# The Overview Report of the Serious Case Review in respect of Child D

This report is the property of Calderdale Safeguarding Children's Board.

# Contents

# GLOSSARY

## FAMILY:

| | |
|---|---|
| **Child D:** | Subject |
| **Sibling 1:** | Full Sibling of Child D |
| **Sibling 2:** | Half Sibling of Child D |
| **MD** | Mother of Child D |
| **FD** | Father of Child D |
| **MP:** | Partner of Mother during late 2007 |
| **MS2** | Mother of Sibling 2 |

**In order to protect the identity of Child D's surviving siblings, all three children will be referred to within this report by the female pronoun.**

| | |
|---|---|
| **A & E** | Accident and Emergency |
| **CSCB** | Calderdale Safeguarding Children Board |
| **CAF** | Common Assessment Framework |
| **CCG** | Community Care Grant |
| **CHAS** | Calderdale Housing Association |
| **CHYPS** | Calderdale Housing Young Parents Scheme |
| **CPS** | Crown Prosecution Service |
| **CSC** | Children's Social Care (known at the time as Children and Young People's Care Services) |
| **CYPS** | Calderdale Young People's Service |
| **GP** | General Practitioner |
| **HAC** | Housing Advice Centre |
| **IRT** | Initial Response Team |
| **JSA** | Job Seekers Allowance |
| **LSCB** | Local Safeguarding Children's Board |
| **NEET** | Not in Education, Employment or Training |
| **PAU** | Paediatric Assessment Unit |
| **OFSTED** | Office for Standards in Education |
| **SCR** | Serious Case Review |
| **SCRP** | Serious Case Review Panel |
| **TOR** | Terms of Reference |
| **YOT** | Youth Offending Team |

# 1. INTRODUCTION

## 1.1 Circumstances that led to this Review

1.1 Child D was born in Calderdale on 26.10.08 to MD (Mother of Child D) and FD (Father of Child D) and lived with them throughout her life. Child D had one full sibling, (Sibling 1) who was just under two years old at the time Child D died, and who also lived with Child D and their parents. Child D also had a half sibling (Half Sibling 2), the children sharing the same father. Half Sibling 2 lived initially with her mother (MS2) and later with her maternal grandparents, also spending regular weekends with FD and MD. MD and FD are known to have experienced periods of separation both prior to and after Child D's birth.

1.2 At the time of her death, neither Child D nor her siblings were involved with Calderdale Children's Social Care. Child D had never been subject to any statutory form of assessment or legal proceedings brought by the Local Authority. Referrals had previously been made to Children's Social Care in relation to Sibling 1, but this had not resulted in any continuing involvement.

1.3 On the morning of 3rd March 2009, FD telephoned the family's GP surgery and reported that Child D had a chesty cough and had become floppy. He was told to bring Child D into the surgery in an hour, which he did. When Child D and her father arrived at the surgery she was heard in the waiting room to have a high pitched scream and found to have difficulty breathing when seen by the Nurse Practitioner. An emergency ambulance was called by the Nurse Practitioner and on their arrival Child D was found to be pale, with limited responses. She was given oxygen and transported to the A&E department of the local hospital then transferred to the children's ward and subsequently to the Regional Paediatric Intensive Care Unit to be assessed by Neurological specialists. She was noted to have bruising to the right eye, suspected injury and bleeding to her brain and a small bruise on her clavicle.

1.4 Child D's condition continued to deteriorate and on Wednesday 4th March 2009 the decision was taken to switch off her life support machine as her injuries were not compatible with life. At this point her life was pronounced extinct. Child D was 4½ months old.

1.5 During the early hours of 4th March 2009 Calderdale Children's Social Care notified the West Yorkshire Police Child Public Protection Unit that Child D had suspected non accidental injuries. A police investigation was initiated into the circumstances surrounding her death.

1.6 A post mortem was undertaken on 5th March 2009 and established that the cause of death was hypoxic ischemic encephalopathy associated

with a right sided subdural haemorrhage, which, in lay terms, is an injury to the brain. It was also identified that Child D had clinically detected unilateral retinal haemorrhage, which is damage to the eye structures. A number of unexplained small bruises were noted.

1.7 At a Finding of Fact Hearing within subsequent care proceedings for Sibling 1 (see para 1.6.4) in August 2010, judgement was reached that the acute injuries leading to Child D's death were likely to have been a result of non-accidental trauma. Information was also available to the court, regarding the presence of unexplained healing rib fractures, which were later estimated to have been caused between 3 and 6 weeks prior to Child D's death. No information about these fractures was available to any of the agencies during the timeframe covered within the Serious Case Review.

1.8 Both the parents of Child D were arrested on suspicion of murder and interviewed under caution regarding the injuries sustained by Child D. They were subsequently released on Police Bail pending further enquiries following the release to the police of a judgement made within the civil court proceedings relating to Sibling 1. The police enquiries were ongoing at the time of this Review.

1.9 On 4th March 2009 OFSTED and Government Office Yorkshire and Humberside were notified of Child D's death. On 5th March, relevant agencies were requested to secure their records in the event of further enquiries being necessary.

1.10 An Initial Serious Case Review Sub Group was convened and met on 30th March 2009. At this meeting, the recommendation as to whether to undertake a Serious Case Review was deferred pending the completion of a full post mortem report. The decision was considered by the sub-group again on 2nd October 2009 and a decision deferred again on the basis that there were differing medical opinions regarding the cause of Child D's injuries.

1.11 It was 6th August 2010 before the SCR Sub Group considered the matter further when information was received which suggested that abuse was a likely factor in Child D's death. The meeting agreed to defer the recommendation to the Calderdale Safeguarding Children Board Chair pending the outcome of the Finding of Fact within the legal proceedings regarding Sibling 1 which took place in August 2010. The medical opinion regarding the cause of the injuries was fully explored in the Finding of Fact Hearing and a conclusion reached on the balance of probability that the injuries were non-accidental.

1.12 On being informed of the outcome of the Finding of Fact the Independent Chair of the Safeguarding Board on 18th August 2010 concluded that a Serious Case Review should be undertaken.

1.13 It is the view of the Author that the decision not to initiate a Serious Case Review for a period of almost 18 months resulted in an inappropriate time delay which is inconsistent with learning lessons from local cases and will have impacted on the recall of those involved. Whilst the cause of death and the details of the post mortem finding were indeed unresolved, there was nevertheless adequate information, including the view of the examining paediatrician at Calderdale Royal Hospital, to indicate from an early stage that there was a significant possibility that Child D had died as a result of non-accidental injury. In this context and given that the family had received services from a number of agencies an early decision to undertake a Serious Case Review would have been in the interests of local learning.

1.14 An Independent Chair and Author for the Review were appointed in September 2010 and a Serious Case Review Panel (SCRP) established to manage the process with representation from the relevant agencies invited.

## 1.2 The Terms of Reference of the Review

1.2.1 The Terms of Reference for the Serious Case Review, which fully set out the scope and context of the Review are attached as Appendix A. A summary of the Terms of Reference is as follows:

1.2.2 The Terms of Reference were established in line with the requirements of Working Together 2010, which states that a Serious Case Review must:

*Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children*

*Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result*

*Improve intra and inter agency working and better safeguard and promote the welfare of children*

1.2.3 In addition the following key lines of enquiry were identified:

**Key Lines of Enquiry:**

***TOR1***: *To establish the facts of what was known to each agency in relation to:*

- *Child D*
- *Sibling 1*
- *Half Sibling 2*
- *Mother of Child D*
- *Father of Child D*

***TOR 2:*** *Establish what services were provided to Child D and the family and to what extent they were based on assessed need.*

***TOR 3****: Identify any issues in relation to:*

- *Domestic Violence*
- *Substance misuse*
- *Mental Health*
- *Risk of Physical Abuse*
- *Risk of Neglect*
- *Parental Learning Disability*

*and determine whether each agency responded to the issues within local and national policies, procedures and guidance in relation to safeguarding*

***TOR 4:*** *Examine whether assessments relevant to each agency were undertaken at appropriate points and whether the quality provided a sound basis for decision making.*

***TOR 5:*** *Was historical information used appropriately to inform assessment decisions and future planning?*

***TOR 6:*** *To what extent did services take account of issues such as: race & culture, language, age, disability, faith, gender, sexuality and economic status and how did this impact upon agencies' assessment and service delivery.*

***TOR 7:*** *Was the management oversight and supervision in this case adequate.*

***TOR 8:*** *Identify any gaps in inter agency working with regard to the duty to safeguard and promote the welfare of the child.*

***TOR 9:*** *Examine the effectiveness of mechanisms and practice in determining thresholds for the provision of family support services.*

***TOR 10:*** *For the Overview Report to consider whether the death of Child D was predictable or preventable.*

***TOR 11:*** *Establish good practice and highlight any learning points from the case to make recommendations to the LSCB as appropriate*

1.2.4 The Key Lines of Enquiry were drafted in such a way as to ensure Independent Management Reviews (IMRs) provided by each agency detailing and analysing the service they provided to the family, were adequately rigorous in their information gathering and analysis. Whilst the IMRs were required to consider each of the Key Lines of Enquiry in

turn, the Overview report did so in an integrated manner in order to give proper weight to the key areas for critical analysis arising out of the information provided within the IMRs.

1.2.5 The Terms of Reference identified that the time period for consideration by the Serious Case Review begin with the ante-natal period for Sibling 1 ending a short period after the date of Child D's death ie:

**September 2006 to end of March 2009**

1.2.6 The ToR also required that relevant historical information be included within the Review in summary form as far as it was pertinent to the Key Lines of Enquiry. Relevant information subsequent to the death of Child D which would inform the Review in relation to the subsequent safeguarding of Child D's siblings was also to be included.

1.2.7 The time period was identified in order to obtain a full understanding of any significant events in relation to all three children of the family as far as they were relevant to the Key Lines of Enquiry. In particular, the inclusion of information regarding Half Sibling 2 and her mother was considered with care and has only been included in the Overview Report when it may be directly relevant to the experience of Child D and Sibling 1.

1.2.8 The Panel reviewed the time period during the process of the SCR to ensure that it was still considered fit for purpose in the light of emerging information. The panel remained satisfied that the timescale had been appropriately identified.

## 1.3 Membership of the Review Panel

1.3.1 The Serious Case Review Panel was made up as follows:

| **Agency or Organisation** | **Role** |
|---|---|
| Colleen Murphy | Independent Chair |
| Calderdale Children's Social Care | Interim Head of Children's Social Care |
| Calderdale Children and Young People's Service | Principal Officer<br>&<br>Head of Children's Social Care (Designate) |
| Calderdale PCT | Nurse Consultant – Safeguarding Children (Designated Nurse Child Protection) |
| Calderdale and Huddersfield NHS Trust | Consultant Paediatrician<br>Designated Doctor Child Protection |
| West Yorkshire Police | Detective Chief Inspector |

1.3.2 None of the panel members had direct operational responsibility for the family or staff involved.

1.3.3 The incoming Head of Children's Social Care (Designate) attended on three occasions after being appointed to the role during the course of the Review.

1.3.4 Also in attendance at the Panel meetings were the following:

- Calderdale SCB Business Manager
- Calderdale SCB Administrator
- Sian Griffiths, Independent Overview Author

1.3.6 **Colleen Murphy, Independent Chair**: The Chair of the SCRP is Colleen Murphy. Ms Murphy works as an Independent Social Worker undertaking a range of work specifically in Children's Services and quality assurance. Ms Murphy has been a qualified social worker for twenty one years, and has previously worked in social work and social work management positions in Local Authorities as well as a management position in a voluntary agency.

Ms Murphy has undertaken previous Chair and authorship of Serious Case Reviews. Ms Murphy is not employed by any Local Authority or agency other than commissioned pieces of work of an independent nature.

1.3.7 **Sian Griffiths** is the Independent Author of the Overview Report. Ms Griffiths works as an Independent Social Worker. She is not employed by any Local Authority or Agency other than for commissioned pieces of work of an independent nature. Ms Griffiths has been a qualified social worker since 1987, working both in the Probation Service as a practitioner and manager and later as a Family Court Advisor in CAFCASS. Ms Griffiths has previously authored Serious Case Reviews for other Safeguarding Boards.

## 1.4 Timescale for conducting the Review

1.4.1 Calderdale Safeguarding Children Board, in line with Working Together 2010, required that the Overview Report be completed and submitted to OFSTED within 6 months. However, due to an oversight at the time, when there was no LSCB Manager, OFSTED was not informed as required of the timescale. Once the oversight became apparent the interim manager notified Ofsted and a submission date was agreed for 4th March 2011.

1.4.2 The Serious Case Review Panel has ensured that the timescales were met regarding the preparation of reports. However, a short delay was incurred in relation to establishing a date for presentation to the Board.

## 1.5 Methodology of the Review

1.6.1 The Panel requested and received Individual Management Reviews from the following agencies:

- Calderdale Children's Social Care
- Calderdale Council Young People's Service (Youth Works)
- Calderdale and Huddersfield Foundation NHS Trust
- NHS Direct
- NHS Calderdale Provider Services
- Yorkshire Ambulance Service
- NHS Calderdale Commissioner
- West Yorkshire Police
- Calderdale and Kirklees Careers Service.
- Calderdale Family Services Children's Centres (SureStart)

1.6.2 Information was sought from:

- West Yorkshire Probation Service
- Calderdale Community Learning Disability Team (Adults)
- South West Yorkshire Mental Health Trust
- NSPCC
- CAFCASS
- Education
- Housing Services

Each of these agencies, with the exception of Housing, confirmed that they had not provided services to Child D or the parents. It was established that the Housing Service had very limited information which did not justify the preparation of an IMR but was provided in the form of letters from the Housing Options Service and a Housing Provider.

1.6.3 Copies of the Children's Social Care records, including assessments, relating to the time period covered by this SCR, were provided to the Overview Author.

1.6.4 A Finding of Fact hearing within the Care Proceedings regarding Sibling 1 took place in front of Mr Justice Bodey prior to the start of this Review and Judgement was set down on 12 August 2010. In November 2010 the SCR panel was given access to the judgement in order to provide background and contextual information.

1.6.5 The Serious Case Review Panel met on the following dates:

- 21st September 2010 (half day meeting)
- 1st November 2010 (full day meeting)
- 23rd November 2010 (half day meeting)
- 9th December 2010 (half day meeting)
- 11th January 2011 (half day meeting)
- 8th February 2011 (half day meeting)

1.6.6 A meeting was organised by the Independent Chair and Independent Author on 21st September 2010 in order to brief IMR authors with regard to their role. Authors had access to ongoing advice and support from the Panel. At the 1st November 2010 Panel meeting, each author attended separately to present their first draft to the panel, receive feedback and identify any support necessary according to individual requirements.

1.6.7 IMR authors were also advised to consider lessons from previous SCRs in their Individual Management Reviews.

## 1.7 Parallel Processes

1.7.1 Following the death of Child D a criminal investigation was initiated during which both parents were interviewed and subsequently released on police bail. At the time of this Review, the parents were both still subject to police bail.

