Calderdale Safeguarding Children Board Response to the Serious Care Review of Child D, July 2015

1.0 Background

1.1 This Serious Case Review was undertaken in August 2010, concluding in February 2011, following the death of Child D in March 2009, but due to on-going Court proceedings the publication of this review had been subject to embargo.

1.2 When a child dies, and abuse or neglect is known or suspected to be a factor in the death, the Local Safeguarding Children's Board is required to conduct a Serious Case Review (SCR) into the involvement that organisations and professionals had with that child and their family. It is an expectation that the decision to proceed to a Serious Case Review should be taken with the minimum delay possible.

1.3

a. The requirement for Calderdale Safeguarding Children Board (CSCB) to carry out a Serious Case Review at the time of Child D's death was detailed in Chapter 8 of Working Together to Safeguard Children: a Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children (HM Government 2010) and in the Local Safeguarding Children Boards Regulations 2006.

The purpose of any Serious Case Review is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result and
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children' Working Together to Safeguard Children (2010), Chapter 8

1.4 In order to ensure the Serious Case Review identifies any lessons that should be learned and results in effective changes to protect children from harm, Working Together emphasises the importance of putting 'the child's daily life experiences and an understanding of his or her welfare, wishes and feelings' at the centre of the Review (HM Government 2010: 8.1).

1.5 Following the death of Child D the sub-group responsible for recommending whether a SCR should be initiated decided that because the cause of the injuries leading to her death had not yet been finally established, the decision to proceed or not should be adjourned. This contributed to but was not solely

responsible for the long time it took to make a decision. The decision was made August 2010, 18 months after Child D's death. A breakdown in Board oversight and administrative process contributed to this delay. As a consequence a new SCR Framework has now been developed that sets out the arrangements, quality standards and measures, which include regular reporting to the Chair and the Board any variation in timescales.

2.0 Methodology

2.1 The intention of all Serious Case Reviews is to enable individual professionals and agencies to learn lessons about the way in which they had worked both individually and collectively to safeguard and promote the welfare of the child concerned. This Review was to be conducted to incorporate the then newly published guidance and included a learning exercise for everyone who had been involved in the case. (Careful oversight and final review of the process ensured that this development enhanced the thoroughness of and the learning from the review). The terms of reference were developed in line with paragraph 8.20 of Working Together (HM Government 2010) and West Yorkshire Safeguarding Children Procedures, Chapter 10 (6.6).

2.2 Individual Management Reviews (IMRs) are reports from individual agencies/services that have had a significant degree of involvement with the child and family. They aim 'to look openly and critically at organisational and individual practice' (HM Government 2010: 8.35), to determine whether improvements could be made and to identify how such changes should be effectively implemented to protect children from harm. IMRs including detailed chronologies were requested and received and the agencies that supplied these are listed in the report.

2.3 The SCR Panel, on behalf of the CSCB, commissioned an overview report to bring together and analyses the findings of the IMRs from organisations and others, and to make recommendations for the relevant agencies and the Safeguarding Board. An external overview report writer was commissioned who was independent of all partners and the Board.

2.4 The independent overview author was Sian Griffiths. Ms Griffiths works as an Independent Social Worker and had no prior involvement with any of the agencies providing services to this family or with CSCB (other than in the capacity of an independent author). She was appointed on the basis of her knowledge, experience and expertise.

2.5 The Serious Case Review Sub Group arranged a panel of independent senior professionals from agencies in Calderdale to undertake the Serious Case Review. (Panel members had no direct involvement or operational responsibility for services to the child and family for the time identified for

review). The CSCB also appointed an Independent Chair for the overview panel. This was Colleen Murphy. Ms Murphy worked as an Independent Social Worker and was an experienced Independent Chair.

3.0 Reasons for the Serious Case Review

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

3.2 The cause of Child D's death was subsequently established as hypoxic ischemic encephalopathy associated with a right sided subdural haemorrhage, which in lay terms is an injury to the brain and also clinically detected unilateral retinal haemorrhage, which is damage to the eye structures. A number of small bruises were also identified. At a finding of fact hearing within later Care Proceedings in August 2010 regarding one of Child D's siblings, the Judge concluded that on the balance of probabilities Child D's injuries were likely to have been the result of non-accidental trauma.

4.0 Key Learning

4.1 This Review reached a conclusion that Child D's death could not have reasonably been predicted by agencies and professionals who were involved with or who had contact with the child and family. It did however identify a number of weaknesses in practice across agencies who were in contact with and involved with the child and family, 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.

