Serious case review
overview report
in respect of
Child K

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1. INTRODUCTION

1.1 On 8th January 2014 Calderdale safeguarding children board, (Calderdale SCB) a committee made up of senior managers from organisations which provide services to children and their families in Calderdale, conducted a serious case review of the services provided to a child who will be referred to as Child K. The review was conducted under the statutory guidance from Working Together to Safeguard Children (WTSC) 2013 which states (page 66) that a serious case review should take place "for every case where abuse or neglect is known or suspected and…a child dies". This is the overview report of that review.

1.2 Child K was aged six months when he died in December 2013. He was discovered dead at his maternal grandmother's house. His mother, AW, had taken him and his sister, EW, to her mother's house in the early evening. She went out shopping, taking EW with her and leaving Child K with her mother and her brother. She returned home and could not see Child K who she presumed was in his cot. Some time later she noticed that he wasn't in the cot and, soon afterwards, found him beside the sofa where her mother had been sleeping. Her mother called the police and an ambulance as Child K wasn't breathing. It later transpired that AW's mother had been drinking on the night of Child K's death.

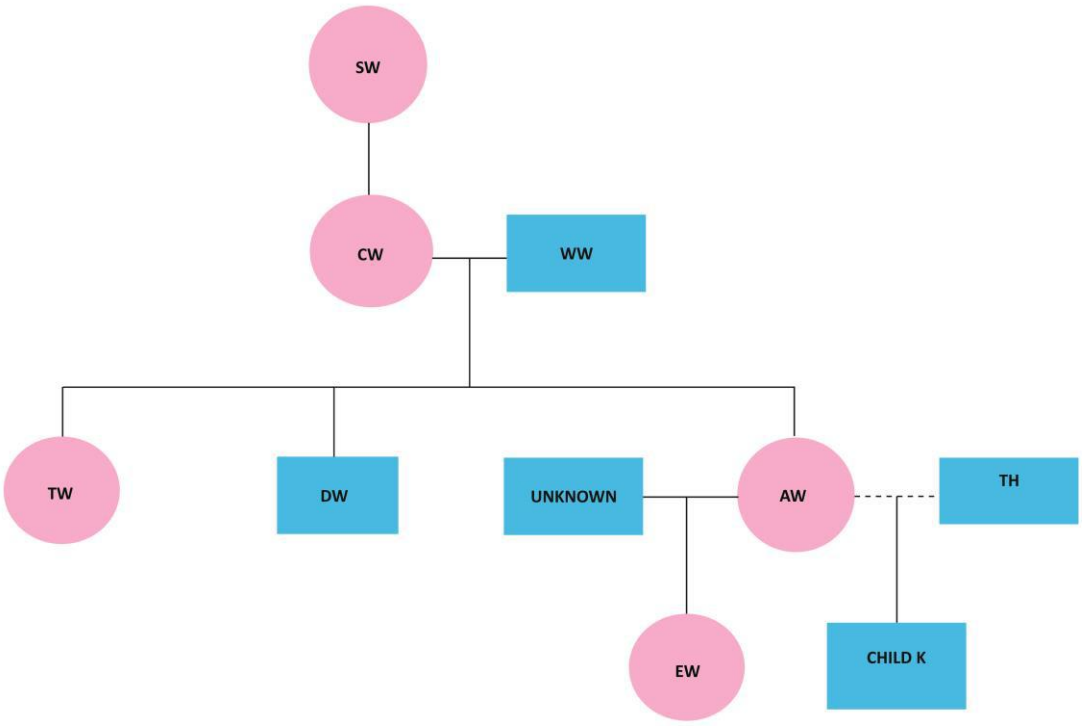
1.3 EW was 3½ years old at the time of Child K's death. In common with other situations where a baby who has older siblings has died this review focuses attention on the care that EW received from her family and professionals.

1.4 During the time of this review AW and her mother were questioned by the police in relation to offences of child neglect but no charges were brought.

Race, religion, language and culture

1.5 All members of the family are English speaking White British. It is not known whether religion is a feature in their lives as this has not been noted in records. Child K's mother and grandmother were described to the author of this report by police officers as appearing to have learning disabilities though there is no formal diagnosis of this**.** Conversations with professionals and family members, case records and reports would suggest that EW had some attachment difficulties and was better cared for practically than she was emotionally. EW was slow to develop her walking and talking. Child K was well looked after by AW, there were signs of good attachment and he was a healthy and well developed baby at the time of his death.

Family tree



2. METHODOLOGY

2.1 WTSC (2013) is clear that serious case reviews are a part of the learning and improvement framework that all local safeguarding children boards must have in place to identify learning from cases in order that local and national practice to safeguard children can continuously improve.

2.2 Reviews therefore must seek to:

- identify precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- understand practice from the point of view of the individuals and organisations involved at the time rather than using hindsight;
- be transparent about the way information is collected and analysed; and
- make use of relevant research and case evidence to inform the findings.

2.3 The purpose of a serious case review is to conduct "*a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children*," (WTSC 2013, page 65). To facilitate this Calderdale SCB set up a serious case review panel (of local senior managers). All panel members were independent of the family and casework. The role of the panel was to assist the lead reviewer in terms of planning the process, consider the evidence and quality assuring this report. The panel developed terms of reference for the review which are included in their entirety in appendix one of this report. The terms of reference included the following key questions for the review to consider:

How has historical information informed assessment and planning:

- Impact of maternal grandmother's alcohol misuse.

- Impact of Domestic Violence.
- Agencies understanding of the history and how that has informed practice.

How have assessments, planning, intervention and review considered:

- Professionals understanding of thresholds and how this informed their risk assessment, decision making and planning.
- How well risks, assessments and plans were documented and communicated.
- Mothers' capacity to parent 2 children at different ages and stages of development.
- The role and involvement of other family members and the implication on the lives of the Child K and EW.

2.4 WTSC (2013) allows local safeguarding children boards to determine their own process for a review. Calderdale SCB decided that this case warranted a participative review with the emphasis upon professional and family involvement.

2.5 Each agency involved with the family was asked to provide a chronology and this was formed into a joint chronology by the Calderdale SCB support team. Each agency was asked to consider any lessons and recommendations that related to multi-agency working or their own agency. These recommendations are included on the overall action plan, managed and monitored by the Calderdale Safeguarding Children Board Case Review Sub Group

2.6 The lead reviewer and author of this report considered the joint chronology, requested actual records where appropriate, met with staff who had been involved with the family, family members and created a narrative. This was shared with staff who were then asked to consider lessons that could be learned.

2.7 The lead reviewer continued to communicate directly with staff either in face to face meetings or via email. He developed a series of questions that this report addressed. Staff were invited to consider their own questions (which were added) and asked to contribute to the analysis, conclusions and recommendations. Staff had sight of this report at the narrative and analytical stage of production.

Independence

2.8 An independent chair, Penny Woodhead was appointed by the safeguarding children board to chair the serious case review panel. Penny is Head of Quality at Calderdale and Greater Huddersfield Clinical Commissioning Groups.

2.9 The lead reviewer was Barry Raynes. Barry is a non-executive director of Reconstruct, a company providing child care training and consultancy to managers and staff throughout the United Kingdom. Reconstruct also supplies advocacy, independent visiting and participation services to children in south west England.

2.10 Barry has thirty five years experience of child protection social work. He has been involved in over 30 serious case reviews since 2007 – either overseeing the work of Reconstruct's consultants or producing overview reports. He has written web-based child protection and child care procedures for more than 50 LSCBs and local authorities in England, Wales and Scotland. Barry has a Masters degree in public sector management and is currently researching a PhD into common language in child protection.

Serious Case Review Panel

2.11 The serious case review panel met on eight occasions between January and August 2014. The overview report was ratified at the local safeguarding children board meeting on 16th September 2014.

