

CALDERDALE SAFEGUARDING CHILDREN BOARD

Serious Case Review

Executive Summary

December 2008

Child A

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Introduction

1. A Safeguarding Children Board is required to carry out a Serious Case Review when a child dies, and abuse or neglect is known or suspected to be a factor in the death. The purpose of a Serious Case Review is to establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.

The circumstances that led to the Review being undertaken

2. Child A died of natural causes in October 2007. There was no definite conclusion that abuse or neglect were contributory factors in the death. However, given the involvement of agencies with A's family in the period prior to the death there were concerns about agency practice in regard to compliance with safeguarding procedures. In particular there was concern in the period preceding A's death, at the lack of a section 47 enquiry, an accompanying core assessment, and a lack of consideration of either support to the family or an initial child protection conference.
3. In these circumstances the Chair of the Calderdale Safeguarding Children Board agreed on the 7th December 2007 on the recommendation of the Serious Case Review Sub-Group, that there should be a Serious Case Review relating to child A's death. It was agreed in consultation with Government Office that the report would be finalised after the completion of Care Proceedings in late November 2008, in respect of the remaining children of the family.

Terms of Reference

4. This Serious Case Review will adhere to the general guidelines for the preparation of a Review set out in Chapter 8 of 'Working Together to Safeguard Children' (2006). The time frame for the Serious Case Review was agreed to be from 1st January 2002 until 12th October 2007. The specific terms of reference are:
 - To identify the lessons to be learned from this case in relation to the way in which local professionals and agencies worked together to safeguard and promote the welfare of Child A and her siblings.
 - To consider the effectiveness of agencies' involvement with child A and also with her family, from January 2002 to October 2007, these being the dates of the birth year of E, the eldest child, and the death of child A.

- To consider the effectiveness of agencies' handling and processes of referral, assessment, decision making and adherence to CSCB safeguarding procedures.
- To consider the effectiveness of support given to child A and her family in the period preceding her death.
- To consider the approach and actions taken by agencies in respect of domestic violence referrals.
- To consider any systemic and institutional deficiencies identified in any agency practice arising from the Review.
- To consider any practice issues arising in this review and how improvements to such practice can be made.
- To make recommendations as may be required, setting out any desired changes, with the overall aim of improving single and inter agency working so as to better safeguard and promote the welfare of the children and young people of Calderdale.

5. Agencies providing reports

- West Yorkshire Police
- Calderdale Primary Care Trust
- Calderdale and Huddersfield NHS Foundation Trust
- West Yorkshire Probation Service
- Calderdale Council Children and Young People's Service (Care Services/Learning Services)
- Calderdale Women's Centre/Domestic Violence Forum
- Calderdale Environmental Health Services
- Pennine Housing

Review Writer

6. The Review Panel consisted of experience professionals from the Police Service; Children's Social Care; Legal Services; Health Services including a Paediatrician; and Domestic Violence Services. The Panel was chaired by an Independent Child Care Professional with no current or previous employment links with Calderdale agencies. None of the professionals had previous

involvement with the case. Overview Report was written by Roger Thompson, who also acted as the Independent Chair of the Serious Case Review Panel. He has never been employed by any agency in Calderdale.

Family Involvement

7. Child A's mother has been visited by the Author of The Review, and her views concerning the circumstances of the death are included in the full report. A letter was sent to child A's father asking for an appointment so as to hear his views. No reply was received to this invitation.

Family Circumstances

8. Child A was the fourth child in the family. The parents and children are all White British. There are features about the family life experienced by the children contained in the agency management reports. These included the adverse physical conditions of the home; the failure to attend health appointments; the serious incidents of domestic violence; and the fact that both child A's parents had been subject to Probation Orders in the period prior to her death.

Key Findings and Conclusions

9. This report has not apportioned any blame for the death of the child A given that she died of natural causes (sudden infant death syndrome)
10. Child A's death has however given the opportunity for there to be an examination of agencies' practice and actions in relation to their work with child A, her siblings, the parents and the family.
11. The Review has identified some shortcomings in agencies' practice, in particular for Calderdale Care Services. It is concerning that there appears to be poor professional practice in relation to the Initial Response Team, which even with the advantage of hindsight, seem to indicate a systemic failure of the service. It is also worrying that concerns about this Team have been highlighted in a recent Serious Case Review, and it is essential that urgent action is taken to remedy the failings identified and resources provided for this.
12. I am aware that the Senior Management of Calderdale Children's Services are aware of this situation and are taking positive and urgent action to address the shortcomings identified.
13. The Review identifies shortcomings in practice in services provided by the NHS. In particular there was very real concern about recording practices, and about the lack of continuity in the early stages of work with this family and children in relation to health visiting staff.
14. Also of concern is the absence of a system for Health professional to have effective contact with social workers when there are escalating concerns about a family/children, and the effective contact cannot be made for some reason.
15. Despite the deficiencies in policy and practice identified there is no evidence of systemic or institutional failures in the Health work with child A and her family. However there is a recommendation in the report for urgent action to be taken to improve the turnover of health visiting staff working with vulnerable families. This is regarded as a significant failing in the consistent support required by vulnerable families.
16. The West Yorkshire Probation Service have analysed their work with the parents of the child A, and have suggested some changes to procedures, particularly when offenders with child caring responsibilities are subject to breach action, which might result in a custodial sentence. This is a positive proposal.

