Lessons Learned and practice pointers (Continued)

In brief the following points were noted where specific services should have functioned better to protect the children and where improvements could be made:

- **Pre-birth assessments and care leavers**
  Policies and procedures must be in place in order to ensure that the appropriate assessments and support services are provided to young mothers. These policies and services should be audited to ensure that they are embedded in practice.

- **Assessments of children and families**
  The need to ensure that assessments are carried out to a good standard and in a timely manner must be reinforced in supervision and training. If an assessment is undertaken in line with good practice then the decisions that are taken are based on sound information and analysis. Assessments should be clear about the aim and purpose of the task and regularly reviewed. It is also the case that in all assessments the child's health information should be shared, checked and considered in order to promote the child's best interests.

- **Child Protection medical assessments**
  Sound professional systems must be in place to ensure that medical assessments are carried out to a high standard. The interagency collaboration must be effective and all decisions should be based on up to date information about the child and the circumstances the child and their family live in. The core agencies must undertake such medical assessments with the child's best interests in mind and must be rigorous in exploring the explanations and reasons given for any injuries or signs of neglect as well as background history. The protocol for child protection medical assessments should be reviewed.

- **Strategy discussions**
  This review noted that the expected practice in relation to strategy discussions had not been followed as the information that existed was not shared and discussed and the risks were not evaluated. Clarity about what a strategy discussion should consist of and the purpose it serves was not in evidence in any of the records. The participation of the professionals from the core agencies; Children's Social Care, the Police and Health professionals; had become confused as the strategy discussion had focussed on the medical and forensic aspect of the injury. The purpose of the strategy discussion must be to decide on a joint basis on joint action to enquire in to the circumstances of a child. The roles and authority of front line staff and their managers in a strategy discussion and in medical assessments need to be clarified and reinforced.

- **Child Protection Conferences**
  It has been reported to the review that there has been an “end to end” review of the child protection system since Keanu's death as it became clear that there had been a general lack of compliance with the child protection procedures and poor performance. All agencies must attend Child Protection Conferences and, if they cannot, they should provide a written report to the meeting.

- **CAF/Family support**
  Skills and knowledge to observe, collate and assess information and detect patterns where there may be issues of neglect and physical abuse must be a part of basic practice in any Children's Centre and nursery setting. All services should analyse the outcome to the child of the service being provided and adjust the service to meet the needs of the child rather than focus on the needs of the parent. Regular supervision of staff and transparent systems to make referrals must be in place in family support services settings. Good recording systems should underpin any services to ensure that a child's records are up to date and reviewed regularly in a meaningful way.

Keeping Children and Young People Safe from Harm, Abuse and Neglect

Northumberland Safeguarding Children Board

Highlighting Lessons from Serious Case Review

National

Date of Review: September 2013
Local Authority: Birmingham
Name: Keanu Williams

Outline

Keanu Williams died on the 9th January 2011. He was just over 2 at the time. He was the youngest of three. His older siblings were living with a family member at the time of Keanu's death. Prior to that they had been subject to child protection plans in 2005 and again in 2006 and moved to live with the relative in 2006. Keanu's mother Rebecca Shuttleworth was a care leaver. His birth father was no longer involved at the time of Keanu's death and his mother was living with a relatively new partner Luke Southerton. She had moved to Torbay in 2007 and returned to Birmingham in 2009 and had had numerous moves after that within the city.

Keanu was admitted to A and E and pronounced dead on 9th January 2011 after a 999 call from his home. He was found to have multiple injuries to different parts of his body, which were non-accidental and the result of separate incidents of assault with several major incidents being sustained over a period of days.

Luke Southerton and Rebecca Shuttleworth were charged with a range of offences. After a trial lasting six months Rebecca Shuttleworth was convicted of murder in respect of Keanu and cruelty to a child in respect of one of the injuries in 2005 to one of the siblings. She received an 18 year sentence. Luke Southerton was convicted of cruelty to a child and received a 9 month suspended sentence and 200 hours community service.

There were a significant number of concerns, referrals and short term interventions from a range of professionals with Keanu and his mother by a range of agencies from before Keanu's birth and throughout his short life.

In November 2009 a significant chance to protect him was missed by a child protection case conference who received a good social work report which clearly identified the risks to him. The Case Conference decided that Keanu was not in need of protection but his family needed practical support.

Three other significant chances were missed in the last few weeks of his life, at a child protection medical in the autumn of 2010, following concerns about a burn to his foot, between Christmas 2010 and New Year 2011 when Keanu attended his two year developmental check up and finally in early January, when his nursery were concerned about bruises, raised their concerns with his mother, but did not report their concerns to social care. He was also seen the following day at an audiology clinic. Three days later he died.

Summary of Findings

- Professionals in the various agencies involved had collectively failed to prevent Keanu's death as they missed a significant number of opportunities to intervene and take action.
- Practitioners across agencies did not meet the standards of basic good practice when they should have reported their concerns, shared and analysed information and followed established procedures for S47 Enquiries (child protection investigations) and undertaken a range of assessments Including medical assessments and child protection conferences.
- There were a number of significant missed opportunities to provide services to Keanu and his siblings, and to assess (and respond to) their needs within a collaborative multi-agency framework. Services should have been provided to promote the welfare of the children, on a number of occasions as they were clearly children in need. On several occasions services should have been provided to safeguard them from significant harm.

Lessons Learned and practice pointers

A number of lessons to be learnt have emerged from this Serious Case Review. If professionals had acted with a more focussed approach on the effect on the child of those around it, the context of the environment and the quality of the care provided to the children by the significant adults.

In brief the following learning points were noted, where improvements in practice would have made a difference:

- Confident professional practice, which proactively seeks out information and is prepared to challenge and question colleagues and parents or significant adults.
- Clear understanding in agencies of mechanisms for making referrals to Children's Social Care and support by designated professionals/ line managers to make referrals.
- Attention to detail and background history to understand the child's world.
- Proactive use of accessible information and record systems, which have been developed to enable easy access to past records.
- Seeing and observing the child with the care giver and talking to children
- Thorough assessments which draw on all relevant agencies information, whether children's or adults services.
- Assessments should be regularly updated and reviewed to take account of changing circumstances.
- Knowledge of neglect and physical abuse needs to be improved across the workforce to enable early recognition and response.
- Supervision, which challenges the professionals to reflect on their practice, and which considers whether the focus has been maintained on the child, including the impact on the outcomes for the child of the services being provided.