2.12 The panel comprised of:

Head of Quality – Calderdale CCG

Service Manager, Safeguarding & QA service

Serious Case Review Officer - West Yorkshire Police

Named Nurse – CHFT

Named Nurse - SWYPT

CSCB Business & QA Manager – Calderdale SCB

DCI/Crime Manager – West Yorkshire Police

Associate Director – CHFT

Service Manager - Family Support

Designated Nurse – CCG

Service Manager - Children's Social Care

Family involvement

2.13 Barry met on two occasions with Child K's paternal grandfather and grandmother, and on one occasion with their son (Child K's uncle) and his wife and, separately, on two occasions with Child K's maternal great grandmother and her partner. Contact was made with Child K's mother and grandmother and to inform them of the review by letter because the police were questioning them at the time of the review. Child K's father was not involved in the process because his learning difficulties meant that he would not have been able to engage with the process. His family explained the issues contained in this report to him.

After the criminal proceedings were finalised and before publication, the finished report was shared with Child K's mother, maternal aunt, great grandmother and paternal grandparents.

Staff involvement

2.14 The staff who were involved with Child K and EW were seen on three occasions.

1 To clarify the case records and to allow the lead reviewer to find out about Child K's and EW's history and develop hypotheses
2 To consider the narrative of the situation and consider possible lessons
3 To be informed of the review's conclusions and recommendations and to offer comments.

Parallel processes

2.15 Child K's mother and maternal grandmother were being questioned by the police during the process of this review. It was therefore not possible to include them in the review process however the report was shared with them prior to publication.

Dissemination of learning

2.16 The learning from this review has already been disseminated by the Calderdale Safeguarding Children Board through the following:

a) Multi Agency Reflective Practice Sessions: Regular forums for practitioners from all agencies led by different professionals to discuss practice so that they can safely and openly consider, challenge and change multi-agency practice based on the themes and recommendations from this review. Learning from these events will be fed back to the Board.
b) Practitioner Forums: The themes which have been identified in this SCR will be considered in locality based forums to foster effective multi-agency working across the geographical partnerships. These sessions are used to disseminate learning as well as check on the progress of changed practice. Learning from these events will be fed back to the Board.
c) Action Learning Sets: Practical 'how to' sessions for staff from different services working from the facts of this SCR.
d) Specific areas of learning: Learning from this SCR will be implemented within the 'Multi Agency Training' programme which is designed to flexibly incorporate the learning from SCRs, Case Reviews and arising needs and priorities within Calderdale.
e) Learning Workshops: Opportunities identified within this report for improving multi agency communication, procedures, policy and or practice will be explored and how these are 'transferrable' beyond this individual case.
f) Action Plans: Translation of recommendations into programmes of action that lead to sustainable improvements in practice will be monitored, implemented and updated through LSCB managed Action Plans through the SCR Sub Group.
g) The outcomes and impact will be monitored longer term through the 'Serious Case Review Thematic Tool Template' which keeps track of all progress and evidence from learning from SCRs in Calderdale.
h) The learning from this review will be in line with the Business Plans, Performance Management Quality Assurance Framework and Learning and Improvement Framework.
i) Specifically for the LSCB will be the need to update the SCR Framework from the learning from this individual case, methodology and outcomes.

Timescales

2.17 The serious case review took eight months between being commissioned and presented to the Board. This is two months beyond the timescale suggested in Working Together to Safeguard Children, 2013.[1] The delay was caused by parallel criminal proceedings and the wish to offer AW and her mother the opportunity to take part in the review; The Calderdale Safeguarding Children Board were notified of the Crown Prosecution Services decision to not prosecute on 22/06/15. Ofsted, the Department for Education and the National Panel of Experts were kept informed of delays throughout the process.

[1] Government guidance relating to child protection

3 SUMMARY OF EVENTS

Historical information

3.1 In 1999 AW, her sister and brother were the subjects of an initial child protection case conference following non-accidental injuries to her brother. His name was added to the child protection register (as it then was) but neither AW's nor her sister's names were added. AW's brother remained on the child protection register for nine months. These records were checked and a number of issues were identified from the file held by Calderdale's Safeguarding and Quality Assurance Service relating to AW's care as a child and teenager. These included a low level of domestic violence, mother's depression and AW's mother's difficulty in coping with her three children. The case conference minutes (1999) suggested that AW had learning difficulties but enquires indicated that she was not in receipt of a formal statement of Special Educational Need, although she was on school action plus and received additional support within school.

3.2 There were no significant incidents recorded on the family until October 2006, seven years later, when children's social care were notified that AW, (then aged 14) was living with a friend's family. They completed an assessment under Private Fostering[2] regulations which noted that AW had been living with the family of a friend of hers since June 2006. The assessment said that since this arrangement AW's "*school attendance, physical appearance and general demeanour improved and she appeared to be much more settled*". AW kept up regular contact with her mother and extended family during the time she lived with this family. Private fostering stops when a young person reaches the age of 16.

2009

3.3 AW became pregnant with EW when she was 17. She was referred to the specialist midwifery service, the Eden team[3] due to her young age. She attended all of her pre-natal appointments. During the pregnancy she was a student at a local college where she successfully completed a painting and decorating course. AW did not have contact with the father of her baby (EW) nor would she say who he was. Midwives were aware that AW had been known to children's social care "*due to her mum's alcohol use*" (joint chronology 09/10/09) and they were aware that she had been living in a private fostering arrangement.

2010

3.4 On 29th March 2010 the community midwife contacted the health visitor and said that AW would need extra support post-natally. On 19th April the community midwife made a referral to the local children's centre because AW was young, had been living in a private fostering arrangement and there were "*historical reports of AW's mum misusing alcohol*" (joint chronology 19/04/10). The referral requested emotional support and attendance at groups. A link worker was allocated to AW on 30th April.

[2] Private fostering means a situation where a child or young person is looked after by someone who is not a close relative. It does not mean that the child or young person is in care to the local authority.

[3] A team of midwives who provide extra support to women with complex needs

3.5 On 7th May EW was born; the pregnancy had been normal as had the birth. Two weeks later AW took EW to college to show her to her tutor and friends. The tutor saw AW take EW out of her pram holding her by one arm and not supporting her head. The inappropriateness of this was pointed out to AW and the tutor later that day made a referral to the First Response Team[4]. Records in the college state that the "*the child did not interact or cry……has dilated pupils and may be concused* (sic) *There was a red mark on the face of the child*," (child protection referral report 21/05/10). The fax sheet accompanying the report was sent on 24th May and makes reference to a telephone call to the First Response Team on 21st May. The joint chronology states that "*tutor received feedback that AW had been visited and was attending parenting classes*". There are no records from children's social care relating to this incident nor any record of the visit to which they were referring. AW was not attending parenting classes at this time.

3.6 On 22nd June AW and EW (now aged 6 weeks) attended baby massage at the local children's centre. *"When AW arrived she was holding EW under one arm…During the session AW gave no contact to EW and…she was quite rough in the way she handled EW…When EW woke up AW just dressed her and left her on the changing mat not talking, smiling, eye contact was again not used….saw EW laying on a adult chair with no-one around her as AW and her mum were at the other end of the sofa not paying attention to her. EW was wriggling around and I looked shocked….AW's mum went to pick up EW saying '…you can't leave her on the chair'. AW's mum did not speak or look at EW and put her over her shoulder. AW did not look concerned*," Children's centre case records, (22/06/10).

3.7 On 2nd July the family link worker visited AW at home and also saw EW and EW's grandmother. The family link worker had spoken to college and discovered that the college had had concerns about AW's rough handling of EW in May. The family link worker spoke to the health visitor on 6th July. The family link worker told her that the college had been told by children's social care that the referral the college had made in May "*was not appropriate*" (joint chronology 06/07/10). The health visitor described AW's handling of EW as "*adequate but brusque*" and the two workers agreed that they would both emphasise gentle handling to AW.

3.8 On 18th October EW (aged five months) started to attend the nursery at the children's centre. There were some concerns expressed at the centre regarding AW's attempts to wean EW at an early age.