4.2 The Review identified that there was a lack of recognition and/or poor understanding of Learning Disability as this may have been of relevance in considering the needs of the family by key agencies. No evidence was available that agencies had in place procedures which might help professionals identify the possibility of parental Learning Disability. This was judged to be a significant omission. Subsequently the Board has implemented guidance and referral protocol including flowcharts for adults at risk and vulnerable children. This is for families where there are parental issues with substance misuse, mental ill health and learning difficulties. The

guidance and flowcharts help practitioners to clarify thresholds and pathways for support between Adult's and Children's Services in order to better support parents / carers and their children.

4.3 The review correctly considered whether Domestic Violence was a relevant factor but found that it was not a significant contributory factor nevertheless past incidents and professional responses were noted. The review identifies learning for agencies to ensure that past incidents even when these are judged to be at the low end of a risk scale are effectively considered at any point where a child or family member comes to the attention of agencies.

4.4 The review identified concerns regarding a shared multi-agency understanding of thresholds, so as to better ensure both a coordinated approach to assessment of need and risk and effective information sharing. These concerns were not felt to be critical in recognising or being able to prevent the death, but importantly reminded everyone of the need for high standards and effective systems. Subsequently the Safeguarding Board and partner agencies have revised threshold arrangements and these are now subject to close scrutiny at organisational and Board level. The Safeguarding Children Board has implemented the Continuum of Need approach, which is a well-established model used widely across the country for ensuring a clear, shared approach to identifying levels of need and risk.

4.5 The review acknowledges that agencies identified some areas where their management oversight and supervision practice required improvement, and evidence that this was acted upon was considered as a part of the review. The Safeguarding Board has continued to support development of high standards of management oversight and supervision of practice. The review concludes that these need to be focused on and therefore identifies specific recommendations for some agencies. These agencies have accepted and acted upon these recommendations

4.6 In identifying the priorities for learning, the Review correctly took into account the recent historical context as this may have impacted upon joint working in this case. Calderdale Children's Social Care and the Safeguarding Board were found by external inspection (Ofsted) to be in need to improvement in a number of key areas. The review therefore considered these facts in forming its recommendations and noted recommendations it would have made but were already identified as a result of the response to the inspection process. The review and its recommendations therefore need to be considered wit this in mind.

5.0 SCR Recommendations

5.1 The Review considered recommendations made in previous Serious Case Reviews both in Calderdale and nationally and made the following multi-agency recommendations:

5.1.1 That Calderdale Safeguarding Children Board prioritised 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.

5.1.2 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. (Common Assessment Framework)

5.1.3 That Calderdale Safeguarding Children Board initiated a short life task centred group to:

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

b) produce a protocol for multi-agency working with parents with learning disability in the context of the Think Family strategy.

5.1.4 That Calderdale Safeguarding Children Board reviewed and updated its procedures in relation to Serious Case Reviews.

5.1.5 That developmental work was undertaken within the remit of the Domestic Violence strategy to consider the practice implications for and particular needs of male victims of domestic violence.

5.2 Individual Agency Recommendations:

There were individual recommendations for each of the following agencies, who accepted the learning points and provided actions and timescales for these recommendations to be acted upon. These were and continue to be monitored and managed by the Case Review sub group.

- Calderdale Council Children's Social Care
- Calderdale Council Young People's Service (Youth Works)
- Calderdale Council Family Services (Children's Centres)
- Calderdale and Kirklees Careers
- Calderdale and Huddersfield NHS Foundation Trust
- Education
- West Yorkshire Police
- Yorkshire Ambulance Service
- NHS Direct
- NHS Calderdale Primary Care Trust Provider Services
- NHS Calderdale primary care Trust Commissioning Services

6.0 How the Board has overseen and ensured that the recommendations were acted upon?

6.1 Although this case was concluded in February 2011, the members of the Case Review Sub Group were asked by the Chair of the Board to prepare the review for publication following the conclusion of the Court Case in June 2014. This review and the completed action plan from the SCR were presented to an Extraordinary Board meeting held on the 16th September 2014. This Board Response has been completed following the signing off of the report and action plan at this meeting in preparation for publication. This was to ensure that the review and report met the standards required currently and that there was evidence that recommendations and learning had been acted upon.