1.7.2 Following the Death of Child D, action was initiated by Calderdale Children's Social Care to ensure the safety of Sibling 1 and Half Sibling 2. Section 47 Enquiries were initiated in relation to Sibling 1 who was placed with the paternal grandparents under an interim Care Order. Care Proceedings in relation to Sibling 1 were ongoing during the course of this review. Half Sibling 2 was assessed as suitably cared for by her maternal grandparents and therefore no care proceedings considered necessary.

1.7.3 An inquest was opened immediately following Child D's death and adjourned to a date to be fixed. The coroner was subsequently informed that a Serious Case Review was being undertaken.

## 1.8 Family Involvement in the Review

1.8.1 The Terms of Reference explicitly required the Panel to seek the Family's contribution to the review. The panel agreed that the family members who should be invited to contribute should be the Mother and Father of Child D. Child D's siblings were not considered of an age to be involved in the review.

1.8.2 The panel agreed that the carers of Sibling 1 and Half Sibling 2 should be informed of the review. Attempts to contact MS2 were unsuccessful as no contact information was known to agencies, but Sibling 1 and Half Sibling 2's grandparents were informed by staff from Children's Social Care. Consideration was given to specifically inviting the grandparents to contribute, but it was concluded that this was not appropriate as they had not had any contact with Child D. The LSCB manager however briefed those informing them to ensure that if they wanted to make any specific contribution this would be made known to the SCR.

1.8.3 In the light of the ongoing criminal investigation, advice was sought from the police regarding meeting with the parents in relation to the Review. The advice received was that to interview the parents could compromise the criminal investigation and the Panel confirmed their acceptance of this advice.

1.8.4 The Panel agreed that following the conclusion of any criminal proceedings the parents would be invited to discuss the review and in the event of any significant new information emerging that might inform this Review, the Panel would be reconvened to consider whether further enquiries or an addendum to this report should be commissioned.

# 2. The Facts

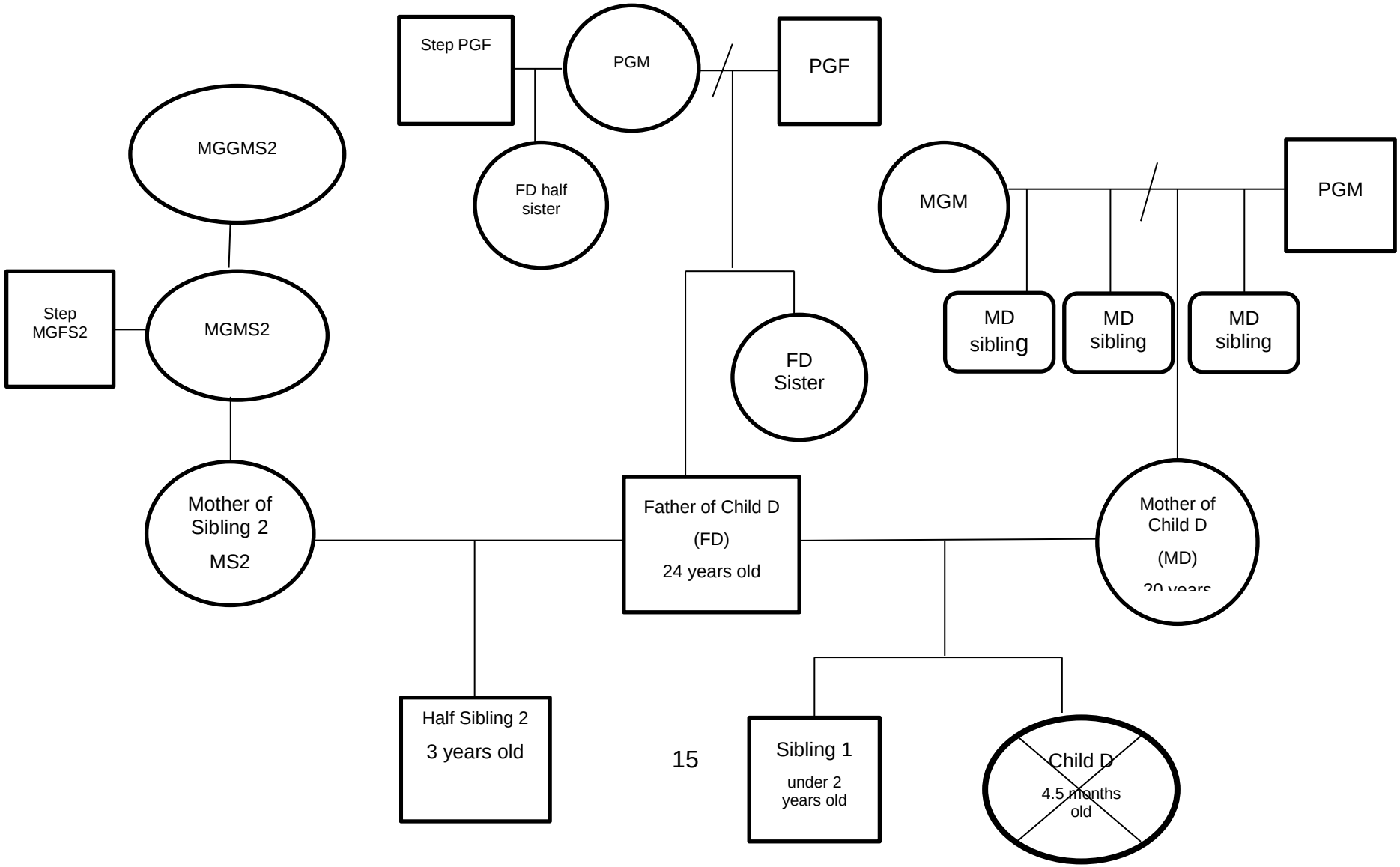
## 2.1 Composite Genogram

An individual Genogram is included within each IMR identifying which family members were known to each agency.

The composite genogram is to be found on the following page.

**GENOGRAM CHILD D**

nb: Ages given are those at the time of Child D's Death



## 2.2 RELEVANT ETHNIC, CULTURAL OR OTHER EQUALITIES ISSUES

2.2.1 Issues of race and culture were specifically identified for consideration within the Terms of Reference :

**TOR 6** *To what extent did services take account of issues such as: race & culture, language, age, disability, faith, gender, sexuality and economic status and how did this impact upon agencies' assessment and service delivery.*

2.2.2 The Review Panel ensured that there was a specific focus on any issues of diversity and all report writers were actively encouraged to consider any such issues in their analyses. Quality Assurance processes in relation to individual IMRs included specific questions in relation to this ToR.

2.2.3 Child D, her parents and siblings were consistently identified as White British and English speaking. Religion was not identified at any stage as of significance to the family or Child D's identity, although there is no information to evidence whether this was discussed with the family. The parents were in a heterosexual relationship. All the family members were born and raised in the Calderdale area and were apparently well rooted within the locality. Extended family members lived locally and appeared to be a significant part of the core family's sense of identity. Child D and her siblings lived within an economically deprived family. For a period, FD had been in employment, but he gave up work to help look after the children and so for all of Child D's life, her family were reliant on state benefits.

2.2.4 During the course of the Review it became apparent that both the Mother and Father of Child D had been identified by some professionals as having a Learning Disability. This was confirmed within a court judgement provided to the SCR. Specialist assessments of MD and FD had been undertaken within the course of the Care Proceedings which concluded that both parents had significant Learning Disabilities, falling within the low to borderline range.

2.2.5 The Mother's Learning Disabilities had to some extent been identified during her education; the Careers Service had identified that MD had been subject to School Action which was linked in part to learning. However, there is no evidence to suggest that she had been able to access specialist services as a result.

2.2.6 At the time the Terms of Reference were set, information about the parents' Learning Disabilities were not available to the panel and as such were not been specifically identified as a factor for consideration. Therefore at the Panel meeting on 23 November 2010, it was agreed

that the Terms of Reference should be amended (ToR 3) and IMR authors specifically requested to include the issue of Learning Disability within their analysis.

## 2.3 Relevant Historical Information

2.3.1 Information regarding family members' lives and background prior to the Terms of Reference has been gained from: the contributing agencies; the Family Court Judgement; information provided by the parents to professionals following the death of Child D. No single agency had a comprehensive history of the family.

2.3.2 Both MD and FD originated and were brought up in the Calderdale area where each had extended family. The Genogram identifies the family members who were known to the agencies, however, it is recognised that this does not represent the full extent of either family.

2.3.3 MD is understood to have experienced neglect as a child. At age 16 MD made a specific allegation that she had been abused by a family member. No criminal prosecution took place and MD was required by her family to leave the family home. An assessment of MD was undertaken by Children's Social Care and an action plan completed in November 2005. She was not subject to any support or supervision by Children's Social Care but was enabled to access Supportive Lodgings where she stayed from March to October 2006 at which point she lost this accommodation. During her time in supportive Lodgings a referral was recorded as having been made by a support worker to Children's Social Care for outreach support in view of her recognised vulnerability. No further information was available to the review as to the outcome of that referral.

2.3.4 MD was twice cautioned for common assault, in May 2006 in relation to another young woman and in February 2007 in relation to an assault on FD.

2.3.5 FD had one previous conviction for Wasting Police Time in September 2005 for which he received a fixed penalty. Information provided by the police also identifies that he had self harmed in the past.

2.3.6 It is likely that the parents of Child D met during the summer of 2006 and their first child, Sibling 1 was conceived shortly afterwards. Their relationship was punctuated by two known periods of separation.

# 3 INFORMATION KNOWN TO AGENCIES AT THE TIME

## 3.1 Composite Chronology of significant events.

The combined chronology which is attached as Appendix B to this report, details the relevant contact episodes between the children, their parents and each agency. Each individual IMR and the Health Overview Report includes a full detailed chronology and narrative containing all the information regarding the agency's involvement with the children. This section will therefore focus on highlighting the key events and contacts with the family. Events relating to Half Sibling 2 and her mother's family will only be referred to when there is a possible relevant connection with MD or FD. Section 4 will critically analyse these events and contacts.

## 3.2 Period prior to the birth of Sibling 1

3.2.1. The first evidence of contact between one of the agencies and the parents of Child D within the timescale of this review was by the Young People's Service (Youth Works), which provides a client directed service for hard to reach young people. In February 2006 MD had presented at the town centre Drop In facility when she talked to a Youth Worker about having anger management issues. A file was opened but there was no further contact from MD until September 2006.

3.2.2. In August 2006 MD attended A&E, when it was established that she was pregnant. During her pregnancy MD was seen at the Early Pregnancy Assessment Unit and had routine ongoing antenatal care. On one occasion she told a community midwife that she had panic attacks. It is not known if she was registered with a GP at this time.

3.2.3. MD was also in contact with Calderdale and Kirklees Careers as a young person 'Not in Education, Employment or Training' (NEET) and informed them that she was pregnant but was not planning to live with the child's father. During the autumn of 2006 MD was referred by the Careers Centre to a training course for young expectant mothers. MD's attendance at the training course became erratic over time and she was finally excluded in January 2007. Calderdale and Kirklees Careers identified her as requiring Intensive Support, she disclosed anger management problems, recurring nightmares and it was recorded that she had been subject to School Action.

3.2.4. On 11th September 2006 MD presented as homeless at the Youth Works' Drop In centre. She had been deemed intentionally homeless by the Housing Options Service due to repeatedly staying out overnight from her provided accommodation. Arrangements were made by Youth Works to find her temporary accommodation and help her resolve the related financial difficulties. After a couple of weeks MD and FD's relationship had improved and at some point they began

living together. However, their accommodation situation appears to have been insecure. Throughout September and October of 2006, Youth Works continued to help and support MD with applications for Housing and financial help, including Community Care grants. There was no direct contact with FD at this stage.

3.2.5. Half Sibling 2 was brought to A&E in October 2006 with a rash, but there is no record of the accompanying adult. In November 2006 it is noted that Half Sibling 2 was being cared for at times by FD and MD, although the extent of their involvement with Half Sibling 2 at this time is not known.

3.2.6. On 29 December 2006 Half Sibling 2, who was at the time 16 months old, was brought to the A&E department with a scald to the chest, reportedly as a result of having pulled over a cup of tea. Again there is no record of the attending adult. The explanation of the injury was accepted by the medical staff, no further action was considered necessary other than a follow up discussion by the Health Visitor in relation to safety in the home. Half Sibling 2's scald was appropriately treated following the A&E attendance.

3.2.7. MD next made contact with Youth Works at the beginning of January 2007. She had separated from FD and was again homeless. Youth Works liaised on her behalf with the Housing Advice Centre and MD was placed in temporary accommodation. There was then a further gap in contact until April 2007 when MD again sought help to apply for a Community Care Grant having found accommodation with a private landlord.

3.2.8. On 18th January 2007 MD was cautioned for an assault on FD, having punched him in the face during an argument when he had visited her at a friend's address. The Police Domestic Violence Coordinator visited FD after the assault and offered to put in place "Cocoon Watch" a system whereby friends and neighbours are encouraged to contact the police if they have any concerns. FD declined the offer as he said he and MD had reconciled in the interests of their unborn baby.

3.2.9. The Police Domestic Violence Unit informed the Domestic Violence midwife of this assault. No notification was made to Children's Social Care in relation to the incident, this is identified as being as a result of the police assuming that follow up would be undertaken by the Domestic Violence midwife. The midwife sought MD's consent to make a routine referral for MD to SureStart (Family Services); no further information is available as to the outcome.

3.2.10. FD also presented at A&E on 29th January 2007 following an assault. It is not noted who committed the assault or whether any information about, or implications for, his children were identified.

3.2.11. Half Sibling 2 was brought to A&E by ambulance with her mother, MS2 on 30th January 2007. There is no record of any connection with FD or MD and it is not known if either had had any recent contact with

Half Sibling 2. It was stated in the ambulance report that Half Sibling 2 had a screaming fit, and then went floppy and blue. Half Sibling 2 was triaged and there were no immediate concerns, but MS2 left with Half Sibling 2 before being seen by a doctor

3.2.12. In February 2007 it is first noted by Community Midwife 1(CMW1) that MD was not registered with a GP during the timescale of this review and she was encouraged to do so.

3.2.13. During the ante-natal period in early 2007 MD continued to seek help and advice from Youth Works in relation to accommodation problems. She is noted to have taken up her own private tenancy at the end of February 2007. There is no information as to whether FD was living with her at this time.

3.2.14. On 7th March 2007 police were called to an assault on FD in the town centre, by the mother of MS2 following an argument during a meeting to hand over Half Sibling 2. FD was uninjured and did not want to make a complaint. A check was made on the Child Protection Register and although it is recorded that Half Sibling 2 was seen by the attending officers there is no reference to the wellbeing of the child. The police records indicate that a Domestic Violence notification was sent to Social Care and Health. There is no record available as to whether the notification was received by Children's Social Care.