2011

3.9 On 14th January 2011 the family link worker stated in supervision that AW was "*well cared for and AW is more interactive with EW and diet improved*" joint chronology (14/01/11). One week later the family link worker closed the case though EW retained her place at the nursery. The closing summary stated: *"Supported mum to get into college, apply for nursery and get benefits in place. 4 baby massage sessions attended. Young parents group on 1 occasion only.. Seemed to be coping well but saying too tired to come out to groups. Attending college and EW attending nursery. AW taking some advice e.g. providing toys, but appears generally not to have taken advice consistently around weaning, rough handling and supporting EW's head appropriately….Some positive interaction between AW and EW on some occasions noted,"* (joint chronology 21/01/11).

3.10 On 8th December the health visitor made a referral to physiotherapy as EW (now aged 19 months) was neither standing nor walking alone.

[4] Children's social care

2012

3.11 On 15th May the nursery contacted the health visitor and expressed their concerns about AW's toilet training of EW, (now aged 2). The health visitor followed this up two days later during the completion of EW's two year check. She noted that EW was a *"lively and sociable toddler. Walking in a rather loose limbed way but confidently. Manipulated her toys in an able manner. Reported to be saying approx 12 words with better understanding and communicates a lot by gestures. Mother not worried about EW's speech and says she reads to her etc. ….Discussed toilet training and Mother said she had stopped because Nursery said she was too young…….AW deals with her child in a brusque manner, but is always dedicated to her wellbeing"* (health visiting case record 15/05/11).

3.12 On 13th June an early years practitioner at the nursery noticed that EW's earrings had been digging into her ears and mentioned this to AW. She wrote in her records, "*as I walked away mum pulled EW towards her and she fell down. I went over to help her up and mum pushed her head to the floor and took her earrings out. EW was very upset and I tried to calm her down mum said 'she always paddy's' and pulled her up with one arm*," children's nursery case records (13/06/12).

3.13 On 11th July a referral was made from the senior early years practitioner at the centre for family support from their own family link worker. The practitioner commented that "*AW's relationship with her own mother and her childhood experiences had impacted upon her parenting ability. Mum was accessing support through nursery around her parenting but they felt that she needed more support"* (joint chronology 11/07/12).

3.14 On 9th September 2012 it was confirmed that AW was pregnant.

3.15 On 27th September AW completed a self-assessment at the family employment programme. This identified that she "*had support needs around her caring responsibilities (e.g. childcare), her parenting skills, her confidence, motivation and aspirations, her work related skills and qualifications, lack of basic skills (e.g. numeracy/literacy/IT), that she had a learning difficulty which presents as a barrier to finding employment, a lack of work experience,"* (joint chronology 27/09/12).

3.16 On 3rd October the family were discussed in supervision at the children's centre. The nursery had no concerns about alcoholism and there was no current evidence of a problem. *"Concern noted that AW didn't show praise or cuddles to EW and therefore the quality of the attachment between them was questioned. AW noted to be 'detached' from the assessment process and at times showing lack of interest. Concerns raised about delayed speech. Recommended the 'chatty monkeys' speech and language group to support at the Children's Centre,"* (joint chronology 03/10/12). Two weeks later the nursery made a referral to the speech and language therapy service for EW.

3.17 On 16th November AW was visited by a family link worker at home. She wrote that the house smelt of urine and EW was grubby but, on the other hand, AW was tickling and cuddling her. AW spoke positively about her second pregnancy and said she was in a good relationship with the father.

3.18 On 29th November AW met with her community midwife. This relationship continued throughout the pregnancy. AW kept all her ante-natal appointments. She said that she felt supported throughout the pregnancy. An assessment was undertaken in line with the policies and procedures existent at the time by the midwife about safeguarding and these raised no concerns.

3.19 On 5th December the speech and language therapist stated that EW had a severe language delay and it was agreed that she would receive speech and language therapy at nursery.

2013

3.20 On 11th January the family link worker visited AW and EW at home. EW looked well and the worker suggested that AW attend a parenting course; AW said she would think about it.

3.21 There were no concerns noted over the next three months and on 17th April a multi-agency meeting took place; present were the community midwife, health visitor, AW and great grandmother and staff from the nursery. It was agreed that a CAF[5] was required for EW as well as speech and language development, physical development and toilet training.

3.22 Child K was born on the 19th June; his father was present at the birth. During his short life Child K had regular contact with his extended families.

3.23 On 1st July the health visitor noted that AW still cared for EW and Child K in a "brusque" manner but that she was confident that AW can care properly for Child K. This was the 5th visit by midwives or health visitors since Child K had been born. Child K was seen by various professionals on seven occasions in the next three weeks and there were no concerns noted.

3.24 On 25th July the speech and language therapist telephoned the nursery to say that "*during a group session, AW 'grabbed EW's throat with her hand causing her cheek to 'squish' (puff out). Grandma commented that 'let's take her home, she's rubbish'. EW was struggling to concentrate within the group. They attended a further group the next day where AW was reported to grab EW tightly on the wrist and the group leader intervened to stop it. EW then grabbed the hair of the group leader*," (joint chronology 25/07/13).

3.25 The following day AW was visited at home by the family link worker and the senior early years practitioner. *"EW was full of beans she looked well although when* (we) *arrived at the property we could hear AW shouting loudly at EW. Child K seen, red around nostrils, blocked nose. AW said Health Visitor said there was nothing to worry about. Discussed concern that mum had been observed to grab EW around the face during one session and on the wrist on another session. They asked if this was how she normally managed her behaviour and mum responded 'no'. AW again will think about attending a parenting course……CAF read out to AW at her request although she didn't pay much attention and was 'not really bothered'. CAF signed,"* (joint chronology 26/07/13).

3.26 After this home visit it was decided that to support AW and to ensure that nursery staff saw EW each week during the summer holidays a place was offered for EW to attend the nursery for two days a week funded by the nursery.

3.27 On 20th August the nursery staff recorded "*bruising to the underneath of both EW's arms – purple but fading. To get explanation from AW*", (joint chronology 20/08/13). There are no records to indicate that any further action was taken.

[5] Common assessment framework – a multi-agency assessment

3.28 On 9th September a TAC[6] meeting took place. The nursery nurse, speech and language therapist, early years support teacher, health visitor and AW were present. The following issues were covered:

- Toileting issues,
- Speech and language,
- AW's rough handling of EW at the speech therapy group,
- EW's speech difficulties,
- Forthcoming hearing test, AW's outdoor area.

It is unclear from the TAC minutes whether there had been a discussion regarding targets.

3.29 On 22nd October a second TAC meeting took place. Present were AW, her mother, a student health visitor, Early Years Practitioner, and the lead professional. Discussion covered

- toileting,
- speech and language issues for EW,
- the fact EW only had a 70% attendance rate, (she had had gastroenteritis),
- AW's parenting skills,
- AW reluctance to sign up for a parenting course.

It is unclear from the TAC minutes whether there had been a discussion regarding targets.

3.30 On 12th November a student health visitor saw AW and Child K at home and recorded that AW handled Child K with confidence and appeared to be receptive to his needs. AW's mother and grandmother were reported to be supportive.

3.31 On 21st November EW's new school reported good progress with her toileting issues.

3.32 Child K was seen by various professionals on at least nine occasions between 22nd October and 4th December. There was nothing untoward noted and Child K was developing well.

3.33 On 4th December the third TAC meeting took place. Present were: AW, her mother, the student health visitor and nursery staff. Issues discussed were

- EW had no hearing difficulties,
- AW had enrolled on a parenting course,
- AW still wanted the support she was getting from professionals,
- the amount of disinfectant used in the house,
- EW's application to reception class,
- EW's speech delay,
- Child K having his own bedroom.

It is unclear from the TAC minutes whether there had been a discussion regarding targets.

3.34 Professionals have said in conversation with this author that they felt that good progress was being made with AW at this point and they were considering closing the case.

[6] Team around the child

3.35 On 12th December 2013 at 1 a.m. police were called by AW's mother who said Child K had been found by the side of the sofa and the police called an ambulance. Police officers found Child K was not breathing and attempted CPR[7] prior to the ambulance arriving. Child K was then taken to Calderdale Royal Hospital and was pronounced dead at 1.26 a.m.

