STAFFORDSHIRE & STOKE-ON-TRENT SAFEGUARDING CHILDREN BOARDS

LESSONS TO BE LEARNED BRIEFING NO. 15:
IN RESPECT OF THE DEATH OF KEANU WILLIAMS- BIRMINGHAM, 2013

What happened?

On the 9 January 2011 an ambulance was called to the home of Rebecca Shuttleworth due to her 2 year old son Keanu Williams reportedly having difficulties breathing. After receiving CPR from the paramedics Keanu was taken to hospital at 8.05pm and at 8.35pm he was pronounced dead. Further examination revealed that Keanu had multiple injuries to different parts of his body. He was found to have a total of 37 injuries including a fractured skull and an abdominal injury.

Following a 6 month criminal trial Rebecca Shuttleworth was found guilty of murder and sentenced to 18 years in custody without parole. Her partner, Luke Sotherton was cleared of murder and manslaughter but convicted on one charge of cruelty to a child.

What were the circumstances that led up to Keanu's Death?

Keanu was born in Torbay, Devon in 2009 and was the youngest of 3 children. At the time of his death Keanu was living with his mother Rebecca and her partner Luke in Birmingham. Keanu had no contact with his biological father. The father of his older siblings had known Rebecca since her early teens. He served two periods in prison for violent offences and was later released on licence with conditions that included not contacting Rebecca or the older siblings. Rebecca later met Luke Sotherton on a social networking site whilst living in Torbay. He was not known to any of the agencies.

Rebecca had a history of involvement with a variety of agencies primarily because she was a care leaver and pregnant as a teenager. It was known that she was vulnerable and likely to need support with caring for her children. Frequent changes of addresses at different periods of time for Rebecca and her children, including periods of homelessness, demonstrated an unsettled and mobile lifestyle. She was known to have relationships with different men, including regularly making contact over social networking sites, with frequent changes in partners.

Over a period of 5 years, a number of referrals were made to both Birmingham children's social care (BCSC) and Torbay children's social care (TCSC) most of which resulted in further enquiries under section 47 of the Children Act 1989. The serious case review found that many of the initial assessments (IA) did not consider historical information or Rebecca's ability to parent and were sometimes completed by unqualified social work assistants. The first initial child protection conference (ICPC) in 2005 involving the two older siblings resulted in both children becoming the subject of a child protection plan based due to neglect associated to poor supervision.

This set a precedent for future interpretations of the background history of the siblings and in due course in respect of Keanu: Rebecca was from this date on always seen to be a neglectful parent as opposed to a parent abusing her children.

Between June and October of 2005 a total of eight failed home visits had been recorded by the health visitor. The only time the siblings had been seen was at nursery on two separate occasions. The reports to the review conference said that Rebecca was making *'good progress'* however there was no evidence to suggest that she was engaging with the child protection plan or that the children had ever been observed with her. Evidence in successive reports mirrored this perception.

Subsequent investigations around this period were conducted by Birmingham and Torbay children's social care who continued to assess the risks to the older siblings and concluded that the risk had been removed because Rebecca and her partner at the time (the father to the older siblings) had moved out of the area. They also knew that the older siblings were now living with their maternal grandfather on a Residence Order. What wasn't known to all the professionals working with the family was that the older siblings had revealed details to school staff which if known to children's social care, would have affected the level of perceived risk to the older children. Rebecca was in fact living with her 2 older children and the children told school teachers they were being hit by their mother. This information was not referred.

Following his birth, the serious case review found that many of the assessments resulting from referrals contained little evidence of any contact with Keanu. This meant that agencies began to lose sight of Keanu as an individual child. Initial assessments did not mention whether checks with other agencies had been undertaken and the other agencies had no record of requests for checks within their records. No analysis was ever conducted that took account of the impact on Keanu or whether Rebecca had any contact with her older children and information was often held in isolation within agencies. The serious case review raised a number of concerns over the lack of joined up working between some agencies which included the health visitor and the GP both of whom were treating Keanu for persistent nappy rash and without knowledge of each others interventions. Notifications were sent to the GP following Keanu's attendance at A&E, however these were never followed up, nor were they shared by the GP with the health visitor.

Because of her transient nature, professionals found it difficult to keep tabs on where Rebecca and Keanu were living. The one constant in Keanu's life was his place at nursery. The review said that, *'the nursery developed a clouded view of Rebecca's ability to care for Keanu because she herself had attended the nursery as a child'.*
When interviewed, Rebecca referred to the staff at the nursery as 'more like friends'.
Little information about Keanu's experiences at nursery was shared with other professionals and key decisions about potential referrals were overturned by inexperienced staff who believed *'it was no longer necessary as they were happy with the situation'*. The professionals that weren't happy with these decisions did not appropriately challenge their other agency colleagues nor escalate this to a line manager, designated or named professional.

On 3 occasions Rebecca took Keanu to A&E. Each time she gave what seemed like a plausible explanation, saying he was *'always bumping into things'.* However, on one occasion the examining doctor discussed their concerns with a supervising Registrar (paediatric doctor in training). This was later discounted as a non-accidental head injury and no referral was made other than a notification to the GP.

Further tests were carried out on Keanu following a referral by the GP to a paediatrician. His hair loss was discounted as a skin condition and he was discharged from hospital being described as a *'well cared for child'*.

Record keeping by many of the agencies often lacked rigour as they were not able to demonstrate who was involved with the family, whether information was shared, if and when meetings were held including the minutes to those meetings and who attended (if invited).

In the last few days before his death, Keanu was attending nursery and staff described him as being 'very distressed'. Several staff noticed bruising on his body; on his chest as well as his tummy. No one at the nursery made a record of any of the marks. A conversation with Rebecca satisfied nursery staff and no action was taken to undertake checks or consult with children's social care. The last time Keanu was seen alive was when he attended an audiology appointment following concerns by the health visitor. It was recorded at the time that it 'was difficult to do the test as Keanu was tired and would not tolerate the examination'. Three days later, Keanu was admitted to hospital with multiple injuries and died.

What do we need to learn from this case?

We should always work with 'healthy scepticism' when working with families where children might be at risk. Asking parents and families how they parent is not always the most reliable way of finding out what is happening in the home. **Watching parenting in action (setting boundaries, play between parent and child) can be much more insightful and informative about attachment relationships.**

Assessments should not be carried out in isolation - we need to share information effectively and should **always ensure we let others know what we know and what we are doing**, **as well as checking out what they know and what they are doing**.

Be aware of your role and responsibilities where there are safeguarding concerns and follow the protocols and procedures within your organisation

ASK -Who else is seeing the child or working with their family?

What do you do if you do not agree with other professionals? – It's healthy to challenge each other - **Use the SSCB Inter Agency Escalation procedure to help resolve differences between professionals.**

Always check historical information and use this to analyse current risk – what does it mean to the child if they are constantly moving, having a variety of carers, missed appointments etc- **put yourself in the shoes of the child.**

Always consider the impact on children of the parenting they experience in relation to the individual child's development and attachment**. Have an understanding of what is good enough so poor parenting does not become the 'norm'.**