3.2.15. During April 2007, Youth Works continued to support MD with applications for grants and also made a referral to the Calderdale Housing Young People's Service (CHYPS).

## 3.3 Birth of Sibling 1 and post natal period

3.3.1. On 24th April 2007, Sibling 1 was born at the Hospital delivery suite. The delivery was uneventful, MD was described as "*confident with baby's care"* and MD and Sibling 1 were discharged 2 days later. There is no reference to FD within the hospital records.

3.3.2. The day following her discharge home, MD brought Sibling 1 into the Youth Works Drop In centre. Youth Worker 1 (YW1) also saw them both in the town centre the following day and was concerned that MD looked tired and unwell. YW1 alerted colleagues to her concerns about MD's welfare and asked them to *"keep an eye out for her".*

3.3.3. Postnatal Care was initially provided by CMW1 who identified no concerns and care was then transferred to the Health Visiting Service. There were some early difficulties with missed appointments, but contact was nevertheless established.

3.3.4. On 3rd May 2007 Half Sibling 2 was brought to A&E with breathing difficulties by an unidentified person. Half Sibling 2 was admitted to the children's ward overnight for observation and discharged home with a nebuliser. No other concerns were noted.

3.3.5. Both CMW1 and HV3 visited the family on 10th May 2007, apparently due to MD double booking appointments. Care was formally transferred to the Health Visiting Service on 19th May 2007. During her visit, HV3 identified that FD was not present, noted that the pregnancy was unplanned and that the couple had experienced relationship problems during the pregnancy. Sibling 1 was noted to be well, FD described as supportive by MD and no concerns were identified. MD told the HV3 of problems with rent arrears.

3.3.6. On the same day MD went to Youth Works saying that she had no nappies, milk or money. She was advised to go to the Job Centre for a crisis loan. The worker also noted an intention to talk to YW1 due to concern regarding MD's mental health, though the nature of the concern is not specified. YW1 followed this up with a Home Visit the next day and on this occasion a friend who was present told YW1 that MD was self harming. No other detail is recorded in relation to the identified concerns regarding MD's "emotional wellbeing" or whether any further action was considered. During the following days YW1 continued to provide support and advice with practical issues regarding financial pressures and housing.

3.3.7. HV3 identified a concern about the care of Sibling 1 during a home visit on 21st May 2007, in that the child's clothing was damp. She discussed this "*at length*" and suggested that Sibling 1 be seen by the GP regarding her chest. On this and subsequent visits the HV talked to MD about "*coping strategies and support*", although whether this was part of routine discussions or indicated a greater degree of concern is not identified.

3.3.8. In further visits during May and June 2007 the Health Visitor noted a concern about Sibling 1's poor weight gain and being dressed just in a vest in a cold house. She advised on feeding and on keeping Sibling 1 dry and warm. She discussed coping strategies with MD again and undertook the Edinburgh Post Natal Depression test which did not indicate post natal depression. She also placed an alert on the GP system.

3.3.9. YW1 also made a home visit during this period. At one point she describes MD as *"struggling with looking after 2 year old and new baby."* It is probable that the 2 year old will have been Half Sibling 2; it is not clear how much time Half Sibling 2 was spending with MD and FD. FD was not seen during this period as he was working.

3.3.10. In mid June 2007 the family moved to a new house, but had not informed their health visitor in advance and therefore she was not aware of their new address

## 3.4 First referral to Children's Social Care June 2007

3.4.1. On Monday 18th June 2007, YW1 made a referral to the Initial Response Team (IRT) at Calderdale Children's Social Care with regard to Sibling 1. YW1 had been told by a friend of MD's that Sibling 1 had been dropped on the head and stopped breathing on the previous Friday, but that the parents had not taken her to Casualty. The referral was made both verbally and in writing following a discussion with YW1's manager and the Health Visitor. Children's Social Care Referral and Information Record identified that the family presented as a risk to staff. There is no explanation of what the risk was, and there is no recording of such a risk by Youth Works. The decision of the Social Work Team Manager (SWTM1) was to identify the referral as High Priority and undertake a S47 Investigation.

3.4.2. YW1 stressed to Children's Social Care that she considered the referral warranted an urgent home visit and was concerned that medical advice had not been sought for Sibling 1 following the alleged incident. However, the social worker team manager, SWTM2, was not able to undertake the visit and asked YW1 to do so instead. It was noted that YW1 had identified that she had a good relationship with MD. Subsequently YWM, YW1's manager, contacted the Emergency Duty Team and raised concerns about Youth Works' staff being asked to undertake an assessment visit, something for which they were not trained. He was told this would have to be taken up with IRT and in the end he agreed that the staff would undertake a home visit.

3.4.3. There is a conflict within the recorded dates as to whether YW1 visited on 18th or 19th June 2007, but it appears likely that YW1 undertook a home visit on the evening of 18th June and reported to Children's Social Care the following day. She said that "*all seemed well*" and that the family had told her the GP had been out to visit Sibling 1 on Saturday. However, SWTM2 later confirmed that no GP visit had taken place. SWTM2 spoke to YW1 prior to her home visit and asked her to "*strongly encourage*" MD to go with her to the A&E department to have Sibling 1 checked over. In discussion with SWTM2 on 19th June, HV1 also identified that she had had a number of *"low level concerns*" regarding Sibling 1's health as well as engagement with Health Services.

3.4.4. On 19th June 2007 SWTM2 arranged for an appointment with a Paediatric Consultant at the Calderdale Royal Infirmary. She also recorded a 'Strategy Discussion'. However, as the only recorded participants were SW1 and SWTM2, this did not meet the definition of a Strategy Discussion within Working Together.[1] The outcome specified in this discussion was the undertaking of a full medical

[1] Working Together to Safeguard Children, 2006 p 116 HM Govt

assessment to identify any injuries and an interview with the parents in order to determine the Children's Social Care response. These actions were carried out that afternoon.

3.4.5. During the course of a discussion between YW1 and SW1, YW1 informed SW1 that Sibling 1 regularly stayed overnight with the maternal grandmother. There is no information in the records to evidence whether a full record check had been undertaken by SW1. Such a record check would have identified the historical allegations that MD had been neglected as a child and may also have experienced other abuse within the family, but this information has either not been identified or not been noted.

3.4.6. Checks were undertaken by SWTM2 with the Police Domestic Violence Co-ordinator, who stated that MD had two cautions for common assault, the most recent being the assault on FD in January 2007. They also identified that FD had been assaulted by MS2. A routine telephone call was made to the NSPCC and Barnardo's and a message left for them to call back, but no outcome is recorded. It is further noted that Child Protection admin were to carry out checks, but no outcomes were noted.

3.4.7. SWTM2 interviewed the parents and liaised with the Consultant Paediatrician and the events as described by the family were as follows: FD stated that he had accidentally dropped Sibling 1 whilst he was carrying the child upstairs, but he had jumped down three steps and caught her. He said that Sibling 1 stopped breathing, but he blew and rubbed the child's face until her breathing returned to normal. MD was not in the house at the time, but was having a night out. FD was caring for Sibling 1 and Half Sibling 2. When MD returned home she found FD was shaken, but Sibling 1 appeared fine and so they did not seek medical help.

3.4.8. When SWTM2 first contacted MD she asked if the social worker would speak to her mother rather than her. The social worker did so.

3.4.9. The medical examination revealed no sign of physical injuries and it is stated "*confirmed the parents' explanation of the incident."* The Consultant Paediatrician (CPaed 1) is stated as believing the family needed extra support, although the nature of this is not specified, and this view was included within the medical report sent to Children's Social Care.

3.4.10. The Children's Social Care records state that a further "Strategy Discussion" took place later that day and that it was attended by, SW1, SWTM2 and SWTM1. This meeting concluded that given there was no evidence of Sibling 1 being dropped no further action was required by the department, but that the Health Visitor would monitor the family.

3.4.11. A record entitled "Initial Assessment – Section 47" was produced by SW1, dated as completed on 19th June 2007. The assessment is not fully completed, in particular the sections relating to the Child's Developmental Needs, Parenting Capacity and Family and Environmental Factors have not been completed. No detailed records of the content of the interview with the parents nor the nature of a video recording made of Sibling 1 are available within the records. However the Assessment comments that *"although MD is a young mother, she has good support networks in both Maternal and Paternal family members. MD and FD share the care of (Sibling 1) and were both observed to be warm and responsive to her needs".* An Action Plan was completed. It identified that there would be support from Youth Works, CHYPS and Health but no further role for Children and Young People's Care Services. No review dates or timescales are identified within the Action Plan nor a lead professional identified.

3.4.12. The outcome of the Assessment is for Case Closure. There is no recorded management signature. The Action Plan was subsequently forwarded to the contributing agencies and the parents.

## 3.5 July 2007 to November 2007

3.5.1. During the second half of 2007 MD continued to maintain contact with Youth Works, who provided advice and support regarding financial problems.

3.5.2. On 16th July 2007 MD and FD went with Sibling 1 to Children's Social Care to seek financial help under Section 17[2] as FD had left his job, due to 'family troubles'. They were given a food package and baby clothes as well as £25 for gas and electricity. No Initial Assessment is within the records.

3.5.3. On 20th July 2007 a 999 call was made by MD in relation to Sibling 1, who was said to have stopped breathing. The attending ambulance crew described Sibling 1 as "very pale". Sibling 1 was observed overnight in the Children's Ward at the hospital and discharged the next morning. It was noted that the medical staff (unidentified) thought it may be the case that Sibling 1 was being overfed, leading to reflux. No follow up visit was considered necessary.

3.5.4. Throughout July and August the Health Visitor continued to visit the family and advice was given regarding feeding, resuscitation and the need to register with a GP. It was noted that Sibling 1's weight fell from the 9th to the 2nd centile and the subsequent weight gain was slow. A small bruise on Sibling 1's forehead was noted as having

[2] Section 17 of the Children Act 1989 places a general duty on social services to safeguard and promote the welfare of children 'in need' and to ensure appropriate services are provided for those children.

been caused by an older child throwing a toy. A nursery nurse visited to provide weaning advice at the request of the Health Visitor as Sibling 1 was being weaned early against the HV's advice.

3.5.5. During a home visit in September 2007 HV3 noted a petechial rash on Sibling 1's head and shoulder, but otherwise described the child as an alert, lively baby. HV3 asked the parents whether they had ever shaken Sibling 1, which they denied and she discussed the issue of shaking babies with them. HV3 told the parents that they must re-register with a GP and seek a medical opinion on the rash. A week later she established that this had not happened and sought advice from the Safeguarding Children Team Nurse Consultant (SGCT2) who advised her to check on GP registration and refer to a Paediatrician. HV3 did so and subsequently discussed Sibling 1 with CPaed1's secretary who passed on advice that Sibling 1 should be seen on the Paediatric Assessment Unit (PAU) and should be registered with a GP or otherwise referred to Children's Social Care.

3.5.6. On 25th September 2007 HV3 gave MD an ultimatum that she would refer the family to Children's Social Care if she did not register with a GP urgently. HV3 continued to pursue the need to register Sibling 1 over the following days and although FD and MD agreed to do so, the registration does not appear to have taken place until some time in October 2007. Sibling 1 was not seen at the PAU. At the beginning of October the HV noted that the parents were planning to separate and that FD appeared to be the main carer for Sibling 1.

3.5.7. HV3 is noted as having spoken to a colleague, HV5, at a surgery on 15th October 2007 and given a detailed verbal handover, therefore it is likely that the GP registration had been completed at this point. She informed HV5 that MD had recently separated from FD and described the history including the referral to Children's Social Care in November 2006, the petechial rash and that MD had weaned Sibling 1 early contrary to health advice. HV5 also noted that MD "*appeared reluctant to comply"* and that she was a young, isolated mother. There is no reference in the handover to FD as a main carer.

3.5.8. On 22nd October 2007 MD visited Youth Works. She said that she had separated from FD and had a new partner (MP). There was discussion over MD's inability to manage her budget and advice given about prioritising her finances to provide for Sibling 1. She continued to call into Youth Works quite frequently, was seen by YW1 at an event with MP and at another Youth Works' event also with MP and received a Home Visit from YW1 and a housing worker (HS1) on 2nd November.

3.5.9. On 30th October YW1 saw FD by chance. FD confirmed that he had separated from MD and appeared distressed. He told YW1 he was worried that MD would not look after Sibling 1 properly. He was encouraged to come into Youth Works to talk about his own support

needs and was subsequently allocated a separate youth worker, YW2.

3.5.10. During this period YW1 noted a number of concerns including:

- MD seen to respond aggressively to MP in public, including slapping him and when challenged by YW1 responded that "he likes it"
- MD failing to take Sibling 1 to the doctor when she was evidently unwell with a temperature.
- MD's continuing financial difficulties, including court appearance for non-payment of council tax and problems budgeting.
- MD reporting that she was worried that an unidentified male who had previously tried to stab her had been released from prison and might be a threat to her.
- MD allowing Sibling 1 to feed herself whilst lying on the floor.
- A possibility that MD was failing to bond with Sibling 1, including leaving her with various people and having limited physical contact unless prompted to do so.
- Allegations of cannabis use by MD.
- MD handing over care of Sibling 1 to FD for significant periods.

3.5.11. On 7th November 2007 MD and FD took Sibling 1 to A&E due to her having breathing difficulties. She was diagnosed with a viral illness and discharged home.

3.5.12. In mid-November MD went to Children's Social Care to seek financial support under Section 17 to pay for gas. Her request was refused and she was advised about managing her finances.

## 3.5 Second referral to Children's Social Care, November 2007

3.5.1. On 15th November 2007 YW1 made a second referral to Children's Social Care in relation to Sibling 1, prompted at this point by MD telling YWM that two people had come to her house, locked her in the kitchen and assaulted MP. It is not stated where Sibling 1 was at the time. Both FD and MD were told that a referral had been made.

3.5.2. The concerns expressed by YW1 were:

- MD's ability to cope with Sibling 1
- Sibling 1's health needs not being met
- MD's non-engagement with health services
- Finance issues
- Separation from FD and beginning of new relationship
- Allegation of a number of people in the house and cannabis use
- Allegation of an assault on MP in the house whilst MD locked in the kitchen.

3.5.3. YW1 recorded her view that MD required:

- allocation of a Social Worker to ensure Sibling 1's needs were met
- Parenting classes for MD
- Support for MD

3.5.4. The following day MD presented at Youth Works in a very distressed state alleging that FD had taken Sibling 1 from her care and would not return her. YW1 contacted FD who told her that a social worker had been in touch and instructed him to keep Sibling 1, and that he could allow MD to visit but not to take Sibling 1 home until MD had been assessed. MD also informed HV6 of what had happened. It was confirmed that Sibling 1 was with FD and they were staying with his uncle.

