CALDERDALE SAFEGUARDING CHILDREN BOARD

Serious Case Review

Executive Summary

Child ‘B’

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1. Introduction

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.

1.1 The circumstances that led to the Review being undertaken

The child B died in December 2007. The Coroner concluded that the child died of natural causes. There was no definite conclusion that neglect was a contributory factor in her death, but she was a disabled child, and the fact that she had been left for seventeen hours prior to her death, would indicate that neglect was a contributory factor. There was also involvement of agencies with the Child B's family in the period prior to her death, and concern about agency practice in regard to compliance with safeguarding procedures. In particular, there was concern at the lack of a section 47 enquiry, an initial child protection conference, a proper assessment on the family and a lack of consideration of the family's support needs.

As a result of these circumstances, the Chair of the Calderdale Safeguarding Children Board agreed in February 2008, on the recommendation of the Serious Case Review Sub-Group, that there should be a Serious Case Review relating to child B's death.

1.2 Terms of Reference

The Serious Case Review followed 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 June 2006 until December 2007. The specific terms of reference were:

1.2.1 To identify any lessons to be learned from the death of child B in regard to how Care Services, the Police and Health Services worked together to safeguard and promote the child's welfare.

1.2.2 To identify any lessons to be learned in regard to how agencies worked together to safeguard and promote the welfare of Child B's siblings, especially that of child D.

1.2.3 To enquire as to whether information-sharing procedures were properly followed in regard to referrals from the Police and Health Services to Care Services/Initial Response Team.

1.2.4 To establish the reasons why standard safeguarding procedures were not followed by the Initial Response Team. This included the fact that the referral in September 2007 was not allocated until November 2007, that no assessment or strategy meeting were held, no Section 47 Enquiry or Initial Case Assessment was held in respect of child D's allegations.

1.2.5 To consider why a Core Assessment was not undertaken by the Initial Response Team in 2007 and the children responded to as 'children in need' and a coordinated support plan offered.

1.2.6 To enquire as to whether the thresholds for intervention are too high within Care Services thus placing some children at risk when neglect is a factor.

1.2.7 To consider whether current procedures and practices in agencies can identify children in need and offer the necessary support.

1.2.8 To consider the degree to which some children with disabilities and complex health needs are recognised as 'children in need' by Health Services staff and not just regarded as a health matter.

1.2.9 To consider the efficiency of how referrals, both initial, core and risk assessments were responded to and dealt with by Care Services.

1.2.10 To consider the degree to which current procedures and practices in agencies can identify children in need and support them.

1.2.11 To consider the efficiency of the quality assurance of safeguarding practice and decision making in the Initial Response Team by Team Managers and the consequent oversight and challenge by middle managers.

1.2.12 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.

Following the approval of the Independent Chair of the Calderdale Safeguarding Children Board to the holding of a Serious Case Review in respect of child B, the Serious Case Review Panel was convened and met on the 21st April and 9th June 2008.

A draft report for agency consultation was made available, prior to approval of the final Overview Report at a meeting of the Calderdale Safeguarding Children Board on 18th September 2008.

1.3 Agencies providing reports

1.3.1 West Yorkshire Police

1.3.2 Calderdale Primary Care Trust

1.3.3 Calderdale and Huddersfield NHS Foundation Trust

1.3.4 Calderdale Council Children and Young People's Service (Care Services/Learning Services)

1.3.5 West Yorkshire Ambulance Service

1.4 Overview Report Writer

The Overview Report was written by Roger Thompson, who also acted as the Independent Chair of the Serious Case Review Panel. He has a background in Social Services and the NSPCC. He is now self-employed and among other work, is the Independent Chair of the City of York Safeguarding Children Board. He has never been employed by any agency in Calderdale.

1.5 Family Involvement

Child B's mother has been visited by the Author of the Overview Report, and her views concerning the circumstances of the death are included in the full report.

A letter was sent to child B's father asking for an appointment so as to hear his views. No reply was received to this invitation.

