

# **CALDERDALE SAFEGUARDING CHILDREN BOARD**

## **Serious Case Review Executive Summary December 2009**

### **Child C**

## **CHILD C EXECUTIVE SUMMARY**

### **1. CIRCUMSTANCES LEADING TO THE SERIOUS CASE REVIEW**

**1.1** Child C was admitted to hospital as an emergency at the age of six weeks. She was diagnosed as having meningitis, and was also found to have multiple bruises and bone fractures. She was made subject of an Interim Care Order and placed with foster carers on her discharge from hospital

**1.2** Child C's parents, X and Y were subsequently convicted of offences of child cruelty, and her father was additionally convicted of Grievous Bodily Harm. Both parents received custodial sentences.

**1.3** Child C's name was placed on the Child Protection Register shortly before her admission to hospital and was therefore subject to a multi – agency Child Protection Plan.

**1.4** Following child C's admission to hospital and the discovery of her injuries, the Chair of the Calderdale Safeguarding Children Board decided that there should be a Serious Case Review in relation to Child C's illness and injuries.

### **2. TERMS OF REFERENCE FOR THE REVIEW**

**2.1** This Serious Case Review will adhere to the general guidelines as set out in paragraph 8.3 of 'Working Together to Safeguard Children (2006)'.

**2.2** The following key issues will be addressed:

- To identify any lessons to be learnt in relation to how the agencies involved with the family worked together to safeguard and promote Child C's welfare.
- To examine whether or not the production and completion of the core assessment/pre-birth assessment:

a) was carried out in a timely manner,

b) gathered key information within the three dimensions of the Assessment of Children in Need and their Families Framework (herein referred to as 'The Assessment Framework'), in line with the requirements of a core assessment (DOH, 2000)

c) adequately investigated key safeguarding issues including the mother's long standing history of substance misuse, and the permanent removal of her two older children from her care.

d) skilfully analysed the parents' situation, their capabilities and potential risks they might pose to the unborn child

e) identified an evidence based plan to safeguard the welfare of the child, consistent with the analysis of information gathered

- To highlight examples of good practice in relation to the completion of the core/pre-birth assessment and to examine the reasons for any shortcomings in procedural matters and professional practice.
- To determine to what extent the view taken by the staff of the Calderdale Substance Misuse Service of the mother's co-operation with workers, and their assessment of her progress on the methadone withdrawal programme, reflected an understanding of safeguarding issues relating to her unborn Child C and of the potential risks posed to the child by her drug dependence.
- To determine the extent to which the shared multi-agency understanding of the parents as co-operative with workers and of the overall situation as being at a level of "medium risk" to the child, reflected a rigorous analysis of the safeguarding issues inherent in the couple's situation
- To determine whether or not the decision to convene the initial child protection conference was made at an appropriate stage in the life of this case, whether or not it took place within the correct timescales and if not, why any delays occurred.
- To examine the contribution made to the conduct of the case by the local authority's Law and Administration Service with respect to the question of risk of significant harm to the child, including the gathering and analysis of information relating to the actions taken to secure the safeguarding of the mother's older children, and the overall family history and current situation.
- To determine whether or not support offered to the couple before and after the birth of the child was consistent with the needs of a family with complex needs, including the mother's long term drug dependency resulting in the relatively recent adoption of her two previous children, and a first time father who was estranged from his family due to violence from them.
- To examine the quality of communication within the multi-agency network, and its impact on the handling of this case, highlighting examples of good practice and establishing the reasons for any poor practice.
- To examine the quality of communication between the health professionals in relation to the lack of movement of the child's leg, paying particular attention to the reasons for the lack of follow up by health practitioners.

- To compile a multi-agency action plan consistent with learning points relevant to all agencies

### 3. AGENCIES PROVIDING REPORTS

Relevant agencies who had had involvement with the family were asked to submit Internal Management Reviews, detailing, summarising and analysing the work they had done in respect of the family, and identifying any learning points in relation to policy and practice. The following agencies provided IMRs to the Overview Panel which was set up to complete the Serious Case Review.