3.5.5. During that day, and throughout the parents' separation, YW1 provided support to MD, and YW2 provided support to FD. Between them they made arrangements for MD and FD to access mediation in order to attempt to resolve the contact arrangements for Sibling 1 and also supported them to access legal advice. Both FD and MD attended the drop in centre on a number of occasions.

3.5.6. YW1 contacted IRT on 19th November 2007 and was told that they had no record of Sibling 1 being removed by Social Services. HV6 spoke to SW5 and said that she had visited Sibling 1 and FD and she had no immediate concerns. SW5 left a message for FD to contact her, but there is no further record of any conversation with him.

3.5.7. On 20th November 2007 YWM e-mailed SW7 to clarify what Children's Social Care position was with regard to the referral and asked for MD to be informed of what was happening, but did not appear to get a response. On 27th November YWM phoned Children's Social Care and requested to speak to either SW1 or SW6, but they were unavailable. YWM said that he would e-mail, but there is no record as to whether he did so or whether he received a response. No further information appears to be received by Youth Works from Children's Social Care regarding any action to be taken.

3.5.8. On 26th November 2007, the police visited MD after they had been told by MP that MD was threatening to kill herself. MD was found to be safe and well and told them that MP had said this because she had ended their relationship.

3.5.9. On 28th November 2007 FD texted YW1 and said that "*FD can have Sibling 1…She will be better off with him…. I don't care anymore…I'm going away and I'm never coming back."* YW1 telephoned MD who said that she was going to go to London with MP and have more children. YW1 persuaded her to calm down and arranged to see her the following day. MD kept the appointment which involved going to meet her solicitor with YW1.

3.5.10. On 20th November 2007 Family Services Team 1 received a referral from a Health Visitor (not identified) requesting support to access services for a male lone parent. A Parent Link Worker (PLW1) visited FD at the end of November and informed him of the support services available in the area, specifically a Fathers' Group. FD did not take up the services offered. PLW1 attempted on a couple of further occasions to revisit, but at the end of December was informed that FD had returned to live with MD which was in the Family Services Team 2 area. PLW1 made a referral to that area team which was noted as being received on 8th January 2008.

3.5.11. On 30th November 2007 SW6 spoke to the Health Visitor. SW6 said that she had seen MD and FD at the office and advised them to seek legal advice. The Health Visitor records confirm that SW6 had stated '*MD should only have supervised contact with Sibling 1 and that Sibling 1 should remain in FD's care*.' SW6 is also recorded as saying that should MD resume care of Sibling 1 this should lead to an assessment by Children's Social Care and a probable case conference. SW6 had advised FD to seek a Residence order.

3.5.12. MD remained in contact with YW1 and on 7th December 2007 told her that she had separated from MP and wanted to concentrate on regaining care of Sibling 1. At this point she said that she had had no contact with Children's Social Care.

3.5.13. HV 6 visited Sibling 1 and FD on 11th December 2007. FD told HV6 that Children's Social Care had closed the case and told him to seek legal advice about the care of Sibling 1. Sibling 1 was reported to have had a slight weight loss and nappy rash which FD was treating with egg white as well as sudocrem. FD also stated that he had taken Sibling 1 to the GP regarding her chest. The HV notes that Sibling 1 was very quiet during the visit.

3.5.14. Also on this occasion FD is recorded as saying that he had been involved in a police investigation in the past due to allegations by his step sister of a sexual nature. FD was at the time living with his uncle and cousin and it is recorded that his cousin has spoken to his uncle about FD cuddling her. There is no evidence of HV6 taking any action in relation to these comments.

3.5.15. At some point during December 2007 FD and MD become reconciled. The date is unknown but MD is recorded as accompanying Half Sibling 2 to A&E with breathing difficulties on 16th December at which point Half Sibling 2 was diagnosed with tonsillitis. HV6 visited the family as arranged on 28th December. Sibling 1's weight is recorded as having increased, MD and FD presented as positive about the future and MD appeared to be handling Sibling 1 well.

3.5.16. On 13th December 2007 SW6 recorded receiving a letter from MD's solicitor seeking information regarding what advice had been given by Children's Social Care. SW6 informed the solicitor that they had no further involvement and had advised both parents to get legal representation.

3.5.17. Following their reconciliation, both parents continued to access services at Youth Works.

3.5.18. In January 2008 FSW1 and FLW1 of Family Services for the Team 2 area visited MD and FD at home. MD was in bed at the time and refused to come to meet the workers. Registration for Children's Centre 1 was completed. It was noted that the home was cold. FSW1 subsequently left a phone message for HV6 but there is no record that this was returned. FSWTM2 made two more attempts to contact MD in January, without success. A decision was therefore made with the manager to close the case, but reopen it if MD asked for support. FD's support needs are not noted. There is no record of any liaison with the referring Health Visitor.

## 3.6 March 2008 to birth of Child D October 2008

3.6.1. In March 2008 MD told HV6 that she was pregnant and that the family were planning to move to another area. HV6 advised them to register with the GP Surgery, which they did later in the month. The family did not in the event move due to financial problems. Sibling 1 was identified as progressing well with satisfactory weight gain and the next routine visit followed in April 2008 when Sibling 1's progress was confirmed.

3.6.2. Over the subsequent months both FD and MD maintained occasional contact with Youth Works and MD accessed routine ante-natal care. HV6 and CMW5 discussed the previous referral to Children's Social Care in April and the midwife contacted Children's Social Care, although there is no information of this within Children's Social Care records. An alert was recorded in the HV records regarding the previous concerns.

3.6.3. Routine HV contact took place in relation to Half Sibling 2. There is no reference at this point to the involvement of FD and MD in her care.

3.6.4. On 5th July 2008 a 999 call was made in relation to Sibling 1 following a febrile convulsion. Sibling 1 was recorded by ambulance staff as "*lying on the floor, post ictal and pyrexial".* Her parent (which one is not recorded) said that she had lightly banged her head and had a fit.

3.6.5. Sibling 1 was admitted to the Children's Ward at the Calderdale Royal Hospital where she had further fits. Low blood sodium was identified. It was also documented that Sibling 1 was drinking large amounts of fluid and the parents advised not to allow this and also advised about appropriate feeding methods. FD and MD had to be reminded about this several times whilst Sibling 1 was on the ward. CPaed 1 in consultation with a specialist identified the most likely cause to be either excessive intake of liquid or endocrine problems.

3.6.6. Sibling 1 was discharged the following day and HV 6 was informed by the hospital, in particular regarding the concerns about the amount Sibling 1 was drinking. HV6 visited twice during July. She discussed the issue of feeding with the parents, noted that Sibling 1 was gaining weight satisfactorily and was generally in good health and also made a referral to Sure Start (Family Services). Issues identified in the referral were: antenatal and postnatal support, parenting skills, safety review and dietary advice in the context of the issue of fitting caused by low sodium.

3.6.7. On 8th September 2008 FD told HV2 that the family had not received their benefits and had no money for food. She advised them to go to Children's Social Care and seek financial support under Section 17 which they then did. After liaising with CMW1 and the Job Centre the family were given £50. A further 'referral' is recorded on 15th September in similar terms. It is unclear whether this is a separate referral or the implementation of the actions resulting from the referral on 8th September 2008. In any event there is no record of an Initial Assessment having been completed in relation to either date. A telephone discussion took place between SW6 and MW1 in which MW1 informed the social worker that MD was pregnant again. SW6 told the midwife that Children's Social Care did not have ongoing involvement with the family and suggested that she monitor the situation and consider a CAF if she had concerns.

3.6.8. HV2 and FSWTM2 made a joint visit to the family on 16th September 2008 and issues as outlined in the referral were discussed. The areas highlighted by FSWTM2 were: home safety, parenting and signposting to other services. FD is noted as undertaking most of the childcare. A referral for a crèche place for Sibling 1 was made and she attended a couple of days later. However, after two occasions, she stopped attending as MD said that she was always ill after having been there.

*3.6.9.* FSWTM2 and FLW1 followed up this joint visit on 3 further occasions during the autumn. They provided advice about feeding and, undertook a home safety check. The problems with feeding that had been raised with the family on previous occasions, eg Sibling 1 being given tea to drink from a bottle, continued to be noted. MD expressed concerns about Sibling 1's speech and language and referred to their

financial difficulties. MD also said that they intended to take Sibling 1 to the birth of Child D and was advised to discuss this with the midwife. During a phone discussion with HV2 later in the month, FSWTM2 expressed concern that MD and FD were not listening to what was being said to them. HV2 said that in her experience "*you think they haven't listened however they have".*

3.6.10. During one of their visits it is noted that FD was reading a magazine and showed FSW2 and MD *"unpleasant pictures",* continuing to show them despite being requested not to. There is no information about the nature of the pictures or what the implications of this might be.

## 3.7 Birth of Child D to death of Child D

3.7.1. Child D was born by normal delivery in hospital on 26th October 2008. Child D and MD were discharged the following day and routine postnatal checks took place initially by the Community Midwives, routine care being discharged to the Health Visiting service on 7th November 2008.

3.7.2. HV6 recorded Child D as developing satisfactorily, although there were ongoing problems with nappy rash. Advice was repeated on various occasions about appropriate feeding for both children. MD spoke about problems in the relationship with FD, but said that she was not depressed. HV6 spoke to Child D's parents about registration with the GP so that her immunisations could be arranged; this was achieved in early December.

3.7.3. A few days after Child D was born, the family moved to a new house in a different area, leading to a transfer from Family Services Team 2 Area to Family Services Team 1 Area. FSW3 undertook a home visit prior to the transfer and planned a joint visit with the new worker. Advice was given again about not overfeeding Child D and about home safety. Both children were seen by FSW3 and Child D, who was asleep, was described as clean and well.

3.7.4. A 999 call was made by FD on behalf of MD on 17th November 2008 as she was suffering from chest pains. She was assessed at the hospital and discharged with antibiotics.

3.7.5. MD and FD informed HV6 during a visit in November that Sibling 2 was now living with her grandparents because they did not feel her mother was "*a fit parent*". This was also noted by the HV for Half Sibling 2 who referred her to Children's Social Care and is noted as having considered undertaking a CAF. The outcome of the referral was that no action was felt necessary and the case closed. MD and FD told their health visitor that they would like Half Sibling 2 to live with them and they intended to take legal advice. FD later told HV6 that the arrangements had been resolved with Half Sibling 2 living

with her grandparents in the week and staying with FD and MD at weekends.

3.7.6. On 15th December 2008 Sibling 1 was taken to hospital by ambulance having again experienced fitting. She was found to have a chest infection and given antibiotics. It was documented again that she was drinking large volumes of fluid. She was discharged the following day and referred to the Health Visitor to respond to the "*huge amount of fluid*" she was drinking with her parents. A letter outlining the concerns was sent to the GP by the Paediatrician. Two follow up appointments at the clinic were offered to Sibling 1, but they were not kept. Sibling 1 also seen by the GP in early January with eczema like symptoms and asthma was also noted.

3.7.7. Family Services visited the family in December and arranged for them to have safety equipment which they would need to pay for with a loan from the Credit Union to be arranged after Christmas. Family Services then made a number of unsuccessful attempts to contact the family after Christmas. PLW2 finally made contact with MD towards the end of February 2009 and arranged a home visit in March, which ultimately did not take place as Child D was by this time in hospital.

3.7.8. On 12th January 2009 FD contacted NHS Direct and told them that Sibling 1 had blue lips and was struggling to breath. A referral was made to the Out of Hours GP Doctor Service, by which time MD said that Sibling 1 was now asleep and breathing normally. She told the doctor that Sibling 1 had fallen off the sofa. It was agreed Sibling 1 would see her own GP the following day and the parents subsequently took her to the GP as advised. The doctor described Sibling 1 as very active and smiling and gave advice to the parents as to what symptoms to watch out for and when to seek urgent help.

3.7.9. Also in January 2009 the parents re-established contact with Youth Works, attending at the drop in centre. On 13th January 2009 FD told YW2 that he and MD had separated again, MD and the children were currently staying with a friend, but he expected to have all three children at the weekend. Over the following days FD accessed practical help and support from Youth Works to resolve the resulting financial issues.

3.7.10. On 3rd March 2009 FD telephoned the GP Surgery and said that Child D had a chesty cough and had become a bit floppy after having her normal feed at 10:30. He was told to bring the child into the surgery in an hour's time. Whilst in the waiting room the Nurse Practitioner noted that Child D had a high pitched scream, she identified that her heart beat was slow, breathing was interrupted, she had a small bruise on her chest and a red line around her neck. The Nurse Practitioner called 999 for an ambulance and sought advice from the call taker whilst waiting for its arrival.

3.7.11. On arrival the ambulance crew administered oxygen and Child D was taken to hospital. On reflection medical staff noted that FD appeared to have limited understanding of how serious Child D's condition was. On arrival at the hospital he told staff that Child D had become unresponsive after being fed. He called MD who was still in bed upstairs and she gave Child D mouth to mouth resuscitation, but the child remained floppy. The details of what happened were to some extent contradictory and the exact history of events, prior to presentation at the GP surgery, continues to be unclear.

3.7.12. Child D was transferred to a regional specialist unit in Leeds. She was formally pronounced dead at 16:18 on 4th March after her Life Support Machine had been switched off.

# 4 CRITICAL ANALYSIS

4.1. This analysis will be based on the individual agency contributions to the Review; discussions held within the SCR Panel; access to the Finding of Fact within the Care Proceedings for Sibling 1 and the author's own contributions. The IMRs provided for this Review contain a high level of detail regarding the individual agencies, which will not be replicated here. Each Key Line of Enquiry has been considered in producing the Overview Report and this consideration has been integrated within the analysis. The focus of this analysis will be to use examples from the collective information to identify key areas for improvement and learning on the basis of all the information provided. It will conclude by reflecting on whether the death of Child D could have been predicted or prevented.

4.2. The IMRs have identified a number of issues arising out of their reviews which although not key themes within the overall analysis of the service provided to Child D and her family, nevertheless have led to learning for the individual agencies. As a result, individual agencies have identified a number of recommendations for themselves which did not necessitate individual consideration within the Overview Report.

4.3. Child D was the second child of young white British parents, her mother was 20 at the time of the child's death and the father was 24. The family were living in poverty and there is evidence that they were vulnerable. Child D in her own right was in effect known only to universal health services, although during her life other agencies did have limited contact with the family. Whilst Child D's family did have previous contact with Children's Social Care there was no known information at the time of her death that would have identified her as a child at risk of significant injury from her caregivers.

4.4. However, irrespective of whether Child D might reasonably have been viewed as being at risk of serious physical injury, there was information available both at the time, and more obviously with hindsight, that Child

D was born into a family that were in need of additional support. This was known to a greater or lesser extent to the different agencies but it has become clear that a full picture of the family's vulnerabilities was not known by any one agency or professional.

4.5. Professionals had little direct knowledge of Child D given her age and the extent of agency involvement. As a result, there is very limited information about her. This review has not been able to identify any descriptive information about Child D, her developing personality, her needs, her experience of the world. The lack of any information about Child D as an individual represents a major gap in our understanding of her short life.

