Serious Case Review

Learning Workshop

February 2015

LSCB must deliver Serious Case Reviews (SCR) where:

- abuse or neglect of a child is known or suspected;

  and
- either the child has died;
- or the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

This session

- Gives an overview of the case of Child K- Blake Fowler & the findings of the SCR
- The story Blake's life is tragic
- It is upsetting and hard to hear the details
- Be aware of this
- Look after yourselves and each other.

The Review

- The Review covers a period from 2007
- It continues up to and beyond Blake’s death in December 2011
- Takes us to April 2012 when it was initially decided that there be no further action in relation to a prosecution
- Police decision was re-considered and overturned in April 2014
- Further Police investigations were carried out, during which Blake’s mother, her partner and her partners brother were arrested
- December 2014 the Crown Prosecution Service decided that they would take no further action in this matter.

The Review

- The Serious Case Review was delivered by experienced Independent lead reviewers
- Panel of LSCB members representing the services involved
- Blake's maternal grandmother participated in the review
- The Report and LSCB response to this case was published on 18th February 2015
- The review showed failings across the system that was intended to protect Blake
- The LSCB expressed deep regrets for these failings
- The LSCB has detailed in its response how improvements have been made and continue to develop.

Blake Fowler

- 7 year old boy
- Taken to Southampton General Hospital in December 2011 with serious head injuries
- His condition deteriorated and he died the following day
- Doctors were told that Child K had fallen from a sofa while in the care of his mother’s partner, and the partners brother
- The initial medical opinion was that his injuries were not consistent with the explanation given
- The family were known to a number of different services as a result of repeated incidents of domestic abuse and long-term concerns about the safety and welfare of the children particularly Blake
- Blake has 2 surviving siblings, who now live in foster care.

Reviewer’s Comments

Child K was physically, emotionally and sexually abused, and he was neglected, physically and emotionally.

From infancy he repeatedly witnessed the domestic abuse of his mother, in assaults which were increasingly frequent and violent.

It is a mark of his resilience that he continued to present much of the time as lively and cheerful, but the failure to see that this presentation masked a lifetime of abuse is alarming.

This was not a case which required particular investigative expertise or determination. Evidence of abuse and neglect was repeated and explicit.

Findings

- More than one violent adult involved in family life
- The male thought to be Blake’s biological father at the time had a history of perpetrating domestic abuse
- Mother’s partner also known to be a perpetrator and had other violent behaviour in his history
- Mother was seen only as a victim of domestic abuse
- Mother was not seen as a potential risk to Blake
- Desire to engage with mother to improve her parenting rather than understanding the level of dangerousness present in the adults
- Services did not put Blake’s voice, experience and welfare at the centre of this case.

Findings

- Injuries were noticed at pre school, school and other settings
- Mother reported that injuries sustained when Blake was in the care of, who was at that time, thought to be his biological father
- Evidence of physical abuse regularly apparent in Blake's life from variety of sources
- An incident at a supermarket and reports to NSPCC from workmen nearby to the family home
- Maternal grandmother had reported grave concerns on more than one occasion which had not been acted on
- Medical practitioners reported significant inconsistencies provided to explain bruising

Findings

- These incidents were not acted on appropriately, correct child protection procedures were not instigated
- This was not challenged or concerns were not escalated by agencies involved
- Confusion about purpose of meetings & processes that took place in response to significant incidents.

Reviewer's Comments

"It is now nearly three years since the death of Child K, and the review heard of many changes in the design and delivery of services in Southampton since then. Nonetheless there were serious systemic and also individual failings, which were found in many of the organisations contributing to this review".

Themes for Learning

1. Using Child Protection Procedures Effectively
2. Domestic Violence and Abuse
3. Recognition of Dangerousness in adults
4. Escalation of concerns
5. Staffing and Supervision
6. Response to Child Death
7. SCR Process.

Why did this happen?

- Safeguarding was not everyone’s business …until the child is safe
- Poorly integrated and managed service provision across the partnership
- High demand for top tier interventions impacting across partner agencies
- High caseloads and staffing vacancies with no recruitment plan
- Low morale and poor management

- Lack of strategic leadership
- Lack of grip and pace in planning either for the workforce or our children
- Limited focus on performance
- An absence of a clear vision or direction of travel for Children's services in the City.

What happens next?

1. Detailed response given at time of publication
2. LSCB has a plan monitored by the board for outstanding actions
3. Individual services also have detailed improvement action plans
4. Monitoring and evaluation of progress through LSCB
5. Quality assurance of services.