Calderdale Safeguarding Children Board

Learning Lessons from Serious Incidents in Calderdale

Child D

Background

1.1 In March 2009 the family of Child D, who was aged 4 months, telephoned their GP surgery and described her as having a chesty cough and being a little floppy. They were told to bring Child D into the surgery for an appointment in an hour. When she was brought to the surgery by her father, she was seen to be having difficulty breathing and an emergency ambulance was called. The ambulance arrived within 7 minutes and Child D was taken immediately to the Calderdale Hospital and then transferred to the Regional Specialist Unit in Leeds. Her condition deteriorated and the following day the decision was taken to turn off her life support machine as her injuries were not compatible with life and she was formally pronounced life extinct.

1.2 The cause of Child D's death was subsequently established as hypoxic ischemic encephalopathy associated with a right sided subdural haemorrhage (Brain Haemorrhage), which in lay terms is an injury to the brain and also clinically detected unilateral retinal haemorrhage, which is damage to the eye structures. A number of small bruises were also identified. At a finding of fact hearing within later Care Proceedings regarding one of Child D's siblings, the Judge concluded that on the balance of probabilities Child D's injuries were likely to have been the result of non-accidental trauma.

1.3 Child D had been living with her parents, who were in their early 20s and her older sibling, who was not yet 2 years old, in their family home. She also had an older half sibling, who lived with her maternal family but stayed frequently at weekends with Child D's family. Child D had routine contact during her life with universal services, specifically health services, but she had no contact with Children's Social Care and was never subject to any referrals or assessments by Children's Social Care.

1.4 Child D and her family were white British, religion was not identified as of significance to them and none of the family had physical disabilities. Although it was not recognised by agencies other than Youth Works at the time, both Child D's parents had Learning Disabilities within the low to borderline range. Child D's mother in particular was identified as vulnerable given difficulties within her own family background as a result of which she had herself been known to Children's Social Care when she was a child. The parents were for much of the family's life reliant on benefits and were known to need other support from agencies involved with them.

1.5 Child D's parents had been in contact with both universal and targeted services prior to her birth. Sibling 1 had been the subject of two referrals to Children's Social Care by other agencies and her parents had also referred themselves on 2 or 3 occasions to Children's Social Care, seeking financial help. None of these referrals had led to Child Protection proceedings being initiated and the family were not involved with Children's Social Care at the time of Child D's death.

1.6 Child D's parents had sought and received help themselves from Calderdale Young People's Service (Youth Works) prior to the birth of Sibling 1 and continued to access this support intermittently throughout the period covered by this Review. Youth Works, which is a voluntary, client led service, provided them with a significant level of help in relation to housing and other practical problems as well as offering personal support. The mother was briefly involved with the Careers Service which arranged a training placement for her during her pregnancy with Sibling 1.

1.7 West Yorkshire Police responded to two assaults on the father of Child D during this period, by both Child D's mother and the mother of Half Sibling 2. These assaults have been identified throughout as domestic violence, though it is fair to note that there was no evidence that there was a pattern of serious or chronic violence.

1.8 On two occasions, Youth Works made referrals to Children's Social Care arising out of concerns about Sibling 1's care. On the first occasion, there had been an allegation that Sibling 1 had been dropped on her head by her father and that no medical attention had been sought. Children's Social Care initiated a S47 enquiry, but in light of the medical evidence it was concluded that there was no grounds for action within the Child Protection procedures . Youth Works made a second referral in November 2007 when the parents separated, initially leaving the mother as the primary carer for Sibling 1. Their concerns included: the mother's parenting abilities; failure to meet Sibling 1's health needs; lack of engagement with health services; financial difficulties; allegations of an assault taking place in the home and allegations of cannabis use. A S47 Assessment should have been undertaken at this point, but there is no evidence that one was in fact done. Instead, the father, who by this point had taken over care of Sibling 1 was told to seek legal advice regarding residence of the child. The case was closed a couple of weeks later with no action taken.

1.9 A referral was made at this time to Family Services by the Health Visitor requesting support for the father as a single parent. Family Services met with the father and offered support, specifically a Father's Group, but he did not take this up. Further attempts were made by Family Services to engage with both parents, but without success and the case was closed. Shortly after this, the parents reconciled and continued to live together, with one further known separation until the death of Child D.

1.10 In the summer of 2008 following the identification of problem of Sibling 1 experiencing fitting as a result of low sodium, caused by excessive liquid intake, the Health Visitor made a second referral to Family Services. The purpose was to provide antenatal and postnatal support, help with parenting skills, undertake a safety review and give dietary advice. Family support workers undertook a joint visit with the Health Visitor and three individual visits to the Family. It was not however felt necessary to undertake an assessment under the Common Assessment Framework (CAF), which it would appear was not established practice at that time, or to make a further referral to Children's Social Care. No concerns were identified directly in relation to Child D at any point.