4.6. This lack of information is mirrored by a similar gap in our knowledge about Sibling 1's personality, needs, wishes and experience of life within his family. Given her age and the greater degree of involvement by agencies during her life, this is of more concern and suggests that agencies were insufficiently focussed on this child during periods of intervention.

4.7. **Recognition and response to the parents' Learning Disability:** A crucial feature that runs as a thread through the experience of Child D and her siblings is that of the parents' vulnerabilities, in particular their Learning Disabilities and any implications this may have had for their children.

4.8. Information provided to the Serious Case Review contained within the Court Judgement identified the degree to which the parents experienced Learning Disabilities. Specialist assessments after Child D's death identified that both parents had: "*significant difficulties both in communicating their needs and wishes effectively and in understanding complex and relatively non-complex verbal information, discussion and instructions."* The assessment further identified what is known as the "*false apparent competence*" factor which is a not uncommon feature when assessing adults with Learning Disabilities who may present as more able than they actually are.

4.9. Research has demonstrated that the fact of parental Learning Disability should not of itself be assumed to present a risk to the care of children. *"…IQ by itself is not a predictor either of the occurrence or of the non-occurrence of purposeful child abuse…".*[3] However it should be recognised that parents with Learning Disabilities are more likely to be experiencing other adverse factors such as low socio-economic status, unemployment and social isolation and have less access to "informal social learning".[4] As such they face greater pressures as parents. There is also considerable evidence to suggest that the children of parents with Learning Disabilities are disproportionately brought into the care system with one estimate that up to 60% of parents with a

[3] Tymchuck, (1992) in: HM Govt Good Practice Guidance on working with Parents with a Learning Disability, June 2007, p42

[4] SCIE Briefing: February 2005.

Learning Disability will at some stage have their children taken into care[5]. Known protective factors in relation to parenting capacity include strong supportive social networks and positive psychological factors[6].

4.10. Information with regard to Child D's parents, in particular the mother, would indicate that they may not have had access to the sort of positive support that they needed and may have also experienced other vulnerabilities such as economic hardship and emotional stresses that, combined with their Learning Difficulties, placed them at greater risk as parents. The importance of positive support by agencies, where parents with Learning Disabilities do not have access to supportive factors within their own family and community networks, should be at the forefront of assessment and planning by agencies. Good practice guidance from the Department of Health/DFES produced in 2007 stated as follows:

*"Referral and assessment procedures, eligibility criteria and care pathways should prevent avoidable difficulties by:*

- *Recognising low levels of need which, if unaddressed, are likely to lead to difficulties for parents and undermine children's welfare.*
- *Recognising support needs at the early stages of the parenting experience.*
- *Anticipating support needs which may arise at different stages in a family's life cycle."*[7]

4.11. Children's Social Care and Calderdale and Kirklees Careers both had access to recorded information with regard to the mother's Learning Disability but there does not appear to have been historical information available to the agencies about the father's cognitive abilities. Calderdale and Kirklees Careers were aware that the mother had been assessed in school at the level of 'School Action', which is the first level of identification of Special Educational Need. This was therefore taken into account as part of the service which they provided.

4.12. Children's Social Care also had information within its records that would have identified that MD had a Learning Disability as a result of the referral and assessment that took place in 2005. A housing support worker also recorded having made a referral seeking support for MD to Children's Social Care during 2006 given her vulnerability. There is no information as to whether this referral was received. However, it would appear that the available information regarding parental Learning Disability was not accessed when referrals were received about MD's children, or, if it was, was never recognised as significant.

[5] MENCAP, Website.
[6] SCIE Briefing: February 2005
[7] DFES/Dept of Health 2007, p10

4.13. Children's Social Care staff did not have access to the full range of information which might have triggered questions about the parents' cognitive abilities particularly regarding identified health issues. In the absence of such information, given the possibility of "false competence" in their presentation and given their limited contact with the family over time, it is difficult to make a judgement as to whether social workers could have been expected to identify parental Learning Disability.

4.14. During the time period covered by this Review there was no specific protocol or practice approach in place within Children's Social Care which might have contributed to practitioners' awareness of and capacity to identify parents with Learning Disabilities and therefore consider their support needs and those of their children. Given the high statistical representation of Looked After Children whose birth parents have a Learning Disability this represents a significant gap in good practice within the authority. During 2008 a joint audit was initiated by Adult Services and Children's Social Care to identify parents with a Learning Disability. A consequent draft protocol was produced but has not yet been finalised. The issue of establishing a co-ordinated response to parental Learning Disability is therefore subject to a recommendation within this report.

4.15. Of the other agencies that had contact with the family it is particularly puzzling that the possibility of Learning Disabilities was never considered by health professionals. Health agencies collectively, and some of the health professionals individually, had significant contact with the parents. In particular the continuing problems the parents experienced in relation to undertaking basic care tasks for their children could reasonably have been expected to alert health professionals that cognitive abilities might be playing a part. This is most apparent in relation to the repeated difficulties with regard to the high liquid intake for Sibling 1 which failed to trigger professional curiosity as to the explanation for the parents' behaviour.

4.16. There appeared to be a belief by Health professionals that the parents would change their behaviour in response to instruction and that they understood what was being told to them, despite evidence to the contrary. A tendency has been noted in the research regarding Learning Disability for parents to respond affirmatively to professionals requirements leading to "*over-optimistic assumptions about the extent of parents' understanding and capacity to put agreed plans into practice"*[8]*.* Had Health professionals been alert to the parents' Learning Disability, they may have been better placed to see the contradiction within the parents' actions in a different context. Both the hospital based staff and the health visiting service missed opportunities.

4.17. Youth Works however, were clearly aware, based on their own direct contact with the parents, that Learning Disabilities were a factor. They adapted their own practice to meet the parents needs and '*they*

[8] DCSF (2008): Parental Learning Disability and Children's Needs p vii

*believed it to be obvious that both parents had additional support needs'.* Their recognition of the issue might have been a feature of particular knowledge and skills within individual staff, but it is also likely that the quality of their relationship with the parents enabled them to develop a good understanding of their capacity and needs. Had Youth Works been engaged within an inter-agency planning process the good quality information they had in relation to the parents could have contributed significantly to assessments.

4.18. The impact of the parents' Learning Disabilities not being recognised meant there was never a proper assessment of their cognitive functioning and therefore no assessment of their particular needs as parents, or their understanding of the advice and instructions that they were being given by professionals. At various points within the IMRs it has been acknowledged that parental responses may have been a consequence of Learning Disability but this was not taken into account in assessing these responses.

4.19. The information about the parental approach within this review, suggests that the adults were struggling to understand or cope with the practical demands of caring for young children. Had the parents' Learning Disability been recognised, it should have led to specific consideration of developing effective means of communication with them, not least in relation to issues such as medical care. Support systems could have been put in place and parenting capacity reviewed over time in this context. It does not follow axiomatically that this would have prevented Child D's death, but it might have improved parental capacity and reduced parental stress.

4.20. Two specific recommendations have been made within Individual IMRs as well as a multi-agency recommendation in relation to this key theme:

**Multi Agency: Recommendation 3**

**Calderdale Family Services: Recommendation 4**

**NHS Calderdale Commissioning: Recommendation 6**

4.21. **Assessment:** The quality and appropriate completion of assessments is a key feature in relation to Child D and her family. This arises both in relation to the statutory assessments resulting from referrals to Children's Social Care, but also the approach to assessment taken by other agencies. Whatever the particular agency requirements, a common feature was a focus on individual events, without a corresponding focus on whether there might be a pattern of concerns over time.

4.22. Two referrals to Children's Social Care raising concern about the welfare of the children were properly initiated by Youth Works. The parents of the children also presented on 3 occasions to the Initial Response Team seeking financial help stating they had inadequate finances to feed, clothe or keep their children warm.

4.23. The assessment process arising out of each of these referrals has been critiqued within the Children's Social Care IMR. In summary there was a failure to meet expected service standards on each occasion. In particular, the second referral from Youth Works presented a missed opportunity to undertake a full assessment of the family functioning and the needs of the children.

4.24. The first assessment undertaken in June 2007, following the allegation that Sibling 1 had been dropped, demonstrated a number of deviations from expectations including: inappropriate arrangement made for non Children's Social Care staff to undertake the initial home visit; no properly constituted Strategy Discussion; lack of clarity about process and the recording of processes undertaken. The assessment which was started as a S47 assessment was never fully completed, possibly because of the outcome of the medical examination.

4.25. The primary concern was an allegation that Sibling 1 had been dropped on her head, but it was concluded following medical examination that this had not in fact happened. Given the medical view, the decision by Children's Social Care to take no further action was an appropriate one. However information was provided during the course of the assessment which could have alerted social care and consequently the other professionals, to more general concerns about parenting capacity. These included: the family history of the mother; incidences of violence by the mother against the father and a suggestion by the Paediatrician that this was a family that required support. It is noted within the S47 assessment that the mother has good support networks, but it is not clear on what basis this is evidenced and no link is made with her own experience of being parented.

4.26. It would not be reasonable to expect, even with hindsight, that recognition of greater family vulnerability at this stage would itself have been of such a nature as to justify further involvement by Children's Social Care. However, had the assessment resulted in a more effective Action Plan, or had the use of a CAF been considered, this could have been an opportunity for those agencies involved to develop a more co-ordinated approach to providing support to the family.

4.27. The second referral from Youth Works in November 2007 which related both to an event – the separation of the parents, and a series of low level concerns - should have triggered an Initial Assessment but this did not happen. No Initial Assessment is contained within the Children's Social Care records, and there is no evidence that one took place. Some limited enquiries were undertaken, there is no record of the child being seen, or indeed the parents and Children's Social Care's understanding that the key agencies viewed the father positively seems to have been the only basis on which a judgement was reached.

4.28. The focus of the response by Children's Social Care was purely on the issue of parental separation and advice given to the parents as a result. No response was made to the detailed concerns of the referring agency and the referral appears to have drifted until it was prompted to be closed a couple of weeks later by a solicitor's letter. No

consideration appears to have been given to the possibility of the parents reconciling or reaching an agreement which could put Sibling 1 at risk in the context of the concerns raised by Youth Works.

4.29. There are quite different recordings of the nature of the advice that was given to the parents at this time. Information provided to Youth Works by the parents was that Children's Social Care had advised that Sibling 1 should remain with her father and that the mother and should not have unsupervised contact unless an assessment was carried out by Children's Social Care. Similarly the Health Visitor records a telephone conversation with Children's Social Care in which she is told that the parents have been advised to seek legal advice and confirms the parental view of the advice given. However there is no definitive recording by Children's Social Care of the advice given at the time, and on closing the case and writing to MD's solicitor it is simply stated that there is no Social Care involvement and that the parents have been told to seek legal advice.

4.30. Two possibilities present themselves about the advice given. Either advice was given to the family as to who should care for Sibling 1 despite no adequate assessment having been undertaken regarding Sibling 1's welfare or needs, or the advice was unclear, open to misunderstanding and inadequately recorded.

4.31. This episode raises concerns both about the general quality of the assessment, but also the particular way in which Children's Social Care responded to a referral relating to parental separation and a dispute over private arrangements for the care of a child. The approach taken suggests that there was a lack of a clear understanding of the interface between public and private law. A separate recommendation has therefore been made by the Overview Author (see para 5.2.15)

4.32. During the timescale of the review, the family presented on 3 separate occasions at IRT seeking financial help under the remit of S17 of the Children Act ( Child in Need). Viewed as individual episodes there may be no particular reason for these to trigger specific concerns about the children's welfare. The parents were reliant on state benefits and occasional financial crises would not in themselves indicate a risk to children. However, the lack of any system to identify such presentations as "*a continuing process not an event*"[9] led to missed opportunities to establish a holistic picture of the family functioning. This aspect of practice is subject to a specific recommendation by the author of the Children's Social Care report.

4.33. It is also the case that the last three Serious Case Reviews undertaken within Calderdale have identified recommendations for the improvement of practice in the Initial Response Team and in relation to Assessment practice. In the intervening period there has been a clear recognition of systemic problems affecting the Initial Response Service of Calderdale Children's Social Care.

[9] Working Together, 2010 p137

4.34. In October 2009 Calderdale Children's Social Care commissioned an independent diagnostic report[10] from Price Waterhouse Cooper, completed in December 2209, which reviewed the "front door" services that were being provided and identified recommendations and an action plan. Following the subsequent OFSTED inspection in January 2010 which judged performance as inadequate, Calderdale became subject to an Improvement Notice. Children's Social Care initiated a Transformation Programme to directly address the concerns identified regarding the quality of frontline assessment identified. The weaknesses identified within this Serious Case Review are of a fundamentally similar nature. Given this history and the consequent recommendations and inspection regime, it was concluded that there was little to be achieved by effectively reproducing the same recommendations within this Review.

4.35. The practice of assessment within other agencies was also significant in the story of this family. There was a lack of a structured or conscious process of assessment as well as gaps in assessment, which undermined agencies' ability to understand and respond comprehensively to the family's needs.

4.36. Youth Works, whilst not evidencing a formal assessment process in relation to the families they worked with, clearly recognised the vulnerabilities within the family, were able to identify indicators of concern and when it was appropriate to share those concerns with Children's Social Care under both Section 17 and Section 47 of Children Act 1989 they did so.

4.37. Family Services responded to a referral to provide family and parenting support to the parents of Child D on two occasions. At the time of their involvement between 2008 and early 2009 there was no structured system in place to assess a family's needs, rather the approach was purely to respond to the immediate issues identified by the referring agency. The lack of their own clear assessment meant that there was no corresponding action plan or objectives in place for working with the family and no system of review. Given the limited role played by Family Services with Child D's family, the lack of a clear system for assessment should not be accorded undue significance in relation to their work with the family of Child D as a target family in need of services. However, it has been recognised as a weakness in practice within the Family Services IMR and addressed in a specific recommendation.

4.38. The Health Visiting Service had a key role in assessing the needs of the children and Health Visitors undertook the required Health Visiting Assessments appropriately. There is evidence that some of the extra needs of the family were recognised as is seen in the decision to undertake an increased level of health visiting and also the referral to Family Services. However, there was an absence of a holistic

[10] Price Waterhouse Cooper, January 2010

approach to the family. Issues of concern, whether problems over managing persistent nappy rash or failure to register with a GP were responded to individually but not framed within a context of overall family functioning or consideration given to the full developmental needs of the children in the context of safeguarding. That the Health Visiting Service did not initiate a CAF in relation to Sibling 1 undoubtedly represents a missed opportunity to properly assess and therefore support this family.