1.6 Family Circumstances

Child B was the fourth and youngest child of her mother. Her father is not the father of the other three children. 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 include adverse home circumstances, and in respect of child B a disability.

1.7 Racial and Cultural Issues

There are no racial or cultural issues to be considered in this case.

2. Practice Issues and Lessons Learned : Key Findings and Conclusions

2.1 This report has not apportioned any blame for the death of the child B given that the coroner's inquest has concluded that she died of natural causes.

2.2 Child B's death has given the opportunity for there to be an examination of agencies practice and actions in relation to their work with Child B, her siblings and family.

2.3 The Overview report has identified some serious shortcomings in agencies practice, in particular for Calderdale Care Services. It is concerning that there appeared to be poor professional practice in relation to the Initial Response Team of Calderdale Care Services, which even with the advantage of hindsight seems to indicate a systemic failure of the service. It is essential that urgent action is taken to remedy the failings identified and provide any necessary resources. I am aware that the Senior Management of Calderdale Children and Young People's Services are aware of this situation and have taken positive and urgent action to address the shortcomings identified.

2.4 The Overview Report has also identified shortcomings in the services provided to the family in respect of Calderdale NHS. In particular there is concern that there was a variance from standards of practice required and a failure to adhere to required policy and process. Examples are the failure to undertake a formal mental health assessment by the health visitor and the lack of planned follow up by midwifery services around the alcohol/substance misuse by mother.

2.5 The Overview Report has also identified concerns about practice whereby a child such as B with emerging developmental concerns and where there were significant family

problems was not brought into a multi-agency assessment process prior to her discharge home from hospital following her birth. There is a need for robust multi-agency assessments prior to the discharge of such a child and this policy need has been significantly emphasised by the findings of the Victoria Climbie investigation and the recent National Children's Bureau report. This has indicated the importance of Children's Care Services staff being available at the hospital to assist with multi-agency assessments and the fact that this service seems to be lacking in Calderdale. It is important therefore for the Calderdale Children and Young People Service to review this situation and improve the contribution of social work support to multi-agency assessments prior to vulnerable children being discharged home.

2.6 It is important in a report, which is critical of practice also to emphasise that there were some committed staff, who carried out good work with the family, which was acknowledged by the mother. In particular, the work carried out in hospital prior to the child B's discharge home following her birth seems to be of a good standard and appropriate contact was arranged by the Child Development Team and appropriate follow up appointments with the Paediatrician took place. The mother also gave positive feedback in respect of the health visiting service.

2.7 The report has addressed the terms of reference given by the Serious Case Review Sub-Group and its conclusions, lessons to be learnt and recommendations contained in the report follow on from these terms of reference and the analysis from the agency management reports.

2.8 The report has addressed the terms of reference contained in section 1.2 of the Overview Report.

2.9 The report has identified lessons to be learnt from the death of child B in regard to how services work together to safeguard and promote the child's welfare.

2.10 The report has identified lessons to be learnt in regard to agencies working together to safeguard and promote the welfare of child B's siblings.

2.11 The report has addressed the issue of information sharing procedures and whether they were properly followed with regard to referrals from the Police and Health Services to Care Services. Care Services did not respond appropriately to information provided by the Police in respect of the allegations of sexual abuse of child B's elder sibling and the letter from the Consultant Paediatrician in respect of concern about the father's

access to the child B. This matter was part of the wider concern about the functioning of the Initial Response Team.

2.12 The report has analysed and established the reasons why standard safeguarding procedures were not followed by the Initial Response Team. This includes the fact that the referral in September 2007 was not allocated until November 2007, and that no Section 47 Enquiry or Initial Assessment was held in respect of the sexual abuse allegations. These concerns were part of the wider concern about the functioning of the Initial Response Team.

2.13 The report has addressed the issue of why a Core Assessment was not undertaken by the Initial Response Team in 2007 and the children responded to as "Children in Need" and the failure to establish a coordinated support plan.
It is of concern that an Initial Assessment was not completed, which would have led to a Core Assessment, and a support package for the family and children.