Key Themes

2.1. Child D had no previous involvement with agencies

Child D was only 4 months old at the time of her death and had limited contact with agencies. Children's Social Care had no cause to have contact with her and there was no information prior to her death that suggested she had either been subject to physical harm or was at risk of physical harm from her parents.

2.2. Parental Learning Disability

The parents' Learning Disability was a significant feature within this case and may have had an impact on parental capacity in the absence of additional support. However, it was the case that this was not recognised by all agencies at the time. It is the case that the parents' abilities may have been masked to some extent by what is frequently referred to as "false apparent competence" whereby adults present as more able than they in fact are. However, this is not an unusual feature of Learning Disability. Parents with Learning Disabilities are more likely to be experiencing other adverse factors such as low socio-economic status, unemployment and social isolation and in order to parent successfully are understood to have a particular need for good family and community support networks and positive personal psychological factors. As a result no assessment was undertaken either of their cognitive abilities or whether they had adequate capacity and support to meet both their own needs and those of their children

2.3. Assessment

The quality and adequacy of individual episodes of assessment has been identified as an area of weakness in relation to a number of the agencies, specifically: Children's Social Care, NHS Calderdale (Health Visiting) and Family Services. Given the generally low level of individual concerns identified however, a theme that also emerged was a focus on the assessment of individual events, without a corresponding focus on whether there might be a pattern of concerns over time.

2.4. Threshold for Intervention

The history of the referrals to Children's Social Care and the subsequent responses illustrated a lack of clarity by all agencies about what was the threshold for intervention by Children's Social Care. It was identified that staff within other agencies, in particular Youth Works did not believe that action would be taken if they made a referral, a belief which is supported by their experience on one of the occasions relating to Sibling 1. It is suggested that the impact of this was to create a

culture amongst some non-social care professionals of not making referrals due to the expectation that it would not lead to an intervention.

2.5 **Management oversight and supervision**

Gaps in the provision of management oversight and supervision was a factor in the quality of service provided by a number of agencies.

2.6 **Multi-agency working**

A key thread running through the services provided to this family relates to the quality of multi-agency working.

2.7. **Domestic Violence**

Domestic Violence has not been a major feature of this case, but has nevertheless been identified and the potential for improvements to practice recognised. The father of Child D is known to have been subject to assaults by the mother on two occasions, though these appear to have been at the less serious end of the spectrum and there is no information to suggest it was of the chronic nature often associated with Domestic Violence.

Firstly although the domestic violence identified was not of the most serious kind there were some failures by professionals to consider the possible implications for the welfare of the children. Secondly the panel considered whether, because in this instance the victim of the violence was a man, it was treated with less seriousness than would have been the case with a woman victim.

Conclusion

There was an avoidable delay in initiating the Serious Case Review.

The Review concluded that although there was no evidence to suggest that Child D's death could have been predicted and therefore could have been prevented, opportunities to provide a suitable and comprehensive service to Child D's family which might have better met their needs were missed and a number of lessons for learning have therefore been identified.

Each agency had individual action plans addressing their shortfalls which were identified throughout the Serious Case Review. These action plans indicate that all the recommendations were carried out. For further details refer to your agencies named or designated Safeguarding Lead.

Multi-Agency Recommendations

1: Calderdale Safeguarding Children Board prioritise the development and implementation of a multi-agency working protocol with regard to neglect, to provide a shared understanding for professionals to identify and respond to concerns about neglect.

Response: *Neglect Strategy and Multi-Agency Toolkit produced and implemented across Calderdale*

2: Calderdale Safeguarding Children Board put in place provision to assess the strength of inter-agency working with particular regard to the use of CAF.

Response: *CAF replaced by Early Intervention Single Assessment. CSCB Performance Management dataset monitors use of Single Assessments. CSCB Looking at effectiveness of outcomes from CAF / Single Assessments.*

3: Calderdale Safeguarding Children Board and Calderdale Adult Safeguarding Board

a) raise awareness within member agencies of the particular needs of parents with a learning disability.

b) finalise the draft protocol between Children's Social Care and Adult Social Care in relation to working with families where there is parental Learning Disability.

Response: *Joint Adult and Child Protocol Flowchart launched by CSCB April 2014. Measuring impact through Early Help and Prevention sub group. Promotion led by Principal Social Worker*

4: Calderdale Safeguarding Children Board reviews and updates its procedures in relation to Serious Case Reviews.

Response: *Refresh and Rewrite of SCR Framework due to be completed October 2014 after Revised Working Together 2013, SCR guidance from Sequeli and NSPCC.*

5: Developmental work is undertaken within the remit of the Domestic Violence strategy to consider the practice implications for and particular needs of male victims of domestic violence.

Response: *The Maze Project was established and addresses the needs of male victims of Domestic Violence as part of work with the whole family*