4. ANALYSIS

4.1 Analysis was completed via:

- discussion with family members and professionals,
- sight of the joint chronology, case records and reports,
- discussion at panel,
- email exchange with practitioner and managers,
- consideration about research relating to
    - neglect,
    - serious case reviews,
    - parents with learning disabilities,
- feedback from professionals.

4.2 During the process I identified various lines of inquiry and grouped them as follows.

Issues highlighted in the narrative

a) 27 negative comments compared to 9 positive
b) Social care response to referral from college
c) Speech and Language Therapy (SALT), possible referral to children's social care
d) Bruising – how was it dealt with?

4.3 The terms of reference set the following broad areas for enquiry and these were kept in mind throughout the review process and are addressed specifically later in this report.

How has historical information informed assessment and planning:

a) Impact of maternal grandmother's alcohol misuse.
b) Impact of Domestic Violence.
c) Agencies understanding of the history and how that has informed practice.

How have assessments, planning, intervention and review considered:

d) Professionals understanding of thresholds and how this informed their risk assessment, decision making and planning.
e) How well risks, assessments and plans were documented and communicated.
f) Mothers' capacity to parent 2 children at different ages and stages of development.
g) The role and involvement of other family members and the implication on the lives of Child K and EW.

4.4 To this third set of questions I have added

h) Challenging families when working in partnership
i) Written guidance in place in Calderdale

as these were issues that emerged during the process of review.

4.5 This section will address the three areas in turn following a consideration of what is known about the broad issues that are relevant in this case.

[7] Cardiopulmonary resuscitation

4.6 EW and Child K were not in receipt of services from Calderdale children's services nor subject to child protection plans. Professionals considered they were being looked after "*adequately but brusquely*" by AW whose parenting ability, compared to other mothers receiving help from the children's centre, was considered by children's centre staff to be "5" on a scale of 1:10. The family's needs were graded at level 2 (using Calderdale's continuum of need guidance – see paragraph 4.43) by most of the professionals who worked with the family but this was increased to level 3 by a senior early years practitioner because she believed that EW would benefit from a CAF.

4.7 Child K died suddenly in unusual and unexplained circumstances; his mother and her mother were questioned in relation to child neglect by the police and they are both considered to have a low level of learning disability[8] (albeit unassessed) by most of the professionals who have met them. This analysis will therefore consider the research relating to neglect, Sudden Unexplained Death in Infancy, (SUDI) and parents with learning disabilities.

National context

4.8 There are three broad areas which require consideration of research in a national context:

a) Neglect
b) Sudden unexpected death in infancy
c) Parents with learning disabilities

4.9 Neglect is the most common category of those children made subject to child protection plans yet neither local nor national governments know how many children are experiencing neglect. Prevalence studies suggest that the figure may be up to 10% of the child population, approx. 1.2 million, (Radford et al 2011).

4.10 Neglect, especially of babies, can be life threatening. Background factors that should alert professionals to danger are

1. A family history of alcohol and drug misuse
2. Chaotic households with poor living conditions
3. Large families
4. Premature birth
5. Older siblings with a history of neglectful care
6. Children already subject to child protection plans, (Brandon, 2013).

4.11 Whilst it could be said that three of these factors; (1), (2) and (5) may have been present in this case; their impact was at a relatively low level. There is no evidence of drug use; grandmother was reported occasionally to have a drink problem but there is little to suggest that this was a serious issue; the care Child K received was positively commented upon by all professionals.

4.12 The term SUDI, sudden unexpected death in infancy, is the death of an infant, (aged less than one year) which was not anticipated by anyone involved with the child 24 hours prior to their death. The causes of SUDI are not fully understood, but established risk factors include placing babies on their fronts, parental smoking, premature birth or low birth weight and co-sleeping. There are currently over 200 SUDI deaths a year in England and Wales (Sidebotham et al 2011) and maltreatment is rarely seen as the cause of death of these infants. Although numbers have reduced in recent years a high proportion of sudden infant deaths now occur among more vulnerable families

[8] significantly reduced ability to understand new or complex information, to learn new skills
reduced ability to cope independently which starts before adulthood with lasting effects on development.
(Department of Health. Valuing People: A New Strategy for Learning Disability for the 21st Century. 2001).

living in areas of high deprivation (Blair 2006), many in a potentially hazardous sleeping environment, including sofa sharing with an adult who has recently consumed alcohol or narcotics (Blair 2009), a finding relevant to this review.

4.13 Neither AW nor her mother had a formal diagnosis of having a learning disability but both, when being questioned by the police, had appropriate adults allocated to them after being assessed by a health care professional.

4.14 The Norah Fry Institute (2006) published a report entitled *Finding the Right Support* where they noted that parents with learning disabilities can be good enough parents, but they need more time than most parents to learn new skills and more support to do so. AW was receiving that support and professionals believed, just before Child K's death, that AW was responding to their intervention.

Issues highlighted in the narrative

4.15 The narrative in this report focuses much more on EW than Child K despite the fact that this review has been caused by Child K's death. This is appropriate as the focus of this report should be:

- what can we learn from professionals' intervention with AW when she was bringing up EW? and
- were there warning signs in AW's parenting of EW that meant that Child K was at risk?

27 negative comments compared to 9 positive

4.16 The full narrative contained 27 comments that were concerning from the less significant, "*the house smelt of urine"* (joint chronology 16/11/12) to more serious "*AW grabbed EW's throat with her hand …Grandma commented that 'let's take her home, she's rubbish,"* (joint chronology 25/07/13). In contrast it had nine entries of a positive nature "*EW was full of beans she looked well"* (joint chronology 26/07/13).

4.17 In discussion with professionals it became clear that there were more positive events witnessed than were recorded in their case notes and, therefore, the chronology and narrative. I considered that there may be a further issue inasmuch as the authors of the chronology may be inclined to add negative remarks but fail to include positive ones. I examined the full case records and compared them to the entries in the chronology and was satisfied that this was not the case.

4.18 Discussions with the practitioners who knew the family elicited the following. AW could be off hand with her children, a little cold, sometimes very literal in her understanding of instructions and monosyllabic in her answers. At other times she demonstrated warmth towards her children, took on board advice from professionals and demonstrated that she was making improvements in her parenting ability. It is also worth noting that all concerns expressed related to AW's care of EW and not Child K. Child K was described as a bonny baby, developing well, meeting all his milestones and the relationship between AW and Child K was warm and caring. Professionals who had known AW for a few years commented that her care of Child K as a baby was much better than her care of EW when EW was a baby.

4.19 Professional's view of AW's parenting of EW was that it was "good enough" though well below what many people would consider to be adequate. Professionals agreed that compared to other parents who attended the children's centre, AW scored "5" on a scale of 1:10 with "10" being "the worst parent you've come across" and "1" being "the best".

Social care response to college referral

4.20 In late May 2010 AW took EW, then aged about two weeks to college. AW was seen by a tutor to be handling EW roughly; he spoke to her and made a referral to children's social care First Response Team. In addition to the rough handling the college tutor recorded that EW "*has dilated pupils and may be concused* (sic) *There was a red mark on the face of the child"*, (child protection referral report 21/05/10). Shortly afterwards a family link worker spoke to the college and discussed their concerns. She recorded that she was told by the tutor that the college had been told by children's social care that the referral "*was not appropriate*" (joint chronology 06/07/10). It would have been better had the social worker fed back to the referrer using more positive language than "not appropriate" for example "this was a referral that did not meet the threshold for referral to children's social care" because an "inappropriate referral" implies that the referral should never have been made.

4.21 Discussions with the social care representative at a panel meeting resulted in the following response. "*There is no record of the referral suggested 14/5/10 and I can only assume that as the tutor states a telephone referral was made (and it does not state was followed up in writing) that advice was given re NFA*[9]*……. based again on the tutor's comments 6/7/10 he was informed it was an inappropriate referral and subsequently the team did not input the call onto the system. The tutor states in the record 14/5/10 that 'mother had been visited and was attending parenting classes' it is not clear who told him this and who visited and whether it was an involved agency or SC*[10]*"* (email to author 02/06/14).