2.14 The report has enquired as to whether the thresholds for intervention are too high within Care Services, thus placing some children at risk were neglect is a factor. It is apparent that during the period covered by the Overview Report, there was no evidence of any meaningful threshold for assessing intervention by Care Services. There were inadequate response times, poor management oversight, poor recording and a failure to have a consistent response criteria for intervention, other than a stated priority for child protection referrals, although the allegations of sexual abuse were not investigated. It would appear that there were no meaningful thresholds for intervention in respect of children at risk of neglect.

2.15 The report has addressed the issue as to whether current procedures and practices in agencies can identify children in need and support them. In the period covered by this Overview Report, there was not evidence to demonstrate that there was a robust process for identifying children in need and in supporting them.

2.16 The report has addressed the issue of children with disabilities and with associated health needs and who are recognised as children in need by health service staff but may require multi-agency attention to these needs. There was a failure to have a Care Services contribution to the planning of the discharge home of child B, who was disabled, where there were a range of concerns about home conditions, and where there was general concern about the family. It was important for there to be a Care Services input to the pre-discharge planning from hospital of the child B to the family home. The report has suggested that

Calderdale Children and Young People's Service should review their current social work arrangements to children being discharged from hospital.

2.17 The report has focused on how referrals and assessments were responded to and dealt with by Calderdale Care Services. There has been acknowledgement that during the period covered by this Overview Report, there was a failure by the Initial Response Team of Calderdale Care Services to respond in an appropriate timescale to referrals. Also in this case the initial assessment was not completed or recorded properly.

2.18 The report has considered the degree to which current procedures and practices in agencies can identify children in need and support them. During the period covered by this Overview Report, the Initial Response Team did not identify and support children of a family, who were in need of support. Equally there were practices identified in Health, which also did not offer the necessary support to the family, including the failure of the Health Visiting Service to assess the mother's mental health, and the lack of a planned follow up by Midwifery Services around the mother's alcohol and substance misuse.

2.19 The report has addressed the issue of the effectiveness of quality assurance of safeguarding practice and decision making in the Initial Response Team by Team Managers, and the consequent overview and challenge by middle managers. It is clear that the operation, and management oversight of the Initial Response Team was significantly below the required standard, during the time covered by this Review.

3. Recommendations

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 recommendations in the agency management reports, and these are listed in the Agency Action Plans. This is not to diminish the importance of all the matters raised by agencies, but they should not detract from the key recommendations set out below. They require 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 been taken to put in hand changes and remedies to shortcomings identified in the Overview Report.

1. Recommendation to the Group Director of Children and Young People's Service, 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 a safe and timely manner in regard to the safeguarding and protection of children.

2. Recommendation to the Group Director of Children and Young People's Service, Calderdale Care

Calderdale Care Services should review their arrangements in respect of social work support to children in need being discharged from hospital and provide a service, which assists in the multi-agency planning for children being discharged.

3. Recommendation to the Chief Executive of Calderdale Primary Care Trust

The Primary Care Trust should ensure and monitor the requirement of primary care staff to deliver health care in line with Calderdale Child health Promotional Programmes.

4. Recommendation to the Chair of the Calderdale Safeguarding Children Board

The Safeguarding Board should require all agencies to remind their staff that if they are concerned about the action or lack of action of another agency, that they should make representations to a higher level in that agency to ensure that the necessary action is taken.

5. Recommendation to the Chair of the Calderdale Safeguarding Children Board

The Safeguarding Children Board should review and make clear to all agencies the current thresholds in Calderdale in respect of children at risk of neglect.

4. Action by Calderdale Safeguarding Children Board

On 18th September 2008, at a special meeting of the Calderdale Safeguarding Children Board, the Overview Report in respect of Child B was received and approved.

The Board and constituent agencies 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 ongoing implementation of the recommendations and agency action plans.

Roger Thompson
Independent Chair
October 2008