews. Any reviews commissioned before the change remain as SCRs.
This publication, produced by the MSCP, aims to share the learning from the George SCR to allow professionals to reflect on their own practice. The full overview report is published on the MSCP website.

Trigger event

In 2018 the Ambulance Service was called to a street in London to attend to an unresponsive 3 year old child, (George). George had suffered a cardiac arrest, he was resuscitated and taken to hospital. Staff became suspicious of the varying versions of events and differing addresses offered and initiated safeguarding referrals. Despite intensive care, George died 3 days later.

Following a criminal investigation, it was found that mother's then partner had twice pushed his car seat back and crushed George. Mother and her partner were imprisoned for offences relating to George's death.

SCRs are conducted by the area in which a child is ordinarily resident, which in this case was unclear because of the family's high level of mobility. Medway as the last area of stable housing and registration with health services, agreed to commission the review.

Summary of known background

Mother had experienced a troubled childhood leaving her vulnerable to abuse and exploitation. George's reported father had a criminal record including offences related to domestic abuse, arson and drugs. Mother's partner at the time of the trigger event had an extensive juvenile record which continued into adulthood and included sexual offences, domestic and other forms of violence.

Mother booked for her ante-natal care with George when she was 18. She made good use of services and no significant medical or social concerns were identified; although paternity was not explored. During her pregnancy there was a Police attendance at a domestic incident which prompted a notification to Children's Social Care but due to non-engagement no assessment was completed.

When George was born he and his mother initially went to live with a relative. Recognition of risks within that arrangement triggered a voluntary placement of mother and George in 'supported accommodation' commissioned by Children' Social Care. Contrary to bail conditions imposed on him for alleged crimes, George's father continued to have daily contact with mother and George supervised only by mother.

The supported accommodation provider's concerns about mother's ability to manage were shared with the health visitor and attempts were made to brief the social worker. A child and family assessment that was completed did not identify risks posed by his father, but George was made the subject of a child protection plan under the category of neglect. Observations of mother were mostly positive, and a need to complete a parenting programme and a cognitive assessment were agreed.

Mother had agreed to remain in the supported accommodation but due to circumstances within the family also spent a lot of time with her mother. The accommodation providers reported coercive and controlling behaviour toward mother from George's father and grandmother. Mother proved unable to assert herself or prioritise George's needs.

Mother subsequently left the supported accommodation to live with George's father. The multi-agency core group supporting the agreed plan was not used effectively and the quality and quantity of social work input was insufficient. Due to apparent progress the case was (unjustifiably) stepped down to child in need status.

Following a high-risk incident of domestic abuse mother's case was referred to MARAC (multi-agency risk assessment conference). Safety measures were put in place although not all were pursued. Mother had moved into a home paid for by George's father although she claimed there was no contact and they later returned to live with family. George came to the attention of a hospital Emergency Department at this time following 2 reported accidents in the home.

Mother, George and his father relocated out of Medway and a comprehensive MARAC to MARAC transfer took place.

When 2 months later, mother returned to Medway she reported to professionals that she was in a new relationship. Soon afterwards Children's Social Care closed the case. George's father was reported not to be in contact and neither the potential risk of the new partner nor mother's ability to safeguard George were considered.

Following attendance at a domestic incident at an address where mother and George were staying in early 2017, Police made a referral to Medway Children's Social Care though no substantive response was made. Mother and George then left Medway though came into contact with services in other authorities.

During their relationship mother's partner was arrested for drug related offences but his risk to children was underestimated. Ex-partners continued to make allegations of domestic abuse against him.

Whilst staying at the home of a relative, Police were called and told that mother's (reportedly ex) partner had made threats to kill. Notification was sent to the relevant authority, but the process failed to identify and assess the risk posed to George. A report to the Police some weeks later, stated that mother and George had been kidnapped by mother's (ex) partner. The case was dropped when mother presented at a police station and reported they had gone willingly.

It was established as part of the review that in a further local authority a referral had triggered visits and assessment to a home in which George was present along with his mother, although not seen.

George's experiences

It is apparent that the "lived experience" of George was insufficiently recognised or captured in the records of most involved agencies. George was "invisible" during some responses from services. The ongoing succession of dramatic / traumatic events experienced by his mother dominated professional responses and left little scope for recognising how emotionally damaging the constant changes of associated adult / parent figures, locations and absence of peer relationships must have been. Those who pose a danger to more vulnerable adults almost inevitably represent a risk to children.

Whilst nobody could have predicted the fatal trigger incident, George had until then endured and survived the consequences of a succession of domestic crises involving his mother and her associates. Aggregated evidence from participating agencies suggests there would have continued to be damaging events sufficient in number and magnitude to justify a reasonable suspicion that 'he was suffering or was likely to suffer significant harm'.

Overall findings

Mother's past experiences and their impact on her emotional vulnerability remained unexplored. Her cognitive ability was also untested i.e. to what extent was she able to understand the expectations of professionals in the agencies with which she had contact?

The development of relationships with professionals and accurate assessment of risk was hindered by high levels of mobility in the family and dishonesty in what was presented to professionals. Those professionals who had been able to get to know mother and George reportedly were insufficiently involved in order to share their observations and the supervision and management of the social worker was also insufficient.

The focus of Health and Social Care agencies was on mother and child with insufficient recognition that the dangerous men with whom mother associated inevitably represented a significant risk to any dependent child. Information on the risk posed by these men was potentially available.

Learning points

To be effective, the recording, interpretation and assessment of an incident or situation by *any* professional needs to reflect *all* available information e.g. identity and significance of all present and avoid capturing only 'presenting circumstances'. Reflecting their respective sources of anxiety (being re-victimised or held to account for their conduct) the account offered by a victim or a perpetrator of domestic abuse may be partial, confused or inaccurate. If the account is at odds with other available information, it should be explored / challenged.

Those assessing and seeking to mitigate risk to a child or vulnerable parent must define *explicitly* and within a time-frame, demonstrable change before concluding sufficient improvement. Reflective supervision in *all* involved agencies is of central importance to that accurate and reliable identification and management of risk. With hindsight, there is evidence of controlling and coercive behaviours towards George's mother and other partners that was not recognised.

Recommended service improvements

MSCP should:

- Seek confirmation from Kent Children's Social Care that in circumstances when it receives Police notification of an incident involving a child, it reliably captures and responds to all relevant information
- Monitor progress made in implementing all recommendations in agencies' submitted reports or which were identified during the course of the George SCR.
- Seek confirmation that all members agencies' training and development programmes address current lawful definitions and required understanding of 'coercive and controlling conduct'

The MSCP Learning Lesson Sub-group is monitoring the implementation of the above, as well as additional operational recommendations identified by agencies involved in this SCR.