4.22 This explains why there is no record of the call on social care's files. The following observations need to be read bearing in mind the following.

- The incident took place 4 years ago
- We cannot be sure about exactly what was said as the records are not full
- I have been told that historical issues relating to the First Response Team have been highlighted by Ofsted inspectors and addressed, (as follows).

4.23 The First Response Team no longer accept concerns or referral from professionals or the public unless the child in question is an open case. All new enquiries are responded to by the Multi-Agency Screening Team (MAST) which is staffed with social care staff, and agencies including health, police and early intervention. This ensures a consistent service, relevant information is shared and robust decisions are made.

4.24 Marks on a baby under the age of twelve months are extremely concerning and non-accidental injury should always be considered, (Brandon et al 2009). The description that the referral "*was not appropriate*" is worrying. Even if this case did fall below children's social care's threshold (debatable given the previous sentence) the referral is not necessarily "inappropriate". This term implies that children's social care worker's time is being wasted with discussions about unnecessary referrals whereas the truth of the matter is that almost all child protection work is socially constructed wherein different people will place different values on certain acts (Parton, and O'Byrne, 2000). The referral discussion between a social worker and a professional referrer should not be seen as a gate-keeping exercise. Referrals made which don't meet the accepted threshold are not "inappropriate". In these situations a collaborative discussion between the referrer and the social worker should be focused upon meeting the needs of children; even if there won't be direct input from social care.

[9] No further action
[10] Social care

4.25 This issue may now have been addressed due to the creation of the MAST system. The Multi-Agency Screening Team (MAST) now provide an information and advice telephone service to offer guidance if a professional is unsure about making a referral. This allows professionals to talk through their concerns and either identify additional support or provide advice that a social care Intervention is required and a referral will be taken on the information provided.

SALT, escalation of concerns to children's social care

4.26 On 25th July 2013 a speech and language therapist telephoned the children's centre to say that "*during a group session, AW 'grabbed EW's throat with her hand causing her cheek to 'squish' (puff out)…Grandma commented that 'let's take her home, she's rubbish'"* and that the following day, in another group session, AW had grabbed EW "*tightly on the wrist and the group leader intervened to stop it*" (joint chronology 25/07/13).

4.27 The only recording of these incidents is in the children's centre records indicating that it was not recorded by the speech and language therapist, (in telephone discussion with this report's author it transpired that the sessions were run by an assistant). The CAF lead professional followed up the incidents the next day asking AW whether this "*was how she normally managed her* (EW) *behaviour and mum* (AW) *responded 'no*'" joint chronology (25/07/13).

4.28 These incidents should have raised enough concern for the speech and language assistant therapist to have, at least, made a recording. The following email exchange with the first lead professional does suggest that the speech and language therapist followed up these concerns with AW despite the lack of recording. "*I can remember it being discussed…at the first TAC meeting - 09/09/13 where* (speech and language therapist) *discussed what had happened at the group and discussed [mum] taking up Parenting classes as a way forward*," (email to author, 05/06/14).
The answer from AW does not seem to be entirely honest as there are other examples of her rough handling of EW in the narrative.

4.29 It is difficult now to categorically state that this incident should have led to a referral to children's social care. However one should have been considered and there should have been recordings to reflect the discussion and decision. Children's social care's representative at a panel meeting suggested that a referral of this matter may not have led to an investigation but would have likely have led to them questioning how the professionals involved with the family planned to take this issue forward.

Bruising

4.30 On 20th August 2013 the children's centre recorded that they had noticed "*bruising to the underneath of both (EW's) arms – purple but fading. To get explanation from [mum]*," (joint chronology 20/08/13). There are no further records relating to this incident.

4.31 I discussed this issue with professionals and was satisfied that this second matter had been investigated, though not properly recorded. The lead professional produced the following via email "*They were faded bruises which were on the lower part of the underside her arms closer to her wrists….The child was asleep with her arms up at either side her head and as i bent down to cover a child with a blanket I noticed a couple of small circular bruises on one arm and one on the other arm of EW. I spoke to my manager….regarding the bruises and she said to have a word with mum. I did this when the child was collected from the nursery and she said that it had happened as the child was running away from her…and fell and she grabbed her arms to lift her up. I explained to mum that she needed to be careful around how she handled her as children do bruise easily……I could tell that the bruises were not new and had possibly been overlooked as they were small and fading in colour. I did forget to write the discussion with mum in the child file"* (email to author 05/06/14).

4.32 I conclude therefore that the incident was followed up with AW and satisfied that the lead professional believed that the explanation from AW was consistent with the marks. Given that, and the incident fell under the heading "rough handling" with which nursery staff were already supporting AW, it seems clear that the matter was dealt with appropriately.

How has historical information informed assessment and planning?

Impact of maternal grandmother's alcohol misuse

4.33 This question, set before the review had started, assumes that grandmother "misused" alcohol. Given the circumstances surrounding Child K's death this was a reasonable assumption to make when the review was being planned. Analysis of the records though shows little evidence that the maternal grandmother did misuse alcohol; though she did drink.

4.34 There is hearsay evidence about grandmother's drink problem contained in the following nursery entry *"concerns with Family Link Worker that grandma will be collecting EW from nursery as AW is on jury service. They thought grandma may be an alcoholic"* (joint chronology 05/09/12). The concerns did not materialise when grandmother picked EW up.

4.35 In conversation with me the children's centre workers could not identify where this information came from beyond a conversation with AW. Their concerns appear to have abated as on 3rd October 2012, one month later, a family link worker "*discussed the family in supervision and identified that the nursery had no concerns about alcoholism and there was no current evidence of a problem*," (joint chronology 03/10/12). There were no concerns raised by professionals that they had ever seen grandmother drunk, or saw evidence to suggest that she had a drink problem.

4.36 There is no denying that the maternal grandmother did drink alcohol. "*On 3rd January 2013* (grandmother) *attended her GP surgery and, during a routine check, she said that she drank 30 units of alcohol per week which is twice the recommended level for women"* (joint chronology 03/01/13). She may drink more alcohol than is good for her but there was no evidence to suggest that her drinking posed a risk to children.

Impact of Domestic Violence

4.37 The only relevant incident of domestic violence noted was an allegation relating to AW's father when she was 7 years old. The evidence would suggest that it was not relevant to AW's care of her own children.

Agencies understanding of the history and how that has informed practice.

4.38 There is historical information that demonstrates that there have been problems between AW and her mother; AW left home at the age of 14 and was privately fostered. Her brother was, for a short time, on the child protection register fourteen years before Child K died. When AW was privately fostered her physical appearance and health improved and *"she appeared to be much more settled"*.

4.39 The terms of reference questions refer to alcohol abuse and domestic violence in the family but, as covered above, there is little evidence that these were serious problems. Although the professionals who worked with EW and Child K were aware of "alcohol problems" this was only because AW had given them some background information. There was no evidence, memory, nor records of there being any concerns about AW's mother having a serious drink problem. Similarly there was no evidence of domestic abuse being an issue for AW's children.

4.40 No professional, working with the family since EW's birth, was privy to all of the background information. Sharing information is not a simple issue in child welfare work in 21st century Britain. Professionals have to balance the need to exchange information with a family's right to privacy. In circumstances where a serious crime has or may be committed, or where there are concerns about the welfare of a child, information can be shared without consent from adults but, otherwise, consent is needed. In this case there was information on the social care file relating to AW's childhood but there was probably no occasion when this information should have been shared with health or children's centre professionals; I say "probably" because there was the referral to social care from the local college and, had this been considered to be a child protection referral, then it is likely that background information would have been shared at that time.

4.41 The background information that did exist was of a general nature and of poor quality; it lacked clarity and evidence. There is nothing to suggest that EW or Child K would have been considered to have been more at risk had this information been known nor would any different services have been offered to them.

