Executive Summary of the Serious Case Review in Respect of Child D

Calderdale Safeguarding Children Board Chair:

Jane Booth
(2010 – 2013)

1. Introduction

1.1 This report summarises the findings of a Serious Case Review that was completed in 2011 following the death of Child D. [1]

1.2 Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake Serious Case Reviews in accordance with procedures set out in Chapter 8 of Working Together to Safeguard Children (2010).

1.3 When a child dies, and abuse or neglect is known or suspected to be a factor in the death, the LSCB 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. 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. Unfortunately the decision to undertake the Review was not then made until August 2010, 18 months after Child D's death.

1.4 The purpose of a 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), Ch 8

1.5 The Serious Case Review in relation to Child D established the known facts and analysed the actions and practice of the agencies which provided services to Child D and her[2] family. As a result of this analysis, lessons to be learnt were identified and recommendations for improvements in practice made. The Serious Case Review further sought to establish whether there were indicators that could have predicted the events that led to Child D's death or prevented her death.

1.6 Child D had one sibling (Sibling 1) and one half-sibling (Half Sibling 2). As all three children had contact with some of the agencies concerned, reference is made to them within this report. However, to protect the interests and anonymity of Child D's remaining siblings and other family members, the

[1] The letter D has been used to identify the child on an alphabetical basis.
[2] In order to protect the identity of Child D's siblings, all of the children will be referred to in this report by the feminine pronoun.

information about them will be limited to that which is directly relevant to Child D.

2. Terms of Reference

2.1 The Serious Case Review (SCR) was given comprehensive Terms of Reference which formed the basis of its work.

2.2 The Terms of Reference identified that the time period for consideration by the SCR should begin with the ante-natal period for Sibling 1 and end shortly after the date of Child D's death i.e:

September 2006 to end of March 2009

2.3 The Terms of Reference further required that the Review consider relevant historical information as far as it was pertinent to the Key Lines of Enquiry.

2.4 The agencies required to contribute to the Review were identified as follows:

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

2.5 The **Key Lines of Enquiry** identified within the Terms of Reference were as follows:

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

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

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

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

- *Domestic Violence*

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

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

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

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

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

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

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

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

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

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

3. Membership and Methodology of the Review Panel

3.1 The Serious Case Review Panel met on 6 occasions between September 2010 and February 2011 and consisted of:

- Colleen Murphy: Independent Chair to the Serious Review Panel
- Interim Head of Calderdale Children's Social Care
- Designate Head of Calderdale Children's Social Care
- Principal Officer Calderdale Children and Young People's Service
- Nurse Consultant – Safeguarding Children (Designated Nurse Child Protection), NHS Calderdale

- Consultant Paediatrician Designated Doctor Child Protection, Calderdale and Huddersfield NHS Trust
- Detective Chief Inspector, West Yorkshire Police

3.2 Also in attendance at the Serious Case Review Panel Meetings were:

- Calderdale SCB Business Manager
- Calderdale SCB Administrator
- Sian Griffiths: Independent Author of Overview Report

3.3 The Panel considered Individual Management Reviews, (IMRs) which are reports provided by each agency detailing and critically analysing the service provided to the family. These reports included a full chronology of involvement with the family from each of the contributing agencies as identified in Para 2.4.

3.4 The Panel gave careful consideration to the involvement of the family, specifically the parents, within the Review, given the potential importance of their contribution to the learning. However, following the death of Child D, a criminal investigation was initiated during which both parents were interviewed and subsequently released on police bail. The investigation was ongoing at the time the Review took place and in these circumstances the Police advised that meeting with the parents could compromise their investigation. The Panel therefore agreed that following the conclusion of the criminal investigations and any subsequent criminal proceedings, the Panel would reconsider the possibility of seeking a meeting with the parents and reconvene the panel should such a meeting take place and significant new information was identified as a result.

3.5 Following Child D's death, immediate action was taken by Calderdale Children's Social Care to ensure that her siblings were properly safeguarded. Legal proceedings were subsequently taken with regard to Sibling 1 and these proceedings are ongoing.