4.39. The weaknesses are exemplified in the response to the problem of Sibling 1's excessive fluid intake which failed to trigger adequate reflection or professional analysis. Advice and instructions were repeatedly given to the family over time in this regard, yet the problem persisted. Both acute and community health services need to reflect on their practice in this regard. Sibling 1's presentation on at least 3 occasions to the hospital with problems associated with excessive fluid intake and on one occasion identified low blood sodium levels, should have triggered a more comprehensive response. The Health Visitor was also well placed to see this issue in the wider context of the parenting of Sibling 1 over time, to ask questions as to why the parents were not able to deal with this problem and to consider that an explanation might be that they did not fully understand what was being required of them.

4.40. Some common features can be seen across the agencies' approach to assessment, particularly: a lack of focus on the children's experience of the care they received; weaknesses in the collection of historical information; lack of recognition of potential patterns and focus on individual events or problems. The latter issue is particularly significant in enabling agencies to identify when a child may be at risk of neglect which is well recognised in being identified not by single incidents but by a *"thorough investigation that produces a comprehensive picture of the child's care over time."*[11]

4.41. The result of the deficits in assessment was a consequential weakness in establishing clear objectives for intervention and review. Following the first referral by Youth Works and the resulting decision by Children's Social Care to take no further action, an action plan was nevertheless drawn up. However the identified actions reflected the lack of comprehensive assessment. The actions were predominantly related to monitoring and support, in effect identifying the roles already being undertaken by the professionals who were involved with the family in any event. No lead professional was identified, as would have been the case in the event of a CAF being produced, and there was no system for review. A similar approach is reflected in the decision by the Health Visiting service to undertake an increased level of visiting but without any linked objectives or clear plan of intervention.

[11] Munro, 2008, p84

4.42. A number of relevant recommendations have been made within Individual IMRs in relation to this key theme:

**Youth Services: Recommendation 4**

**Children's Social Care: Recommendations, 1, 2, 3**

**Family Services: Recommendation 2**

**NHS Calderdale PCT: Recommendation 1**

**NHS Calderdale Commissioning: Recommendation 1**

4.43. **Threshold for intervention.** Closely linked to the nature of assessments undertaken by Children's Social Care is the lack of a shared understanding regarding the threshold for intervention that was in place at the time. The Youth Works IMR reflected that at the time of these events they had historical experience of making referrals to Children's Social Care when they were concerned about a family or child which they felt had wrongly led to no action being taken. 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. It is of note that the Serious Case Review relating to Child B in Dec 2007 also commented on the fact that thresholds for intervention were too high and recommended review and change. The need for clear threshold criteria was identified as a recommendation in the Improvement Notice in 2010.

4.44. Information from research into referral practice identifies "*a lack of consistency amongst professionals as to when and how to refer a case to social work services and confusion as to the criteria for defining a child in need".*[12] The introduction of the Common Assessment Framework was, in part, intended to contribute to the quality and consistency of referrals across agencies. However, during the period covered by this review, CAF was not embedded within multi-agency practice in Calderdale. None of the professionals appeared to have considered its use in relation to this family. This failing is explicitly acknowledged and addressed in Individual Management Reviews.

4.45. What has been recognised in the interim by Children's Social Care and the Safeguarding Board is this historic lack of clarity and standards with regard to the thresholds for intervention both within Children's Social Care and with partner agencies. Following the OFSTED inspection in January 2010 particular priority was given to developing and implementing the Continuum of Need and Response Model, which establishes clear tiers of need and points of intervention. The implementation of this model is still at an early stage and its effectiveness in relation to outcomes for children will be subject to consideration as part of the ongoing inspection regime.

[12] Horwarth, J, in Wilson & James, 2007 p 251

4.46. The model adopted by Calderdale identifies 5 tiers of need. In considering the information known at the time about Child D and her family it is likely that at the point of the referral in November 2007 Sibling 1 had she been assessed within this model would have come within level 3 "*Children whose health or development is being impaired*". This would have led to a co-ordinated multi-agency response.

4.47. A number of relevant recommendations have been made within Individual IMRs as well as a multi-agency recommendation in relation to this key theme :

**Multi-Agency: Recommendation 2**

**Youth Services: Recommendation 1**

**Children's Social Care: Recommendation 5**

**Family Services: Recommendation 7**

**NHS commissioner: Recommendation 4**

4.48. **Management oversight and supervision:** The significance of good quality management oversight and supervision is a theme for several of the agencies involved. The importance of active management support for front line practitioners in ensuring good consistent practice within safeguarding cannot be overstated

> *"Without supervision or accessible professional consultation, practitioners working with children and families with early needs may struggle to cope".* [13]

4.49. The Children's Social Care IMR considers that supervision was better at the time of crisis, although this is not robustly evidenced. However it also clearly states that the oversight and supervision of the assessment process was "*particularly poor*." Team managers were actively involved in decision making but there is no evidence that they created opportunities for reflection either for themselves or for other social work staff. The IMR has been unable to identify any evidence of systematic supervision and no supervision records were identified. As such Children's Social Care was unable to demonstrate either effective performance management or that there was the opportunity for practitioners to benefit from support and critical reflection on their work.

4.50. In the context of a high pressure first assessment service, such as that provided by the Initial Response Team, supervision has a particularly important role to play. Decision making has to be managed in the context both of time pressures as well as pressures on resources and as such calls for a particular level of skill and reflection to ensure mistakes are minimised and careful decisions made regarding the level of assessment undertaken.

[13] Brandon et Al: Biennial Analysis of Serious Case Reviews 2003-5 p105

4.51. Children's Social Care have, since the events covered within this review, updated their supervision policy, including provision of training for supervisors and quality audit by direct observation. In the context of further organisational changes as part of the Transformation Programme designed to strengthen access to supervision, it has not been considered necessary to include a further recommendation within this report in this regard.

4.52. Health Visitors could have played a pivotal role in identifying that this was a vulnerable family who might benefit from a multi-agency response. Individual Health Visitors had significant contact with the family and were in possession of information that could have triggered concerns about the children's experience of being parented and should also have led to those professionals seeking management advice and support. However the lack of an underpinning organisational system to review the wider needs of children where there are low level concerns is a significant weakness in the context of: it being usual for health visitors to manage caseloads that are higher than those of other professional groups such as social workers; and a supervision model which is reliant on individual health visitors identifying families where there are low levels of concern. This is an issue that has appropriately been addressed and identified as the basis of a specific recommendation within the NHS Calderdale Commissioning report and set in the context of the developing Continuum of Need model.

4.53. As has been acknowledged in the IMR, there was a lack of adequately reflective supervision within Family Services and this has been appropriately addressed with a targeted recommendation. Supervision in the agency seemed to be focussed primarily, even exclusively, on practical issues, as such missing the opportunity to reflect with practitioners on the purpose of their work with families or how best to engage. Good supervision may have for example led to greater clarity about who was understood to be the primary carer for the children, as although the initial referral was in relation to FD, the focus then shifted towards MD, although it is not explicit why this was the case.

4.54. Practitioners within this setting will be working with families with multiple needs, some of whom may be difficult to engage, but who may not reach the thresholds for intervention by Children's Social Care. It is often the case that these practitioners can have considerable personal skills, but may have less professional training or experience in relation to safeguarding children. As such there is a particular need for regular and structured supervision and support to ensure that there is organisational ownership of practice and decision making

4.55. A number of relevant recommendations have been made within Individual IMRs as well as a multi-agency recommendation in relation to this key theme:

**Youth Services: Recommendation 4**

**Children's Social Care: Recommendation 4**

**Family Services: Recommendation 6**

**Calderdale and Kirklees Careers Service: Recommendation 3**

**NHS PCT: Recommendation 5**

**NHS Calderdale Commissioning: Recommendation 5**

4.56. **Multi-agency working:** The experience of Child D and her family shines a particular light on the crucial role of multi-agency working in delivering services to families and protecting vulnerable children. The introduction of the Continuum of Need model has the potential to address many of these concerns, but 2 other issues merit further consideration.

4.57. Where parents have Learning Disabilities it is particularly important that there is good co-ordination between agencies to promote consistency and continuity of information and services[14]. The fact that so many agencies did not recognise that the parents had Learning Disabilities is of particular concern. Whilst Youth Works engaged constructively with the parents in this context, no other evidence has been made available to this Review that would suggest a satisfactory level of professional awareness or understanding of Learning Disability and its potential significance for parents.

4.58. The initiation of an Audit in 2008 (see para 4.14) evidences a recognition within the authority of the need for a co-ordinated response to families where parents have additional needs. However this work has not yet been progressed to completion and the absence of any identified good practice or positive initiatives in Calderdale suggests a weakness that goes beyond individual worker's practice and skill. The Think Family approach ie: "*securing better outcomes for children, young people and families with additional needs by co-ordinating the support they receive from children's, young people's, adults' and family services"* [15] provides a clear framework within which creative approaches could be achieved. A Multi Agency recommendation has therefore been included within the Overview Report to address this concern. (**Multi Agency Recommendation 3**)

4.59. The involvement of Family Services, whilst a comparatively minor one in relation to Child D, has also drawn attention to the accessibility of services for hard to reach vulnerable families within Calderdale. Family Services commissions local agencies to provide support to families, particularly those who have extra needs. Information from this review raises questions about the effectiveness of these services in working with hard to reach families and the nature of the service provided in supporting families alongside other agencies.

4.60. A strategic decision has been made as part of an ongoing Transformation Programme for Children's Social Care that provision Family Services should become part of the integrated, tiered approach represented by the Continuum of Need Model with a dedicated

[14] SCIE Briefing 2005
[15] Think Family Toolkit, HM Govt 2009 p 4

Manager taking responsibility for Early Intervention Family Support. It is intended that the new model will improve collaboration between Family Support and local Social Work teams; it will include a single Intensive Family Support/Intervention Team and place commissioning for services more clearly. This remains a work in progress and improved outcomes for children will need future assessment.

4.61. **Domestic Violence.** Domestic violence has been identified within this Review although not as a primary factor. It is known that on at least three occasions FD was hit by MD or a previous partner, and information available to this Review identified that on at least one of those occasions he was restrained from retaliating in kind. There is however no evidence to indicate that there was the sort of consistently abusive and violent behaviour from MD to FD that is generally associated with chronic domestic violence.

4.62. Two issues of concern arise as a result. Firstly although the domestic violence identified was not of the most serious kind there was a failure by some professionals to act on the possible implications for the welfare of the children once they had been notified of the assaults by the police. Secondly there is a possibility that because in this instance the victim of the violence was a man and the perpetrator a woman, it was accorded less seriousness than it would have been had the positions been reversed.

4.63. We can speculate, but cannot know for sure that the latter issue was the reason for the lack of response by some professionals. In any event it has highlighted that there may need to be gender specific responses to domestic violence. For example, the police offered the father access to Cocoon Watch and also referred to the Domestic Violence midwife following the incident in January 2007. This was, in effect, evidence of gender neutral practice, suggesting that the police did not give the assaults less credence because the victim was a man and was in line with what was routinely offered to female victims of domestic violence. However, whether these sorts of referrals should in fact be gender sensitive rather than gender neutral needs to be given greater consideration. The practice of referring to midwives as a result of domestic violence has developed out of a body of understanding that women are at heightened risk of being seriously assaulted during pregnancy. It is questionable that the same response can simply be applied when the victim is a man who is assaulted by a pregnant woman.

4.64. The Panel were therefore led to consider whether there were particular issues for male victims of domestic violence that needed further consideration in the future provision and design of services. A recommendation to this end is therefore included within the Overview Report.

4.65. A number of relevant recommendations have been made within Individual IMRs as well as a multi-agency recommendation in relation to this key theme:

**Multi Agency: Recommendation 5**

**Police: Recommendation 1**

**NHS Calderdale Hospitals Foundation Trust: Recommendation 5**

**NHS Calderdale Commissioning: Recommendation 6**

4.66. **Substance misuse:** The possibility of substance misuse being a feature in this case was included in the Terms of Reference. Information provided to the review however, only identifies one unattributed allegation of cannabis use, but no other evidence to suggest that substance misuse was of significance.

4.67. **Serious Case Review Process.** This Review has also identified an area of concern for Calderdale Children Safeguarding Board in relation to the effectiveness and transparency of its processes relating to the undertaking of this Serious Case Review. Specifically it has identified that there was a failure to initiate a Serious Case Review in relation to Child D within an acceptable time frame, a failure which may have impacted on consequential learning. No compelling rationale has been provided for this delay.

4.68. Prior to this Serious Case Review, an Independent Review was commissioned regarding the performance of the CSCB following the issuing of the Improvement Notice in April 2010 which had identified a requirement to review the Board's performance. This Independent Review made a range of recommendations all of which have been accepted by the incoming Independent Chair and the Board. In particular a recommendation was made to review the Terms of Reference for all the Board's subgroups, including the Serious Case Review Subgroup.

4.69. Information provided by the CSCB Independent Chair has identified a number of actions that are being initiated to respond to this recommendation, including reviewing Terms of Reference and mentoring by an adjoining authority to analyse the effectiveness of Serious Case Review processes.

4.70. A complementary recommendation has therefore been included within this SCR to reinforce these developments. (**Multi Agency Recommendation 4)**

# 5 INDIVIDUAL AGENCY REPORTS AND RECOMMENDATIONS

## 5.1 Calderdale Council Young People's Service (Youth Works)

5.1.1. Calderdale Young People's Service has provided a chronology and Individual Management Review for this Serious Case Review.

5.1.2. The report has been prepared by the Principal School Link Officer for Learning Services. The author is employed within the Children and Young People's Service of the Council, but within a separate section of the Service. He has no management responsibility within the Young People's Service, nor did he have any previous knowledge of Child D and her family. As such he clearly met the criteria for independence. The author had no direct working knowledge of the Young People's Service and faced a very challenging task in undertaking the review. In doing so he sought and accepted help and advice from the Panel.

5.1.3. The Report was countersigned by the Group Director, Children and Young People's Service, who had no operational responsibility for Child D, her family or the relevant staff.

5.1.4. Youth Works had a significant degree of contact initially with MD and then later FD, throughout the time period identified within this review. Youth Works is part of the Young People's Service within Calderdale Council. It provides a service for vulnerable young adults who would be considered hard to reach by other mainstream services. Youth Works does not have a primary 'safeguarding children' focus, but as part of council services is a partner within multi-agency safeguarding and works within the LSCB policies and procedures. The IMR clearly acknowledges the resulting tensions and presents an open enquiring approach into the implications for the service.

5.1.5. The IMR evidences a number of strengths in the Service provided, including a particularly good level of commitment and skill by the Youth Workers in engaging with the parents of Child D, providing both practical help and wider personal support. The IMR identifies that Youth Works staff were aware of the parents' Learning Difficulties and adapted their individual practice thoughtfully as a result. It identifies that the service took appropriate action, even though it risked damaging the relationship with FD and MD, in making two referrals to Children's Social Care arising out of developing concerns about the parents' capacity to meet their children's needs.

5.1.6. The IMR is balanced in its positive comments whilst recognising areas for development and improvement. It identifies important learning points, including; the need for management escalation when the response from Children's Social Care to the referrals is not considered

adequate and appropriate use of CAF. The IMR identifies the need to improve multi-agency working.