17. The Review has also identified the extent of domestic violence in this family and witnessed by the children. It was vital that such incidents and information about the significant domestic violence within this family, was brought into a child protection plan. This was not done, and there is concern that there is not an adequate system for systematically analysing domestic violence referrals with the Initial Response Team. Such referrals are treated as information and advice matters requiring further discussions with the police and requiring a joint visit prior to deciding whether it is a referral. This has the effect of downsizing the rigour of the assessment process, and reduces their priority.
18. The Review also makes comments about the referral of domestic violence matters to the Calderdale Women's Centre and the need for awareness raising about domestic violence and its impact on children.
19. It is important in a Review, which is critical of practice, also to emphasise that there were some committed staff who carried out good work with the family in difficult circumstances, and which was acknowledged by the mother of child A. In particular there was positive action by the police in respect of the domestic violence referrals, and the mother acknowledged the support she received from her health visitor at the time immediately preceding the death of child A. It is important to state this, and the circumstances surrounding the death of the child A must not allow this to be overlooked.
20. The Review has addressed the terms of reference given by the Serious Case Review Sub-Group and the conclusions, lessons to be learned and recommendations contained in the report, follow on from these terms of reference and the analysis from the agency management reports.
21. The Review has addressed the terms of reference contained in section 4.0 above.
22. The Review has addressed the lessons that need to be learned from this case as to how the local agencies in Calderdale worked together to promote the welfare of child A and her family.
23. There has been consideration of agency effectiveness in their work with the family.
24. There has been consideration of agencies handling of referrals and decision making, with shortcomings identified and recommendations for improvement made.

25. The Review has commented on the failings in support given to child A and her family in the period prior to her death.
26. The Review has considered the issue of domestic violence, and has made a recommendation to the Safeguarding Children Board as a result.
27. The Review has considered as to whether there were any systemic deficiencies identified in any agency. It has concluded that there were such deficiencies in respect of the Initial Response Team of Calderdale Care Services, which are in urgent need of management action so as to effect improvement.
28. The Review has considered practice issues arising in the review and proposals to improve these are contained in agency action plans.
29. The Review makes four key recommendations setting out action and changes, which if implemented would better the safeguarding and welfare of children and young people in Calderdale.

Recommendations

30. In considering recommendations arising from this Serious Case Review, the intention is to focus on a small number of key issues arising from the terms of reference. There are a number of other recommendations in the agency management reports but these are to be followed up by agencies and will also be monitored by the Calderdale Safeguarding Children Board. This is not to diminish the importance of all the matters raised by agencies and the ensuing recommendations, but their number should not detract from the key recommendations set out below.

31. The four recommendations outlined below are considered to be the key ones arising from this serious case review. They need early implementation and should be monitored by the Safeguarding Children Board.

In making recommendations, it is important to emphasise that action may well already have taken place to put in hand changes to systems and procedures identified in the Review.

- **Recommendation to the Group Director of Children and Young People's Services, Calderdale Care Services**
Calderdale Care Services should carry out a systemic review and improvement to the performance of the Initial Response Team, so that it operates in safe and timely manner in regard to the safeguarding and protection of children. This is considered to be an urgent matter for implementation.
- **Recommendation to the Chair of the Calderdale Safeguarding Children Board**
The Calderdale Safeguarding Children's Board should review how domestic violence services and referrals are handled in the Authority.
N.B. This would include the way referrals are handled by the Initial Response Team, awareness raising in respect of domestic violence, the problem of referrals to the Women's Centre, and a review of when the Police should commission a MARAC meeting.
- **Recommendation to the Chief Officer of the West Yorkshire Probation Service**
The Probation Service should review their procedures, to ensure that they move away from the purely child protection focus, so as to take account of the broader aims for children that Safeguarding has introduced.

- **Recommendation to the Chief Executive of Calderdale Primary Care Trust**

The Primary Care Trust should take management action to reduce the number of internal transfer of health visitors to a case, so as to ensure a more consistent and seamless service to children and families.

Action by Calderdale Safeguarding Children Board

32. On 19th May 2008, at a special meeting of the Calderdale Safeguarding Children Board, the Review in respect of Child A was received and approved. It was acknowledged that the report could not be submitted to Government Office until after the completion of Care Proceedings.
33. The Board and constituent agencies also accepted all the recommendations contained in the report, and noted that action had already been taken to implement the recommendations, and agency action plans, so that the lessons learned from this Serious Case Review would be contained in local safeguarding practice and procedures. The Calderdale Safeguarding Children Board will monitor and ensure the on-going implementation of the recommendations and agency action plans.

Roger Thompson
Overview Chair
December 2008