3.6 The Coroner was informed that a Serious Case Review would be taking place. An inquest was opened immediately following Child D's death and adjourned to a date to be fixed.

4. Brief Summary of Events

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

4.2 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 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.

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

4.4 Child D and her family were white British, religion was not identified as of significance to them and none of the family had physical disabilities. Whilst it was not known to all the agencies involved with them at the time, both Child D's parents had Learning Disabilities within the low to borderline range. The parents were for much of the family's life reliant on benefits and were known to need other support from agencies involved with them.

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

4.6 Child D's parents had sought and received help themselves from Calderdale Young People's Service (Youth Works) prior to the birth of Sibling 1 and continued to access this support intermittently throughout the period covered by this Review. Youth Works, which is a voluntary, client led service, provided them with a significant level of help in relation to housing and other

practical problems as well as offering personal support. The mother was briefly involved with the Careers Service which arranged a training placement for her during her pregnancy with Sibling 1.

4.7 Both parents are now known to have Learning Disabilities, and although Youth Works identified this, it was not recognised by other services that the family were in contact with at the time. Child D's mother in particular was identified as vulnerable given difficulties within her own family background as a result of which she had herself been known to Children's Social Care when she was a child. West Yorkshire Police responded to two assaults on the father of Child D during this period, by both Child D's mother and the mother of Half Sibling 2. These assaults have been identified throughout as domestic violence, though it is fair to note that there was no evidence that there was a pattern of serious or chronic violence.

4.8 The family had routine contact with Health Services, including antenatal and postnatal care for the mother and children. Both Sibling 1 and Half Sibling 2 were taken on a number of occasions to Accident and Emergency at the local hospital, predominantly in relation to breathing problems and fitting. Services were also accessed by the parents from NHS Direct in this regard. No patterns of concern were ultimately identified in relation to Half Sibling 2. As a consequence of one attendance at A&E when she was a little over 1 year old, Sibling 1 was identified as having a problem with low blood sodium levels contributing to fitting. She was brought to hospital with similar problems on later occasions and it was identified that the cause of the problem was that the parents were giving her excessive amounts to drink. The Health Visitor Service monitored and advised the parents with this problem and other difficulties they appeared to have in providing good quality physical care to the children. The Health Visitor also referred them to the Calderdale Family Service who had a limited amount of contact with them as a result. Nevertheless, the problems continued over time.

4.9 On two occasions, Youth Works made referrals to Children's Social Care arising out of concerns about Sibling 1's care. On the first occasion, there had been an allegation that Sibling 1 had been dropped on her head by her father and that no medical attention had been sought. Whilst Sibling 1 had been dropped, the father explained that he had caught her and a medical examination showed no evidence of injury, therefore the family's explanation of events was supported. Children's Social Care initiated a S47 enquiry[3] , but in light of the medical evidence it was concluded that there was no grounds for action within the Child Protection procedures.

4.10 Youth Works made a second referral in November 2007 when the parents separated, initially leaving the mother as the primary carer for Sibling 1. Their concerns included: the mother's parenting abilities; failure to meet Sibling 1's health needs; lack of engagement with health services; financial difficulties;

[3] Section 47 Children Act (1989) requires Children's Social Care to undertake enquiries when it is suspected that a child may be at risk of serious harm, in order to assess whether they should take any action.

allegations of an assault taking place in the home and allegations of cannabis use. A S47 Assessment should have been undertaken at this point, but there is no evidence that one was in fact done. Instead, the father, who by this point had taken over care of Sibling 1 was told to seek legal advice regarding residence of the child. The father and a Health Visitor both independently understood that he had been advised not to allow the mother to have unsupervised contact with Sibling 1 without her being assessed by Children's Social Care. This advice is not recorded within Children's Social Care records, the case was closed a couple of weeks later with no action taken. Shortly after this, the parents reconciled and continued to live together, with one further known separation, until the death of Child D.