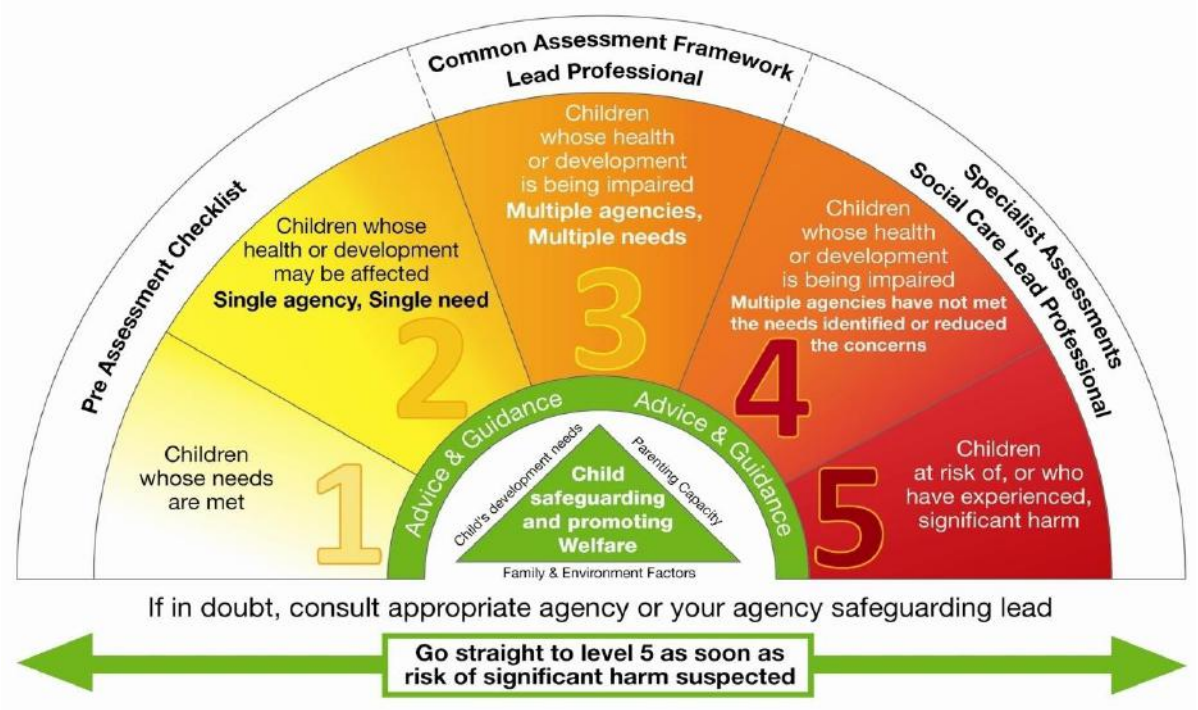
4.42 Whilst it is true to say that the background information suggests that AW's mother would not be a suitable long term carer for children and young people there is nothing there to suggest that she would be an inappropriate support for AW. It does not appear that AW's mother ever looked after the children for long without AW being present.

Assessments, planning, intervention and review

Professionals understanding of thresholds and how this informed their risk assessment, decision making and planning.

Thresholds

4.43 The following diagram is taken from Calderdale's continuum of need and response document. It outlines the five levels of need that all children in Calderdale can be classified under.



4.44 EW was considered by most professionals to be at level 2, though, because the early years specialist at the children's centre thought that a CAF was required, her needs were reclassified to 2/3 so that a CAF could be commenced.
Given that:

- There were a number of concerns raised
- EW had speech and developmental delay
- AW was seen to need enhanced health visiting
- There was
    - children's centre involvement
    - a speech and language therapist allocated

then a classification of "3" would be more appropriate and quite clear if the guidance was being followed consciously. The fact that most professionals thought EW's needs were level 2 may suggest that 'custom and practice' was at the forefront of determining levels of need rather than a conscious application of the Continuum of Need reproduced above.

4.45 There had been discussion about thresholds. In reply to questions from me the first lead professional wrote in email: "*At my CAF training I was made aware that the CAF is a document to support Early Intervention and should be used for families who are between a level 2 and a level 3 as a preventative measure….I felt that this family have always been above a level 2 and as the year progressed I felt that the only way we were going to have any success was to put a CAF in place. Not everybody felt the same way as I did. When I mentioned to* (the link worker) *that I would like to open a CAF on this Family* (she) *said that she is unable to Lead on the CAF as Link Workers are not allowed and that* (her manager) *wanted to close the case as there was not much more they could do. Also the Health Visitor was not of the opinion that a CAF was necessary, she felt that AW was doing the best that she could do"* (email to author 05/06/14).

4.46 The comment that AW was doing the best she could do may be accurate but it implies a focus upon the adult and not the child; a theme that this report will address later on in this section.

Risk assessment

4.47 There is no clear evidence of a risk assessment being carried out despite the fact that, otherwise, assessments were made in some detail. This is not to say that risk was not considered by the professionals, just that there is no concrete evidence of a risk assessment. The word "risk" does not feature in the joint chronology nor have I been made aware that there is a child focused risk assessment in place in Calderdale. Child focused risk assessments should be completed when a child is deemed to be at risk from significant harm and this report will suggest that this should be applied when working with children at a lower level of need.

4.48 Practitioners spoke positively about the neglect tool kit (see paragraph 4.63 in this report) and the toolkit contains a risk assessment. It appears therefore that professionals failed to incorporate the risk assessment element of the tool kit into their planning.

4.49 The neglect tool kit also contains an element at the back of the document for use with parents who may have learning disabilities,, *Preliminary Assessment of parent with a potential learning difficulty.* This suggests that a referral could be made to the Learning Disability team for support and advice. There is no evidence that this referral was made. Furthermore there is a "*Calderdale Integrated working to safeguard children, where parental learning disability or difficulty is a factor*" protocol in use. Staff working with AW were unaware of the existence of this document.

Decision making

4.50 AW was identified as a vulnerable mother who was doing the "*best that she could given her ability*," according to the health visitor. Staff were working hard to keep her engaged in the work that they were doing and AW regularly attended the centre and saw health care professionals. A good decision had been made, by the first lead professional, to adopt a multi-agency and planned approach to the family's needs via the CAF. This was the method by which decisions were being made and those decisions, though not focused enough upon children's needs, (see next section) were appropriate.

Planning

4.51 There were three multi-agency planning meetings; well attended by family members and a range of professionals. These discussed the salient points in the case. However the objectives set in these plans were focused upon process and not outcomes. Actual examples listed under "Needs Identified from CAF (what are the needs of the child)" (EW's CAF) were:

- The need for family link support
- Liaise with EW's school
- Support for AW to register onto a Parenting Course
- Combined visit with family support

4.52 None of these "needs" are "the needs of the child". These listed "needs" are, mainly, "tasks" and should be in the "Action" column of the form. AW attending parenting classes, for example, may indeed be a good idea but the attendance in itself is not an achievement; a child focused objective for attending parenting classes would be, "to improve the relationship between AW and EW". More specifically, and as examples, suitable child focused objectives (relating to parenting classes) in this case could have been

- "to reduce the negative remarks made to EW by AW and her mother"
- "to ensure that AW's handling of EW becomes more nurturing and gentler"
- "to increase the amount of praise that AW gives to EW"

4.53 This point is important. If professionals set child focused objectives then work is measured on the issues that really matter; whether or not children are developing as they should be. In this case child focused objectives may have indicated that, though AW was working with professionals, progress wasn't being made as far as improving life for EW was concerned.

4.54 Given that the meetings were attended by a range of professionals I would presume that the practice of writing process focused needs is systemic and not just located in the individual who completed the form.

4.55 I have discussed this issue with Calderdale's SCB training manager and I have seen sight of the training materials currently is use to address the writing of SMART objectives. The materials are relevant and child focused.

4.56 The training manager confirmed in email communication that staff struggled to understand outcomes. She also said that recent sessions have been poorly attended and the last one was cancelled. This will be addressed in the recommendations accompanying this report.

How well risks, assessments and plans were documented and communicated.

4.57 The case records from health agencies and the children's centre are thorough, descriptive and jargon free. Although there is a failure to write objectives in a child led way actions are well documented and communication in the 'team around the child' was good.

Mother's capacity to parent 2 children at different ages and stages of development.