6.2 This also provided the opportunity for the Board and partners to further review the report and action plan.

6.3 The Board therefore re confirmed that the review and report were thorough, rigorous and appropriate for publication. It also confirmed on the basis of evidence that learning had been acted upon and was clear about what further learning and actions needed to occur, and ensured that these fitted with current strategic and agency priorities. The Board also considered and identified (below) the requirement for it to ensure effective oversight of the continuing implementation of the recommendations and learning.

6.3.1 The Case Review sub group maintains a register of all recommendations and requires both the Board and partner organisations to report on progress on a quarterly basis. This is then assessed and reported to the full Board.

6.3.2 The Board's multi agency case audit programme directly reflects and tests out the learning and reports this to the Board.

6.3.3 The Board's multi agency performance management framework reflects in its core indicators key areas of learning so that compliance can be evidenced and this is reported at every Board Meeting.

6.3.4 The Multi Agency Training Programme has been amended to reflect key learning and this has been reported to the Board and in the annual evaluation.

6.3.5 The Board has reviewed and amended its policies and procedures for joint working and has updated or put in place appropriate amendments and new policies etc.

6.3.6 The Board in its annual report will report on the progress made and the wider impact across partners of the learning, in order to consider whether progress and impact has been good enough.

7.0 Conclusion

7.1 The Serious Case Review 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.

7.2 It was therefore important that the review considered whether at the time these incidents could reasonably be seen to indicate the possibility of potential serious harm. A feature of the learning review element of the review, which reflected changes in review practice, was that it provided the reviewer with the opportunity to engage with the front line professionals involved to assess this in depth. Mindful that research indicates that it is extremely difficult to predict future harm to an individual child; the review was able to identify potential improvements to both joint and single agency working arrangements that would reflect the learning from this episode. On this basis the reviewer and the report were clear that there were no congruent and convergent indicators that the level of harm the child faced was significant at the time.

7.3 The Reviewer and the report does identify that there were some indicators that Child D's parents were not adequately meeting their children's needs and that greater recognition and understanding of these may have created opportunities for different forms of intervention. Although a matter of partial conjecture even had different forms of intervention taken place the review concluded that it is unlikely that this would have identified that the child was at serious risk of non-accidental injury. The review reached a conclusion that Child D's death could not have reasonably been predicted by agencies and those professionals involved

7.4 The review does identify areas where such risks could be potentially reduced in the future, 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 from a whole family approach is therefore a Multi Agency Recommendation (Recommendation 1).

7.5 The Board therefore in setting out its response to the death of D, the learning and recommendations identified by the Serious Case Review is demonstrating its accountability for implementing this learning.

8.0 Comments from the Independent Chair

8.1 As the current Independent Chair for the Calderdale Safeguarding Children Board I have responsibility for ensuring that as a Board we fully comply with the requirements to ensure that when a Serious Case Review in undertaken, that it meets with the required standards. I am also required to ensure and that as a matter of public record that the agencies, professionals and members of the Safeguarding Board have accepted and acted upon what has been learned and recommended.

8.2 I am also mindful that the death of any child is a lasting tragedy, especially for those close to the child. I also need to be sure that the publication of the report in no way compromises the safety and well being of any other child of the family. Such reports cannot avoid bringing to the surface many distressing feelings and emotions, and in this instance I am sure that those involved have sought to both involve the family and take into account their feelings.

8.3 The report was sadly subject to some delay in completion and this was in hindsight partly avoidable, and there are now in place measures to ensure that any delay is managed and kept to a minimum. Given this it was important to ensure that the review and the report were relevant and that they would meet the expectations and requirements in place today. The relevant officers and sub group of the Safeguarding Board have worked hard to ensure that the report and the evidence of what partner agencies have done to implement the recommendations has been collated and assessed.

8.4 As a result of this and although it did not need to, the full Board formally considered the report and the updated assessment of progress. In order to agree the publication of the report and to affirm their commitment to the continued learning and improvements that have resulted from the review. It is notable that all agencies were able to evidence action and progress, and importantly recognise and provide further evidence of the intention to do more.

8.5 This does not of course lessen the sadness, but does serve to provide further impetus to the collective endeavours to improve the effectiveness of how we work together, to better understand the many complex factors and situations that make up our lives and to provide vulnerable children and their families with the best support possible.

Richard Burrows
Independent Chair, January 2014 to present
Calderdale Safeguarding Children Board
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