4.11 A referral was made at this time to Family Services by the Health Visitor requesting support for the father as a single parent. Family Services met with the father and offered support, specifically a Father's Group, but he did not take this up. The parents reconciled shortly afterwards and further attempts were made by Family Services to engage with both parents, but without success and the case was closed.

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

4.13 Following Child D's birth, she received routine care from the Health Service. No concerns were identified in relation to her care or wellbeing during her life.

5. Key Themes arising from the Case

5.1. Child D was only 4 months old at the time of her death and had limited contact with agencies. Children's Social Care had no cause to have contact with her and there was no information prior to her death that suggested she had either been subject to physical harm or was at risk of physical harm from her parents. Given her age, the limited contact she had with agencies, and the lack of opportunity to meet with her parents, there was no information available to the Review about Child D as a unique individual, including her experience of the care she received.

5.2. **Learning Disability:** The parents' Learning Disability was a significant feature within this case and may have had an impact on parental capacity in the

absence of additional support. However, it was the case that this was not recognised by all agencies at the time. Historical information was available within both Children's Social Care and Careers Service regarding parental Learning Disability. One agency, Youth Works, clearly recognised the existence of Learning Disability from their direct work with the parents. It is the case that the parents' abilities may have been masked to some extent by what is frequently referred to as "*false apparent competence*" whereby adults present as more able than they in fact are. However, this is not an unusual feature of Learning Disability.

5.3. Parental Learning Disability in itself is not causally related to risk to children's wellbeing. Nevertheless the children of parents with Learning Disabilities are known to be disproportionately likely to become subject to Care Proceedings. Parents with Learning Disabilities are more likely to be experiencing other adverse factors such as low socio-economic status, unemployment and social isolation and in order to parent successfully are understood to have a particular need for good family and community support networks and positive personal psychological factors.

5.4. It is a particular cause for concern therefore that key agencies, notably Children's Social Care and Health Services, did not identify the parents' Learning Disabilities. As a result no assessment was undertaken either of their cognitive abilities or whether they had adequate capacity and support to meet both their own needs and those of their children. As a result of presentation at A&E, problems were identified by Health Services in relation to the appropriate care of Sibling 1, specifically a low sodium level and consequent fitting due to excessive liquid intake. Despite repeated advice to the parents regarding feeding and intake of liquid, the problems persisted. Had Health professionals been alert to the parents' Learning Disability, they may have been better placed to understand the parents' failure to respond to the advice given and considered more appropriate means of communicating with them.

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

5.6. The first referral to Children's Social Care reached a defensible conclusion on the evidence that the allegation of harm to the child had not in fact taken place and that there should be no further action. It is acknowledged by Children's Social Care that the assessment process was not managed to required standards; however, there is no reason to suggest that had it been, the outcome would have been a fundamentally different one.

5.7. The second referral however did represent a missed opportunity to undertake a comprehensive assessment of the family's functioning and as such consider

what services could have been involved to meet any identified need. Despite a range of concerns about Sibling 1's care being raised in a referral from another agency no formal assessment took place. The focus on receiving the referral appeared to be solely on giving advice with regard to the care of Sibling 2 in the context of the parents having separated. The Review had evidence that Children's Social Care concluded that Sibling 1 should live with the father and have no supervised contact with the mother. However, no adequate enquiries had taken place to justify this position, and no consideration was given to the implications for the child in the event of the parents reconciling or reaching alternative agreements about care.

5.8. The attendance of the parents at Children's Social Care seeking financial help under Section 17[4] revealed some shortcomings in response, though again not to a degree that could reasonably be expected to have affected the ultimate outcome. Each of these presentations was responded to as an individual episode and there was no apparent mechanism to trigger consideration of whether this represented a pattern of ongoing difficulties within the family.

5.9. The Health Visiting Service had a key role in assessing the needs of the children. It was decided to undertake an increased level of health visiting due to the family's particular needs and a referral made to Family Services to undertake supportive work. However, there was an absence of a holistic approach to the family. Issues of concern were responded to individually but not framed within a context of overall family functioning or consideration given to the full developmental needs of the children in the context of safeguarding. That the Health Visiting Service did not initiate a CAF[5] particularly in relation to Sibling 1 undoubtedly represents a missed opportunity to properly assess and therefore support this family.