5.1.7. The **Recommendations** identified for Calderdale Young People's Service as a result of the Review are as follows:

**Recommendation 1:** To ensure that the Young People's Service is fully conversant with the Calderdale Continuum of Need and Response

**Recommendation 2:** For the Young People's Service to develop interagency liaison with agencies that can provide family support services to young parents.

**Recommendation 3:** Provide a training event focussing on working in partnership with parents for staff in the Youth Service.

**Recommendation 4:** Establish a clear system of case review for vulnerable young people who are clients of the Youth Works project.

## 5.2 Calderdale Council Children's Social Care

5.2.1. Calderdale Children's Social Care has provided a chronology and Individual Management Review for this Serious Case Review.

5.2.2. The report has been prepared by the Director of Campus Calderdale. As such the author is employed within the Learning Services section of Calderdale Children and Young People's Service. She has no management responsibility within Children's Social Care, nor does she have any previous knowledge of Child D and her family. She therefore clearly met the criteria for independence.

5.2.3. The author had no experience of Children's Social Care other than within her general professional role. Whilst this provided benefits of independence it also meant that the author had a very challenging task to review and analyse the services provided, particularly in the context of a recording system that is recognised by Children's Social Care as highly problematic. The author sought and received significant help and advice from staff within Children's Social Care as well as the Independent Chair and Author and was highly tenacious and responsive in meeting the demands placed upon her.

5.2.4. The Report was countersigned by the Director of Children and Young People's Services. She has had no operational involvement with Child D or her family.

5.2.5. There was a significant delay in receiving a final version of the IMR that was acceptable to both the Panel and the agency. It is fair to say that the IMR was significantly amended as a result of the internal quality assurance process.

5.2.6. Children's Social Care were involved in five episodes leading to contact with the family of Child D comprising of two referrals from Youth Works regarding concerns over Sibling 1 and 3 self referrals by MD and FD seeking financial help. Calderdale Children's Social Care had no contact with Child D and there was no involvement with the family at the time of her death.

5.2.7. The IMR identifies and analyses a number of weaknesses in the service provided by Children's Social Care, in particular regarding the assessment process, with direct reference to Working Together and other procedural requirements, as well as research findings. The report identifies, with hindsight, a pattern of information about parental vulnerability and low level concerns over the children's welfare that could have been more clearly identified at the time had proper assessments taken place. Information is provided regarding a programme of improvements that have since taken place, however the improvement plan is at too early a stage to evidence outcomes. This is something that will be monitored by Ofsted's inspection regime

5.2.8. The IMR's analysis that the case did not meet the threshold for intervention by Children's Social Care, is open to question in the context of a lack of clearly shared understanding between agencies as to what the threshold of intervention was at that time. In the absence of both an Initial Assessment and explicit criteria, it is not possible to make a judgement as to whether those criteria have been met.

5.2.9. An occasional flaw within the report is a tendency to identify a particular explanation for gaps in practice, for example identifying problems in record keeping as being the result of data migration, whereas in the absence of conclusive evidence, other causes (eg human error) could be considered a factor. Given the recent history of Calderdale Children's Social Care it is understandable that areas of weakness which have already been identified within other contexts are likely to be at the forefront of thinking. However, care needs to be taken to ensure that this does not cloak other possibilities and that there is genuine reflection on the particular learning arising out of this Review.

5.2.10. Whilst critical of the quality of assessments and the lack of robust procedures, the IMR justifiably identifies that Child D could have been considered at risk of neglect, but not that her death could have been prevented by Children's Social Care.

5.2.11. The report establishes that information about MD's Learning Disability went unrecognised by Social Care Staff despite there being historical information recorded in this regard. There is detailed consideration of the implications of Learning Disability for the family of Child D which is integrated into the Learning points and subsequently

the recommendations. However, the report would have been strengthened by a specifically focussed recommendation regarding Children's Social Care's work with parents with learning disabilities. This is addressed in a multi-agency recommendation.

5.2.12. The IMR critically analyses the failings in responding to the referral by Youth Works at the time MD and FD were separated and appropriately critiques the failure to undertake a proper assessment. This however raises a specific area of learning for Children's Social Care which has not been directly addressed beyond the wider issues of assessment. That is, in relation to procedures for considering whether a Child is in Need at the time of parental separation and what the proper role of Calderdale Children's Social Care should be in these circumstances. A specific recommendation is therefore made within the Overview Report in this regard.

5.2.13. The report identifies issues such as staff turnover, lack of capacity in IRT and recognised culture of inadequate completion of IAs as contributing factors and these amongst other concerns are reflected in the recommendations.

5.2.14. The IMR has identified 13 detailed learning points leading to 5 recommendations.

5.2.15. The **Recommendations** identified for Calderdale Children's Social Care are as follows:

**Recommendation 1**: Ensure Children's Social Care staff are: fully trained in; and making effective use of, protocols, procedures and systems underpinning a high quality assessment process.

**Recommendation 2**: Ensure requests for financial assistance under Section 17 are managed, recorded consistently and linked to assessments.

**Recommendation 3**: Carry out investigations and checks thoroughly, ensuring the needs and risks to children are fully understood in the context of the family history and current situation.

**Recommendation 4**: Raise expectations of managers within Children's Social Care of their role in quality assuring the service provided to children and their families.

**Recommendation 5**: Roll out training to all Children's Social Care staff on the Calderdale Continuum of Need and Response to ensure common understanding of levels of need and thresholds for support. Monitor the impact of training.

**Recommendation 6**: Increase the accuracy of day to day recording. Ensure IT systems are fit for purpose and that staff can, and do, use them.

**Additional Recommendation** from Overview Report Author:

That Calderdale Children's Social Care establish policies, procedures and good practice guidelines in relation to their role on receiving a request for information or advice from Court or a solicitor in Private Law proceedings, which ensures that these requests are integrated within the usual systems for making assessments, decisions and providing services about the protection of children

## 5.3 Calderdale Council Family Services (Children's Centres)

5.3.1. Calderdale Family Services Children's Centres has provided a detailed chronology and Individual Management Review for this Serious Case Review.

5.3.2. The report was begun by the Family Services Support Manager who left the authority prior to its completion. It was therefore completed by the Principal Officer for Family Services. Neither author had line management responsibility for the services provided to the family of Child D. The second Author is responsible for commissioning the services that were provided. Both authors were judged to have met the criteria for independence. The Report was countersigned by Calderdale's Director for Children and Young People's Services, who had no involvement with the family of Child D and her family.

5.3.3. Calderdale Family Services provided a family support service to Child D's Family following a health visitor referral for a short period from late 2007 to early 2008. A second period of family support was provided in August 2008.

5.3.4. Family Services had limited contact with the family and were not primary providers of services. Nevertheless, the Review identifies significant areas for learning, including the need to ensure that support offered is based on an assessment process, the lack of adequate supervision and management oversight and the need for improvements in multi-agency working.

5.3.5. The **Recommendations** identified for Calderdale Family Services (Children's Centres) Care are as follows:

**Recommendation 1:** Workers should make efforts to see children and check on their welfare at every family support home visit. There should be a detailed account of the home visit with specific reference to each child; reasons to be recorded if the children are not seen

**Recommendation 2:** All families requiring a family support intervention will have a detailed assessment that will be undertaken at the first home visit by the allocated Family Support Worker

**Recommendation 3:** Work to be undertaken to equip all workers with the ability to identify and assess risks within families

**Recommendation 4:** Within the registration process parents will be monitored for learning difficulties

**Recommendation 5:** Historical data is used as a safeguarding tool to build a fuller picture of the family.

**Recommendation 6:** Case supervision is reviewed and new standards will be set. This will be audited by spot checks on case files

**Recommendation 7:** Where more than one agency is engaging with the family on a regular basis the work is brought together and coordinated under the CAF

**Recommendation 8:** There needs to be a smoother transition between family support services for families that are frequent movers

## 5.4 Calderdale and Kirklees Careers

5.4.1. Calderdale and Kirklees Careers have provided a chronology and Individual Management Review for this Serious Case Review.

5.4.2. The report has been prepared by the Head of Service for Calderdale and Kirklees Careers. The author has had no operational responsibility in the case or any direct involvement with Child D and her family and as such met the criteria for independence.

5.4.3. The Report was countersigned by the Head of Corporate Services who and was not in post at the time of Child D's death and therefore had no knowledge or involvement of the services provided to her and her family.

5.4.4. The IMR provides a comprehensive explanatory statement in order to place the service provided to Child D and her family within context. The service is described as "high volume" in that it deals with very high numbers of young people at any time and there is a high turnover of users.

5.4.5. Services were provided by C&KC to MD alone, during 2006 and early 2007, and pre-dated the births of both Child D and Sibling 1.

The IMR was therefore able to comment on the Terms of Reference in a fairly limited way. It does not identify significant failings in the service provided. Nevertheless the IMR has identified areas for further learning and three resulting recommendations.

5.4.6. One of the learning points is that the identified concern about MD's anger management was not pursued further by the Careers service. Whilst there is no evidence to suggest that had this been pursued by C&KC this would have led to significantly different outcomes or was a failure to meet service standards, it would nevertheless have added to the IMR had the it been clear about the significance of this issue in the context of the service's role and whether there were lessons for the future. It is however not so significant as to justify the addition of a stand-alone recommendation.

5.4.7. The **Recommendations** identified for Calderdale and Kirklees Careers are as follows:

**Recommendation 1**. Clarify guidance on Profile 2000 recording of other agencies involved in cases where Safeguarding may be an issue.

**Recommendation 2:** Look to issue specific guidance on referral to TYS and/or Initial Response Team in cases where young women (16-18) are or have been involved with older men

**Recommendation 3:** Review supervision recording and document retention

## 5.5 West Yorkshire Police

5.5.1. West Yorkshire Police has provided a comprehensive detailed chronology and Individual Management Review for this Serious Case Review including relevant historical information.

5.5.2. The report has been prepared by the Service's Named Professional for Safeguarding Children. The author has had no operational responsibility in the case and was not in post at the time of Child D's death and as such met the criteria for independence.

5.5.3. The Report was countersigned by a West Yorkshire Police Detective Chief Inspector, the Senior Officer with the Strategic Lead for Vulnerable Adults and Children. The countersigner has no direct line management responsibility with family or relevant staff.

5.5.4. The police had no involvement with Child D, but the report appropriately considers and analyses small number of contacts with the other family members. The report clearly identifies gaps in good

practice, in particular in relation to sharing information with Children's Social Care regarding allegations of domestic violence and proper consideration of the welfare of children arising out of incidences of Domestic Violence.

5.5.5. The IMR identifies two key issues for learning; one leading to the recommendation in 6.5.6. The second area for learning relating to review of decisions by more senior officers is identified as having been actioned in 2009 as a result of a previous Serious Case Review. It confirms that the practice has been audited, with a further audit to take place in 2011. In the circumstances the author reasonably concludes that a further recommendation is not required.

5.5.6. The **Recommendation** identified for West Yorkshire Police as a result of the review are as follows:

**Recommendation:** The West Yorkshire Police need to ensure that Officers attending at Domestic Abuse Incidents obtain the details of all parties involved, including children resident or present in the household and physically check on their well-being and ensure their details are entered on the Police systems. On receipt of that information the Police Safeguarding Unit will research all historical information held and make the relevant child protection referral or domestic abuse notification to Social Care.

## 5.6 Yorkshire Ambulance Service

5.6.1. Yorkshire Ambulance Service has provided a chronology and comprehensive Individual Management Review for this Serious Case Review.

5.6.2. The report has been prepared by the Service's Named Professional for Safeguarding Children. The author has had no operational responsibility in the case and was not in post at the time of Child D's death and as such met the criteria for independence.

5.6.3. The Report was countersigned by the Director of Standards and Compliance, who has executive responsibility for safeguarding in YAS and has had no previous contact with, or knowledge of Child D or the family.

5.6.4. YAS identified 7 incidences when the service responded to calls for one of the family members. The IMR author showed considerable perseverance in her attempts to ensure that the maximum possible number of incidents could be identified and analysed, and responding to further requests for checks, despite the systemic problems with achieving this.

5.6.5. The IMR critically and comprehensively examines each of the incidents against practice standards and guidelines. It draws attention to aspects of the service that have been improved since the time of Child D's death, including any extra input given to individual staff as a result of identified gaps in practice.

5.6.6. Examples of good practice are appropriately identified.

5.6.7. The IMR identifies practice of concern in relation to other Health professionals for consideration in the overview report.

5.6.8. The **Recommendations** for Yorkshire Ambulance Service are as follows:

**Recommendation 1:** YAS takes action to ensure that all staff routinely document/sign that a clinical hand-over has taken place in line with existing guidelines

**Recommendation 2:** YAS takes action to ensure that all staff routinely record baseline observations as part of a patient assessment in line with existing guidelines

5.6.9. Additional recommendations for all the health providers have also been identified within the NHS Calderdale Commissioning report (see para 6.10.)

## 5.7 NHS Direct

5.7.1. NHS Direct has provided a chronology and Individual Management Review for this Serious Case Review.

5.7.2. The report has been prepared by the Service's Regional Children's Services Lead. The author has had no operational responsibility in the case and no prior knowledge of the family and as such met the criteria for independence. The Report was countersigned by the Divisional Director of Nursing and has had no previous contact with, or knowledge of Child D.

5.7.3. The IMR identifies and analyses 3 contact episodes with the family, one of which was a routine call in relation to FD and two in relation to breathing problems for Sibling 1.

5.7.4. The report is not structured explicitly to deal with the key lines of enquiry, but these are considered within the body of the narrative.

5.7.5. There are no significant concerns identified about the service provided to Child D and her family. However, the review reflected on

aspects of individual practice which could nevertheless be improved and notes that where required this has been raised with the relevant staff member. The Review took the opportunity to identify 2 areas of general improvement.

5.7.6. The **Recommendations** for NHS Direct are as follows:

**Recommendation 1:** To develop a process where we cascade information across the organisation to share learning relating to research and findings from Serious Case Reviews.

**Recommendation 2:** To cascade child health training to all front line staff. Promote continuous professional development for Nurse Advisors.

5.7.7. Additional recommendations for all the health providers have also been identified within the NHS Calderdale Commissioning report (see para 6.10.6)

## 5.8 Calderdale Foundation Hospital NHS Trust

5.8.1. NHS Direct has provided a chronology and Individual Management Review for this Serious Case Review. Whilst there is a detailed review of the records, the methodology does not clearly identify what staff interviews were undertaken.

5.8.2. The report has been prepared by the Service's Named Nurse for Safeguarding Children. The author has had no operational responsibility in the case and as such met the criteria for independence. The Report was countersigned by the Director of Nursing who has had no previous contact with, or knowledge of Child D.

5.8.3. CHFT provided ante-natal and post natal services to FD, Child D and Sibling 1, as well as emergency services to all members of the family. Child D was cared for at Calderdale Royal Hospital when she received her fatal injuries.