4.58 There is some written evidence to support the view that professionals were thinking about the extra pressures that would be placed upon AW when her new baby was born but there is little that is specific. The CAF is based, ostensibly, around EW's needs (not Child K's) – although, as previously documented, the CAF is written with AW more in mind rather than EW.

4.59 In conversation with professionals it was clear that they were allocating extra service provision for AW to help her to cope with two children and there is evidence that Child K's needs were being considered; his own room being discussed at the third TAC for example.

The role and involvement of other family members and the implication on the lives of Child K and EW

4.60 Professionals spent most of their time working with AW; though they occasionally saw her mother and, on one occasion, her grandmother. Neither of the children were ever considered to be at risk of significant harm, professionals did not have any evidence to suggest that any other members of the family posed a risk to the children and AW's parenting was "good enough". Professionals did discuss the fathers of the children with AW and understood that she had no contact with EW's father and got on well with Child K's father. EW's mother was seen as a support for AW; a support it was felt she needed. It was also noted that Child K's extended family were in regular contact and there was nothing to suggest (nor should there have been) that this was in any way unhelpful.

4.61 Given this it is reasonable to presume that the professionals did not consider that the role and involvement of other family members would have negative implications for the lives of EW and Child K.

Challenging families when working in partnership

4.62 Paternal family members spoke of needing to be careful regarding how AW was approached as they were aware she could stop letting them see Child K. Professionals voiced similar concerns though their fears were she would stop coming to the centre.

4.63 The professionals with whom I spoke were positive about a "neglect tool kit" (provided by Calderdale) that they had used with AW and welcomed such tools. They believed these demonstrated their assessments were based upon research and that parents therefore saw that the professional view was not just based upon the worker's own opinions based upon the worker's own value base.

Guidance in place

4.64 In my examination into practice for this review I have looked at the following forms and guidance:

- CAF form (now replaced)
- Continuum of Need Handbook
- Guide to Information Sharing
- West Yorkshire CSB "information sharing"
- Neglect toolkit
- Protocol for working with parents with learning disabilities

I consider all of these documents to be of varying quality; most are too long, one is contradictory, all are often jargonistic, hard to follow, difficult to complete as a professional and hard to understand as a family member. This will be addressed in the recommendations accompanying this report.

4.65 The *Guide to Sharing Information* and the *Inter-Agency Information Sharing Protocol* are too long, too general and take a long while to get to the point (if I was a practitioner seeking advice). The first document states, on page 3: "*In order to fulfil its duty of confidentiality Calderdale Council will only share information that is necessary to ensure that appropriate care can be provided and with the person's informed consent*" (my emphasis) which is incorrect as information can be shared without consent (informed or otherwise) if sharing information is "*in the public interest or where there is a significant risk of harm to another person,*" (same document page 4). Neither document appears to be specifically about child protection and neither document appears to be easy for professionals to understand.

4.66 The diagram in Calderdale's *continuum of need and response document* suggests that CAF is suitable only for Level 3 but later text in the same document contains the following under level 2 on page 14, "*Assessments of additional needs are best recorded on a CAF form which can be used to access additional services. The CAF practitioner's toolkit provides further guidance and also explains how the CAF process fits in with specialist assessments for example special educational needs"*. As demonstrated in the email sent by the first lead professional CAF training tends to adopt the approach that CAF can be used for level 2.

4.67 The CAF form (in place at the time), , was jargonistic, not written in plain English and unlikely to be well received by families. It is interesting to note that AW was said by workers to be "disengaged" from the CAF process. I believe that these forms could have contributed to that "disengagement".

5. CONCLUSION

5.1 This review has been commissioned because of the death of a baby boy, aged 6 months, called Child K; and yet he doesn't feature much in this report. This is because he was developing well, meeting his milestones, was healthy and was loved by his immediate and extended family. There was far more information available regarding the care of his older sister EW who, in contrast, was not developing and growing up as well as she could have been.

5.2 There was nothing in the records, chronology or narrative, nor any discussions that I have had with family members or professionals that suggest that the sudden and unexplained death of Child K could have been predicted or prevented.

5.3 I have found research, (Blair 2009) that has identified that there is a risk of sudden unexplained death of an infant when adults who have been drinking co-sleep on a sofa with a baby. This is not research that is generally known and it is not included in Government guidance. There is therefore no expectation that the practitioners involved with this family should have had that information. Even if they did have it there were no warnings that there may be occasions when this very circumstance would arise. Blair has said that local campaigns that centre around specific messages about risk factors, particularly on use of alcohol or drugs before co-sleeping in bed or on a sofa have had a measure of success.

5.4 There are two main areas of learning that arise from this report:

- practice should be focused upon children's needs and not those of parents, and
- some guidance in place in Calderdale needs to be reviewed to promote good practice.

Children's needs

5.5 There is a growing evidence base (Horwath 2013) indicating that short term, behavioural approaches are not likely to succeed with families with long standing, complex problems. Referral on to short term programmes can be a coping mechanism for practitioners and managers who don't know what else to do, but they run the risk of setting aside family history in the focus on the present and not taking into account a lack of progress. It is important to have clear mechanisms to report and discuss concerns and to build up a systematic picture of risks and protective factors.

5.6 Neglect requires a carefully coordinated, individually tailored approach, based on a full assessment of the family, which combines both tangible services and therapeutic elements, over a long period of time. Relationships between workers and adult family members are significant and can become a nurturing alliance, but practitioners should keep in mind that the harm that can come from neglect can easily be minimised or downgraded and cases of neglect are very vulnerable to drift or tolerance by professionals of dangerous conditions and poor care.

5.7 Practitioners built up good relationships with AW but the following questions may have helped them to be more child focused.

- What are the needs of the child now and in the future?
- What is the child's experience of care given? (What does it feel like to stand in their shoes)?
- Do the parents understand the child's needs?
- Are the parents able and willing to meet the child's needs now and in the future?
- Do the bad days outweigh the good days?

5.8 Practitioners need to work with families in ways which:

- break down the problem areas
- are specific, consistent and clear with parents, carers and colleagues about outcomes for children and adequate day to day care
- get parents to describe what success will look like and how to get there
- maintains contact with the family, and identifies who is responsible for what and when.

Guidance in place

5.9 Some of the guidance in use in Calderdale at this time is, as has already been described: lengthy, difficult to comprehend and, in places, contradictory. Guidance should be simple to use, based upon research, designed with families in mind and described by practitioners as tools that help them do their jobs better.

6 RECOMMENDATIONS

1. The LSCB, within its Learning and Improvement framework to:
   a. develop and implement a quality assurance system for all plans for children, from levels 2-3, to ensure that said plans contain child focused outcomes that are measured and reviewed,
   b. within that framework to carry out an audit across the 5 levels of need to identify whether "good enough" parenting is realistically and consistently understood and an appropriate standard is being applied, and that child focused outcomes are regularly set as objectives
2. The LSCB to develop a child focused risk assessment framework (drawn from current child protection practice) for use in all assessments for children in levels 2-5 in their continuum of need document
3. The LSCB to require member agencies to consider the issue of challenge to parents (in any ways appropriate to that agency) to determine whether their staff are struggling to maintain the balance between keeping families engaged whilst also challenging behaviour they believe to be inappropriate
4. The LSCB to review guidance regarding information sharing and thresholds to ensure that said guidance is correct, unambiguous, short and helpful for practitioners
5. The Board should satisfy itself that the exit points from MAST are consistent with the Continuum of Need and to satisfy the LSCB that dialogue at the 'front door' is based on resolving needs and concerns, and is child focussed; (refer to paragraph 4.21 in this report)
6. The LSCB to ensure that member agencies' relevant staff (to be decided) receive the existing local SMART training
7. Member agencies to ensure that all practitioners are aware of the learning disability protocol
8. The LSCB to continue to ask Health partners to raise awareness in the community of adults under the influence of drugs or alcohol co-sleeping with infants on a sofa.