- Calderdale Primary Care Trust and Calderdale and Huddersfield NHS Foundation Trust, including Hospital, Midwifery, Community and Substance Misuse services (combined report)
- Care Services, Children and Young People's Directorate, Calderdale Council
- Calderdale Temporary Accommodation and Support Housing Advice Service
- Calderdale Council Law and Administration Service
- West Yorkshire Police

### 4. THE OVERVIEW PANEL

The chair of the panel was a University Lecturer with a practice background in health services and was totally independent of any of the agencies involved in the case.

The author of the Serious Case Overview Report was a member of the Calderdale Safeguarding Children Board who had no connection with any of the agencies involved in the case and who had had no prior knowledge of or involvement with the case.

The Overview Panel was made up of representatives at a senior level from all the agencies involved with the family (see above). None of these professionals had any direct involvement with the family or any responsibility for any of the professionals directly involved with the family.

As there was no appropriate ethnic minority representation on the Overview Panel, an independent report was commissioned to consider issues of ethnicity, culture, language and religion in relation to this family.

## 5. OTHER SERIOUS CASE REVIEWS

5.1 Since the commissioning of this SCR in April 2007, there have been two further SCRs (Child A and B, see [www.Calderdale-scb.org.uk](http://www.Calderdale-scb.org.uk) for Executive Summaries) both of which have been completed and evaluated by Ofsted. There are common practice and systemic organizational issues arising in all three cases which have been addressed in those SCRs and accompanying action plans.

## 6. FAMILY INVOLVEMENT

The parents were interviewed by the author of the Overview Report and their views concerning the services they received from agencies are included in the full report.

## 7. FAMILY CIRCUMSTANCES

**7.1** Child C is the fourth child of X and the first of Y. X's first two children were removed from her care as she was unable to provide them with safe parenting due largely to long term drug dependency. X's third child was stillborn.

**7.2** The overview report addresses a number of difficulties X had faced since her childhood. As an adult she struggled for many years with drug dependency, and she had been supported by drug services in attempting to withdraw from substance misuse. Y was not a drug user. He had experienced some recent family problems and was estranged from his family.

**7.3** Local agencies became involved with X and Y when they moved to the area in the early stages of X's pregnancy with Child C. Local authority children's services became involved because of the history of X's two previous children leading to concerns for the welfare of the unborn baby. At this time X had voluntarily become involved with drug dependency services as she wished to become drug free.

**7.4** During the period between the couple moving into the area and Child C's injuries, a number of risks to the unborn child were evident. These included problems between Y and his family, missed drug service and other health appointments, use of illegal substances despite the support of the drug dependency services and poor quality temporary housing.

**7.5** A child protection conference was held soon after Child C's birth because of concerns connected to X's drug dependency and her previous difficulties in parenting. Child C's name was placed on the Child Protection Register under the category of "neglect". The agencies involved were in agreement that the child should remain at home with her parents.

## **8. KEY FINDINGS AND CONCLUSIONS**

**8.1** The overview report found serious shortcomings in some agencies' practice, in particular, Calderdale Care Services and the combined Health Services. It should be noted that the events of this case took place some considerable time ago (March 2007) and agencies have since taken action to rectify the identified shortcomings (see previous paragraph 5).

**8.2** All agencies actively involved with the family, and in particular health service and Care Services, misjudged the family situation and significantly under-estimated the risks to the child. Although the level of risk was formally assessed as "medium", and the child's name was placed on the Child Protection Register, an unrealistically positive view was taken of X and Y's capacity to provide adequate and safe parenting to their Child C and this permeated the handling of the case. An element of the 'Rule of Optimism' was evident in this case with a resultant lack of focus on Child C's safety and wellbeing.

**8.3** There was a lack of robust management oversight of this case by Care Services and Health Services which meant that the overly optimistic view of the parents and their situation went unchallenged.

**8.4** Multi-agency communication was poor leading to instances of agencies and/or individual professionals not receiving accurate and/or up to date information, and to a lack of purposeful intervention.