5.10. Family Services played a limited role with the family providing parental support in relation to concerns about the care of Sibling 1 and to an even lesser extent with Child D. Whilst it should not be given undue significance in relation to the outcome for Child D, it was the case that the Family Service had no clear system for assessment of the family's needs. As a result there was a lack of clarity about the purpose of their role of means to review the effectiveness of their intervention.

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

[4] Section 17 of the Children Act 1989 places a general duty on social services to safeguard and promote the welfare of children 'in need' and to ensure appropriate services are provided for those children.
[5] CAF is a tool to enable early assessment of children who need additional services or support from more than one agency

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

5.12. There is no evidence that there was a transparent or explicit system within the Initial Response Team of Children's Social Care for establishing what levels of need or concern would lead to ongoing involvement. Inevitably this meant that other agencies were also unclear about when they should refer concerns and what response could reasonably be expected.

5.13. As a result there was no shared understanding of how to assess when low level concerns regarding children's care should lead to a referral or could be considered to constitute neglect. The model adopted by Calderdale since the events considered within this review identifies 5 tiers of need. In considering the information known at the time about Child D and her family it is likely that at the point of the referral in November 2007 Sibling 1, had she been assessed within this model, would have come within level 3 "*Children whose health or development is being impaired*". This would have led to a co-ordinated multi-agency response.

5.14. **Management oversight and supervision:** Gaps in the provision of management oversight and supervision was a factor in the quality of service provided by a number of agencies. There was no evidence of any systematic supervision within the Initial Response Team of Children's Social Care. As such Children's Social Care was unable to demonstrate either effective performance management or that there was the opportunity for practitioners to benefit from support and critical reflection on their work. Given the pressures on time and resources within this setting and the requirement to undertake a high volume of assessments this was of particular concern.

5.15. The lack of an underpinning organisational system within the Health Visiting provision to review the wider needs of children where there are low level concerns is a significant weakness in the context of: it being usual for health visitors to manage caseloads that are higher than those of other professional groups such as social workers; and a supervision model which is reliant on individual health visitors identifying families where there are low levels of concern. This is an issue that has appropriately been addressed and identified as the basis of a specific recommendation within the NHS Calderdale Commissioning report and set in the context of the developing Continuum of Need model.

5.16. Similarly within Family Services, there was no evidence of a system of comprehensive supervision for staff. Supervision in the agency seemed to be focussed primarily, even exclusively, on practical issues, as such missing the opportunity to reflect with practitioners on the purpose of their work with families or how best to engage.

5.17. **Multi-agency working:** A key thread running through the services provided to this family relates to the quality of multi-agency working. Two specific areas of weakness are identified.

5.18. Whilst Youth Works recognised the parental Learning Disability and engaged constructively and thoughtfully with the parents as a result, this was not replicated by other agencies. Other than within Youth Works there was no evidence of a satisfactory level of professional awareness or understanding of Learning Disability and its potential significance for parents. It is of particular importance in the context of parental Learning Disability that there is good co-ordination between agencies in order to promote consistency and continuity of information and services. At the time there was no access to dedicated or relevant multi-agency services for providing specialist assessment or responses to the combined needs of the adults and children within the family. An audit was undertaken jointly by Adult and Children's Services during 2008 in relation to parental learning disability and a draft protocol consequently produced but not finalised.

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

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

5.21. Firstly although the domestic violence identified was not of the most serious kind there were some failures by professionals to consider the possible implications for the welfare of the children. Secondly the panel considered whether, because in this instance the victim of the violence was a man, it was treated with less seriousness than would have been the case with a woman victim. Whilst this remained a possibility, there was inadequate evidence to reach a clear conclusion in this regard. Nevertheless, this led to consideration of the appropriateness of services available to men as victims of domestic violence and a subsequent recommendation.

5.22. **Substance Misuse**: The Review considered whether substance misuse had played a part in the story of Child D, but concluded that as there was minimal reference to substance misuse in any of the information available, that this was unlikely to be the case.