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APPENDIX ONE

TERMS OF REFERENCE

SERIOUS CASE REVIEW

SUBJECT: Child K

PURPOSE OF THE TERMS OF REFERENCE

These terms of reference outline the system of accountability for the review's work. It has been drafted taking into account the following functions:

1. To stand as part of the commissioning contract enabling Calderdale Safeguarding Children Board to determine whether the Lead Reviewer they have appointed has satisfactorily completed the tasks required. This document outlines what responsibilities the Lead Reviewer has and what tasks they are expected to undertake.
2. To act as a public document so that all stakeholders can hold the review to account for any specific failures to adhere to the terms of reference
3. To provide a way for all stakeholders, including the public, to determine whether the terms of reference were adequate for the task.

PURPOSE OF THE REVIEW

The purpose of the review is to improve services and prevent similar deaths or serious injury.

Serious Case Reviews should be conducted in a way in which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisation involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

(Working Together, Chapter 4 para 10, March 2013)

SCOPE OF THE REVIEW

Initial terms of reference will be submitted to the Independent Chair of the CSCB based on information known at the time. It should be noted that the terms of reference are a living document and not set in stone. They may need to be amended, in the light of new information, at any point during the course of a concise review. The Serious Case Review Panel will have responsibility for agreeing any variation to the terms of reference.

The time period is from **15th September 2009**; when mother began using multi-agency children's services with her first pregnancy. The review period ends on the day Child K died: **12th December 2013**. There will be, however, historical information included in the report, in particular from the childhood of the mother of Child K and how this impacted on current assessments and decision making.

The following family members are to be included in the review, including contextual historical information where pertinent:

Child:	Child K
Sibling:	EW
Mother:	AW
Father of Child K (not EW)	
Maternal Grandmother	
Maternal Uncle	
Maternal Great Grandmother	
Maternal Aunt	

ISSUES TO BE EXAMINED

Generic Terms of Reference

- The multi-agency review should consider the period from 15th September 2009 to 12th December 2013.
- Determine whether the policies, procedures and practice expectations of the agencies were followed during this period
- Was there appropriate communication and collaboration within multi-agency assessments and interventions.
- Within the review dates, key practice episodes (KPEs) and the personal impact on Child K should be considered for deeper analysis under the following broad headings:

Specific Terms of Reference

1. **How has historical information informed assessment and planning:**

- Impact of maternal grandmother's alcohol misuse.
- Impact of Domestic Violence.
- Agencies understanding of the history and how that has informed practice.

2. **How have assessments, planning, intervention and review considered:**

- Professionals understanding of thresholds and how this informed their risk assessment, decision making and planning.
- How well risks, assessments and plans were documented and communicated.
- Mothers' capacity to parent 2 children at different ages and stages of development.
- The role and involvement of other family members and the implication on the lives of the Child K and EW.

METHODOLOGY

Barry Raynes from Reconstruct is independently appointed as serious case 'lead' reviewer. The review is managed by the Serious Case Review Panel, Chaired by the Head of Quality for the Calderdale Clinical Commissioning Group. The administration process is managed by the Business and Quality Assurance Manager of the CSCB and the review is quality assured by the Independent Chair of the CSCB.

Agencies providing reports:

1. Children's Social Care
2. CHFT
3. Family Support (Including CAF information)
4. GP – NHS England
5. Safeguarding & QA Service
6. SWYPFT
7. West Yorkshire Police
8. Youth Offending Team
9. Primary School
10. Adult Health and Social Care
11. Calderdale College

Agencies providing chronologies:

1. Children's Social Care
2. CHFT
3. Family Support (Including CAF information)
4. GP – NHS England
5. West Yorkshire Police
6. Primary School
7. Adult Health and Social Care
8. Calderdale College

Organisations and practitioners contributing to reflective events:

1. Children's Social Care (involvement after the death of Child K)
2. CHFT
3. Family Support (Including CAF information)
4. Local Children's Centre
5. GP – NHS England
6. SWYPFT - Psychiatrist
7. West Yorkshire Police
8. Primary School – by phone
9. Calderdale College

A STATEMENT OF GOOD PRACTICE

The approach taken with the review should be proportionate: led by individuals who are independent of the case; professionals fully involved and able to contribute their perspectives without fear of blame; family invited to contribute; publication and inclusion of the final report in the CSCB Annual Report; and improvement sustained through regular monitoring and follow up.

Criminal Proceedings

The mother and maternal grandmother of Child K were arrested on suspicion of neglect and are on Police Bail. This factor may influence and delay the review dependent on outcomes. It will also impact on the amount of involvement the family has with this review.

ETHOS OF THE REVIEW

Family members, wherever possible, are to be included in the review are mother, maternal grandmother, maternal uncle, Father, Paternal Grandmother, Maternal Great Grandmother, and Maternal Aunt. Due to the ongoing police investigation involvement by all members may not be possible, but all efforts should be made to develop supportive and empathetic relationships – which may require appropriate adults, and to explain the inquiry process and hear their experiences.

The family will be advised of arrangements for publication of the report with openness, honesty, integrity, compassion, respect and sensitivity by the lead reviewer or the Business Manager of the CSCB.

It is necessary to ensure that the processes of obtaining information, involving families, hearing from staff and professionals and writing the report have due regard to the matters in s149(1)(a)-(c) of the Equality Act 2010.

Hindsight bias and outcome bias will be recognised and reduced by using analysis which examines how things were and perceived to be at the time, why decisions were made and actions taken at the time.

TIMETABLE

Date	Event	Actions
8th January 2014	SCR Panel Meeting	Decision to undertake Serious Case Review
12th January 2014	Notification	to Ofsted and National Panel of Experts
March 2014	SCR Panel Meeting	Agree ToR and Timeline Agree Agency involvement
March 2014	Contract between Reconstruct and CSCB drawn up inc. TOR	Reconstruct to send contract to JC JC to check contract with LA legal department
March – Early April	SCR Panel meeting with Reconstruct	Contract Agree expected method and style of report
March – Early April	Quality Assurance by Independent Chair	Check process, timescales, intended outcomes and methods
14th – 16th April	Reflective events	1. Individual Practitioners 2. Combined Practitioners and Managers 3. Family
23rd April 2014	SCR Panel Meeting	To review progress to date

9.30am Heath		Coronors Letter
25th April 2014	SCR Sub-group	Update
April - Early May	Quality Assurance by Independent Chair	Review progress to date Update RE: next steps
Early May 2014	Recall event	1. Practitioners and managers 2. Family
22nd May 2014 10am Heath	SCR Panel Meeting	Finalise conclusions, agree recommendations, agree agency actions and learning events.
30th May 2014 10.30am	SCR Sub Group Meeting	Final report agreed Publication and media strategy Response from Board prepared
30th May 2014 2pm Heath	SCR Panel Meeting	Preparation for publication / media / updating family /
Early June	Quality assurance by Independent Chair	
23rd June 2015	SCR Panel	Update and changes made from Board Response
27th June 2014	SCR sub group	Update and consider publication after Criminal Procedings conclusion
12th July 2014	6 months from notification to National Panel of Experts	
5th August 2014	SCR Panel	Publication and Communication agreed after Board decision
2nd September 2014	SCR Panel	Final report agreed
16th September 2014	CSCB Board meeting	Final report agreed Response from Board agreed Media strategy agreed
9th October 2014	SCR Panel	involving Chief Officers of each organisation / Press departments in each org / DfE / National Panel / Ofsted
4th November 2014	SCR Panel	
23rd January 2015	Business Manager and Case Review sub group Chair meeting	Finalise Board Response, Communication Plan, Action Plan
11th February 2015	Feedback Event with Front Line Practitioners involved	Share the report, answer queries, share Briefing from Learning from Child K SCR
15th April 2015	Meet with Paternal Grandparents	Discuss final report and publication
22nd June 2015	Notification from CPS that no charges were made	
8th September 15	Meet with Maternal Aunt	Share final report
10th September 15	Meet with Child K's mother	Share final report

ARRANGEMENTS FOR FEEDBACK AND REPORTING

At each stage it is necessary for the Lead Reviewer to feedback to the SCR Panel.

A report will be written, with recommendations made if appropriate. The report will be published and disseminated after ratification by CSCB.