**8.5** There were significant delays in Care Services completing an assessment of the family situation and of the needs of, and potential risks to the unborn child. The quality of assessment practice was extremely poor. Information was taken at face value, little attention was paid to risk factors and there was a lack of robust analysis of the overall situation.

**8.6** The level of contact by the allocated social worker with the parents was far below the level required to facilitate the development of a good quality working relationship.

**8.7** There were systemic failures in Care Services which led to the case falling from view for a significant period, and to a delay in the convening of a child protection conference.

**8.8** Communication between health professionals was significantly below the accepted standard in the month before the child was admitted to hospital, which left the child exposed to harm. This was particularly the case in regard to Child C's leg with health professionals working on their own, with no reference to others who were known to be visiting the family as well. The health visitor did follow up her advice to the couple in early March to take the child to the doctor but by that time the child was seriously ill with meningitis. The Health IMR indicates that the lack of an identified lead health care professional for the family, an assumption by each health care professional

that the others were managing the situation and a belief that the leg problem was not related to abuse, goes some way to explaining the lack of communication and resulting inaction in this matter.

**8.9** There was a failing in the drugs screening service to take into account child safeguarding issues in assessing the mother's progress on the drug rehabilitation programme. This led to overly positive reporting of the mother's success in reducing her dependence.

**8.10** There were instances of health professionals failing to adhere to local protocols and procedures.

**8.11** Care Services and Health Services did not engage effectively with the father and knew very little at all about him. It was assumed, without question or any evidential basis, that he was a responsible and stabilising influence on the mother.

**8.12** It is not possible to know exactly what the outcome for the child would have been, had the shortcomings identified above not applied in this case. The father had no previous known history of violence and was not previously known to local authority children's services or the police, and it is not appropriate to guess whether or not better engagement with him by Care and Health services, would have revealed any obvious indication of a possibility that he might physically injure his child.

**8.13** However, there was enough information available within the professional network at the point the couple moved into the Calderdale area, to indicate serious potential risk to the unborn baby and it is likely that, with the benefit of a high quality professional practice supported by robust management oversight and good agency systems, it would have been difficult for risks to the child to be so seriously misjudged. A more accurate judgement would have taken the case down a different route, which recognised the need for a identified services and support required to keep the child safe, or alternatively, if necessary, to consider the use of protective legal intervention.

## **9. RECOMMENDATIONS**

Individual agencies have undertaken their own reviews of their practice in this case, have made recommendations for action and have acted on these.

Further recommendations are made by the overview report author as follows:

**9.1** The Serious Case Overview Panel endorses the recommendations contained in the IMRs submitted by the agencies involved in this serious case review.

**9.2** The Chair of the Calderdale Safeguarding Children Board should arrange for multi-agency training to be provided to relevant staff on undertaking and

contributing to multi – agency core assessments, including analysing information and reaching appropriate decisions.

**9.3** The Chair of the Calderdale Safeguarding Children Board should take steps to remind all professionals working with children in need and children in need of protection of the importance of history to children’s current and future safety and welfare and be aware of the ‘Rule of Optimism’.

**9.4** The Director of Children and Young People’s Services should ensure that where a pre-birth core assessment is undertaken and raises child protection concern, the social worker should contact the council’s legal department at an early stage for a preliminary discussion.

**9.5** The Chief Law and Administration Officer for the Local Authority Law and Administration Service should ensure, as far as is practicable, that a solicitor attends a case conference when invited to do so by Care Services and that solicitor will subsequently give any written advice sought by Care Services after the Conference.

**9.6** The Chair of the Calderdale Safeguarding Children Board should arrange for the development of specific practice guidance to assist professionals in assessing children and families cultural, ethnic and religious needs, including the impact these factors may have upon the safeguarding of children and young people and their engagement with professionals.

**9.7** The Chair of the Calderdale Safeguarding Children Board should issue a reminder to all agencies for the need to involve both parents (including fathers/father substitutes) when working with families. The Chair should also arrange for multi-agency training in relation to working with fathers/father substitutes.