5.8.4. The Review identifies a number of points at which practice could have been improved, establishes the lessons to be learnt and links these to recommendations. It also identifies positive developments in practice since the time of Child D's Death, including:

- a specialist midwifery service for vulnerable mothers
- dedicated Paediatric Liaison Sister within A&E
- routine pre-CAF assessments for teenage mothers

The Review would however have been enhanced by more comprehensive cross reference to agency policy and standards, including within the chronology.

5.8.5. The Review rightly considers the issue that no risk assessment was initiated regarding the known incidence of domestic violence from MD to FD. However, there is limited analysis as to the reasons for this. In the context of this being violence perpetrated by a woman to a man, the Review would have benefitted from greater consideration as to whether this may have related to gender or whether there were other explanatory factors. The critical analysis does not note whether the staff member concerned was interviewed, as this may have provided valuable information in this regard. The IMR concludes that the gender of the perpetrator and victim was the significant feature and there is a consequential recommendation. However this assumption, whilst not in itself an unreasonable hypothesis, is not evidenced and would have benefitted from greater exploration within the critical analysis, particularly to identify if this was case and issue specific or had wider organisational implications.

5.8.6. The Review properly details points at which the Learning Difficulties of the parents might have been identified leading to better assessment and support of the family. However, there is no consequential recommendation. This is addressed within the Health Overview report and will be further addressed by means of a multi-agency recommendation.

5.8.7. The **Recommendations** for Calderdale Foundation Hospital NHS Trust are as follows:

**Recommendation 1:** That CHFT will audit the Paediatric non-attendance policy in December 2010

**Recommendation 2**: That CHFT will introduce a standardised approach to postnatal record keeping, within Maternity services

**Recommendation 3:** That CHFT will introduce a system within A&E for recording accurately who is accompanying the child, and who has parental responsibility.

**Recommendation 4:** CHFT will strengthen the foundation level training to include specific guidance for staff in A&E in relation to escalation of concerns around the child.

**Recommendation 5:** CHFT will strengthen the Domestic abuse training to re-enforce that female to male violence is as much a concern as male to female violence and violence in same sex relationships.

5.8.8. Additional recommendations for all the health providers have also been identified within the Health Overview report.

## 5.9 NHS Primary Care Trust Provider Services

5.9.1. NHS Direct has provided a chronology and Individual Management Review for this Serious Case Review.

5.9.2. The report has been prepared by the Service's Named Nurse for Safeguarding Children. The author has had no operational responsibility in the case and as such met the criteria for independence. GP records were reviewed by the Named Doctor for Child Protection and this is included in the Health Overview Report.

5.9.3. The Report was countersigned by the Director of Provider Services NHS Calderdale and has had no previous contact with, or knowledge of Child D

5.9.4. Child D and her family received routine and above core health visiting and GP services from the Trust throughout the period covered by this Review. The family were assessed as vulnerable and needing additional support resulting in increased contact with the Health Visiting Service. Nevertheless, the Review identifies a failure by the service to recognise the children's needs holistically and over time, particularly in relation to parenting capacity.

5.9.5. The Review identifies practice that met required standards but also a number of lessons learnt; ranging from record keeping to the impact of the absence of pro-active supervision for Health Visitors, and makes appropriate recommendations. It clearly links the learning from this Serious Case Review to previous SCRs and identifies improvements in practice since the period covered by this Review.

5.9.6. The Review notes the incidences of domestic violence and the possible impact on parenting skills, but does not comment on what relevant agency policies and procedures were in place at the time in relation to domestic violence and if so whether the Health Visitor followed these procedures. There is no reflection on whether the Health Visitor could or should have spoken to the parents of Half Sibling 2 in this regard. This issue of Child Protection training and Domestic Violence is subject to a further Recommendation in the Health Overview report.

5.9.7. The Review would have been strengthened by a more comprehensive critique of the lack of recognition of the parents' Learning Disabilities. The reported perspective of the professionals was that the parents followed advice despite needing encouragement. However, this does not adequately consider the indicators that were available to the

Health Visiting Service that there might be underlying factors which were impacting on MD and FD's parenting capacity. It remains a cause of concern that the possibility of Learning Disability of the parents, which was recognised by other non-health professionals, was never considered by the Health Visiting Service and this merited more critical reflection within the IMR. The issue of Learning Disability is subject to a recommendation within the Health Overview report and will be further addressed by means of a multi-agency recommendation

5.9.8. Whilst there is explicit recognition of the failure by agencies to consider the use of a CAF to assess and plan for the children's needs, the particular responsibility of the Health Visiting Service in this regard merited greater acknowledgement within the IMR. The IMR does however identify Service wide developments to ensure improved use of CAF since this time. Further reflection in relation to the benefits of review and liaison with Family Services after the referral to that agency in 2008 would also have strengthened the report.

5.9.9. The recommendations for NHS Calderdale Provider Services are as follows:

**Recommendation 1**: Adopt a consistent process for assessing parenting capacity across Children and Young People Health Care Services.

**Recommendation 2:** Processes are further developed to consistently reflect and record the rationale and evaluation of clinical decision making within the electronic clinical record.

**Recommendation 3:** Delegation and Competency Frameworks across Children and Young People's Health Services will continue to be reviewed and audited to reflect changes in guidance, such as the Healthy Child Programme.

**Recommendation 4:** Identify triggers for further action and review, when transferring families between healthcare professionals.

**Recommendation 5:** Extend the current Safeguarding Supervision process to develop a pathway to formalise both the clinical and child protection supervision requirements for children not meeting the threshold of significant harm (Children Act 2004).

**Recommendation 6**: Individual practitioner actions are explored and appropriate remedial action put into place.

5.9.10. Additional Recommendations for all the health providers have also been identified within the NHS Calderdale Commissioning IMR.

## 5.10 NHS Calderdale Commissioning

5.10.1. NHS Calderdale Commissioning has provided a comprehensive chronology and commissioning Overview for this Serious Case Review. The Report details the means by which learning will be disseminated and monitored over time.

5.10.2. The report has been prepared by the Nurse Consultant Safeguarding Children (Designated Nurse for Child Protection). The author has had no line management responsibility for any of the staff members involved. The author on one occasion gave professional advice to a health professional within role, this was discussed at the SCR Panel and it was agreed that this did not raise any concerns regarding independence as such met the criteria for independence.

5.10.3. The Report was countersigned by the Director of Quality and Engagement who has had no previous contact with, or knowledge of Child D or the care provided to her and her family.

5.10.4. The Report properly identifies where practice meets required standards and recognises an episode of good practice by the Ambulance Call taker on 3rd March 2009 when Child D was at the GP Surgery. The report clearly identifies the areas for improvement across the commissioned services for example; the lack of use of historical information held amongst the different health agencies; lack of system to ensure cross reference between family members; follow up of appointment non-attendance. It further identifies where action has been taken in relation to failings in practice by individual staff members.

5.10.5. The indicators of a risk of neglect are well documented within the report and a measured view is taken that the triggers and signs could have been expected to have led to more robust assessment and review at the time and could have been seen to be 'persistent' from November 2007 onwards in relation to Sibling 1. The review recognises the gaps in practice, but appropriately does not conclude that the outcome could have been prevented otherwise.

5.10.6. The additional recommendations arising out of the Health Overview report both for the commissioning and commissioned services are as follows:

**Recommendation 1:** Strengthen existing assessment processes to ensure that historical information is considered in the assessment process to enable holistic assessment

**Recommendation 2:** Consider ways for health services to improve communication when dialogue occurs between differing agencies.

**Recommendation 3:** Ensure that preventative advice is given by NHS Direct regarding Co-sleeping

**Recommendation 4:** Develop a process to easily identify and follow up Children and Young People leaving Health Service departments prior to being seen.

**Recommendation 5:** Child Protection Supervision is extended to include all tiers of intervention within the Calderdale Continuum of Need.

**Recommendation 6:** Child Protection training and guidance is developed and strengthened in relation to the recognition and management of Domestic Violence and Learning Disabilities

**Recommendation 7:** An initial investigation is commenced to explore the concerns in relation to potential staff capability/competence as identified by the YAS IMR.

## 6. CONCLUDING COMMENTS

6.1. Despite the lack of information about them as individuals, it should have been possible to identify that Child D and Sibling 1 were likely to be vulnerable to neglect. There was adequate information, had it been collated, to highlight that the parents were vulnerable and having difficulty meeting the level of care needs of young children, which in itself might lead to increased parental stress.

6.2. From this Review we can identify it was known that: some domestic violence, albeit relatively low level, had taken place; the parents were experiencing difficulty in managing the physical care of their children; there were repeated episodes of problems in relation to feeding. It was also known by Youth Works that these were vulnerable parents with Learning Difficulties. There was reference to cannabis use at one time, but no information that suggested substance misuse was a significant feature. There was historical information that MD herself had experienced abuse and neglect in childhood, that she had anger management and other continuing emotional problems and may have self harmed. Although the parents had access to some support by their own families, the quality and nature of that support was open to question and it is unlikely that they had the level of family support that would been a protective factor in the context of parental learning disability.

6.3. Many of the lessons arising from this review therefore relate to the risk of neglect for Child D and other children of the family. The presence of neglect has been identified in previous Serious Case Reviews as a common feature in cases where children have died and requires a painstaking and comprehensive response from agency in order to

protect children. It is the author's view that the one crucial lesson at the core of this SCR is the paramount importance of a robust multi-agency approach to providing services to Children in Need as defined within Working Together: "*those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services"*[16]

6.4. Whilst the medical cause of Child D's death was quickly established, the issue of whether the injuries leading to her death were caused non-accidentally was not authoritatively resolved until the Finding of Fact in August 2010. The judge concluded that Child D's injuries were non-accidental and suggestive of shaking or jerking her and also raised concerns about the failure of both her parents to access urgent medical help for their daughter.

6.5. On the day Child D received her fatal injuries there was a time lapse between the point when the parents first contacted the GP surgery and her receiving medical attention. Particular consideration has therefore been given as to whether there could have been a different outcome had Child D received more immediate treatment. Medical advice was sought by the Independent Author in relation to whether Child D's death might have been prevented had she had access to more immediate medical treatment. The advice given by the Consultant Paediatrician, Designated Doctor Child Protection, was that it was not possible to reach such a judgement on the basis of the current information available. However, given the information that had been provided by the father to staff at the GP surgery during his initial phone call the advice received to bring Child D in for an appointment the same morning was clinically appropriate.

6.6. The Serious Case Review panel carefully considered the issue of whether it could have been predicted that Child D was at risk from serious physical injury by one of her carers. With hindsight it is possible to identify a number of apparently minor events in relation to both Sibling 1 and Child D which might indicate that either their physical safety in the home was poorly managed or that they might be at risk of some level of physical harm from their carers. Examples include: bruising; reports of both children as babies falling off sofas or otherwise hurting themselves; the petechial rash noted by the Health Visitor; the absence of good home safety arrangements. It is also the case that MD is known to have assaulted FD.

6.7. However it would be misguided to conclude that even a series of incidents of this nature could be reasonably be seen to be indicative of potential serious harm. Research tells us that it is extremely difficult to predict future harm to an individual child. Each of the events was discussed with a professional and the explanations considered congruent. Whilst in retrospect we might consider alternative

[16] Working Together to Safeguard Children ,2010 p35

explanations this can only be highly speculative. There is no conclusive information that, even with the benefit of hindsight, would indicate that either parent had physically harmed any of the children or that there had been meaningful indicators that they were likely to do so in the future.

6.8. Consideration was also given to apparent similarities with the experience of Half Sibling 2 that might suggest a pattern of incidences of concern across the two families. In particular the Panel sought information about a number of health presentations for Half Sibling 2 that could be considered to have similar features, including, fitting and breathing problems, with similar occurrences for Sibling 1 or Child D. However, it was concluded that although there appeared to be some similarities between them, no inference could reasonably be drawn that there was a relevant link on the basis of the evidence available.

6.9. The clear conclusion of the panel therefore was that whilst there were indicators that Child D's parents were not adequately meeting their children's needs and that this may have suggested a requirement for a greater intervention than in fact took place, there was not in fact evidence, that would have suggested she was at serious risk of non-accidental injury. This Review has reached a conclusion that Child D's death could not have reasonably been predicted by safeguarding agencies. It does however identify a number of weaknesses in practice across contributing agencies, particularly in relation to the potential risks of neglect that have been identified in relation to Child D's sibling and then by inference Child D herself. The issue of a shared response to dealing with possible neglect is therefore a Multi Agency Recommendation (**Recommendation 1**)

6.10. Since the events covered within this review Calderdale Children's Social Care and the Safeguarding Board have been subject to critical inspection by OFSTED and a Transformation Programme is now in place. In the light of these developments it has not been considered helpful to identify other multi-agency recommendations that would simply mirror the requirements of other inspecting bodies or which have already been specifically addressed by Children's Social Care and the Board.

# 8 MULTI AGENCY RECOMMENDATIONS

This review has identified a number of recommendations from a multi-agency perspective to complement the individual agency recommendations as follows:

**1:** That Calderdale Safeguarding Children Board prioritises 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.

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

**3:** That Calderdale Safeguarding Children Board and Calderdale Adult Safeguarding Board initiates a short life task centred group to

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. The information from this Serious Case Review to be used as an instructive case scenario to test the effectiveness of the protocol.

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

**5**: That 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.

**Signed on behalf of CSCB and Serious Case Review Panel**

**Jane Booth:** Independent Chair of CSCB

**Date:**

---

**Colleen Murphy: SCRP Independent Chair**

**Date**:

---

**Sian Griffiths: Independent Author**

**Date: 01.03.11**

**BIBLIOGRAPHY**

Brandon, M et al ( 2008 ), A Biennial Analysis of Serious Case Reviews 2003-05, Department of Children Schools and Families. London.

Brandon, M et al (2009), A Biennial Analysis of Serious Case Reviews 2005-07, Department of Children Schools and Families. London.

DFES/Dept of Health (2007): Good practice guidance on working with parents with a learning disability

DCSF (2008): Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice – Executive summary

Haringey (2009) Baby P Serious Case Review.

HM Government, (2000) Framework for the Assessment of Children in Need and their Families. London

HM Government (2010) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. London

Holland, S (2011) Child and Family Assessment in Social Work Practice

Laming (2009): The Protection Of Children In England: A Progress Report

MENCAP website: Have your say – Parents with a Learning Disability

Munro, E (2008): Effective Child Protection

Munro, E: (2010): The Munro Review of Child Protection. Part One

Ofsted (2010) Learning the lessons from serious case reviews: interim report 2009-10. April 2010. Ofsted.

Price Waterhouse Cooper (Jan 2010); Diagnostic Report: Children's Social Care at Calderdale Borough Council

SCIE Briefing Feb 2005): Helping parents with learning disabilities in their role as parents.

Wilson, K & James, A (2007): The Child Protection Handbook