5.23. **Serious Case Review Processes:** The decision not to initiate a Serious Case Review until 18 months after the death of Child D, is not one which can be defended. Whilst there were differences in medical opinion regarding what may have led to Child D's death there was adequate information to identify that non-accidental injury was a significant possibility. The passage of time

has inevitably effected the ability of the Review to access all the information that might have been available immediately after the event. In particular a number of key professionals were no longer in employment and therefore could not contribute their perspectives.

5.24. **Concluding comments:** Whilst Child D herself was not known to many professionals, her parents and Sibling 1 were known to a number of agencies and the parents recognised as vulnerable. What became apparent during the process of the Review was that there was inadequate recognition of the possibility that Child D and Sibling 1 may either be vulnerable to or experiencing neglect. No overarching strategy or multi-agency approach exists with regard to neglect in Calderdale representing a major gap in planning and good practice.

5.25. The Review concluded that there were two key junctures at which different agency responses could reasonably have been anticipated and could have led to a better understanding of the family and identification of their needs. The second referral to Children's Social Care should have led to a statutory assessment under S47 (Children's Act 1998). Although it is unlikely that such an assessment would have identified Sibling 1 as meeting the threshold for statutory involvement of Children's Social Care, it could have been expected to identify that this was a family who needed extra support services. The Review also concluded that other agencies, particularly NHS Calderdale Provider Services should have recognised the need for a more co-ordinated multi-agency approach to the family's needs, in particular by means of the Common Assessment Framework.

5.26. The Serious Case Review panel carefully considered the issue of whether it could have been predicted that Child D was at risk from serious physical injury. 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. However it would be misguided to conclude that even a series of incidents of this nature could be reasonably be seen to be indicative of potential serious harm. Each of the events was discussed with a professional and the explanations considered congruent. Whilst in retrospect we might consider alternative explanations this can only be highly speculative. There is no conclusive information that, even with the benefit of hindsight, would indicate that either parent had physically harmed any of the children or that there had been meaningful indicators that they were likely to do so in the future.

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

6. Identified Priorities for Learning and Change

6.1. It became apparent within this Review that there was a lack of recognition of parental Learning Disability by key agencies. No evidence was available to the Review that agencies had in place procedures which might help professionals identify the possibility of parental Learning Disability. Whilst work was begun in 2008 to develop a multi-agency approach to responding to parental Learning Disability this had not been completed.

6.2. The issue of the quality of assessment has been recognised by Children's Social Care, NHS Calderdale Provider Services and Calderdale Family Services as an area requiring improvement. The result of the deficits in assessment was a consequential weakness in establishing clear objectives for intervention and review. With hindsight the NHS Calderdale recognises that good practice would have been for the Health Visitor to initiate a CAF which would have created the opportunity for agreeing a planned multi-agency response to the family's needs.

6.3. Analysis of the response by Children's Social Care to the second referral also identified the need to develop and improve practice in relation to assessments arising out of parental separation to ensure that such assessments were in line with standards required of other assessment practice.

6.4. The identified concerns regarding a shared multi-agency understanding of thresholds in intervening in children's lives have been fully recognised in the period since Child D's death. Children's Social Care in conjunction with the Safeguarding Children Board has developed and is now implementing 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.

6.5. Inadequacies in management oversight and supervision practice have been acknowledged by the agencies where it is identified as a failing and this is subject to a number of individual agency specific recommendations as a result.

6.6. Whilst not identified as having a direct bearing on the outcomes for Child D, this Review has identified the particularly important role of Family Services in working with often hard to reach families who may be on the cusp of thresholds for intervention by Children's Social Care. As part of ongoing work, plans are in development for integrating Family Services more clearly to undertake work with families with needs that do not reach the threshold for intervention by Children's Social Care.

6.7. In identifying the priorities for learning, the Review took into account the recent historical context. Calderdale Children's Social Care are currently undergoing a major Transformation Programme to improve practice as a result of an inadequate inspection by OFSTED regarding safeguarding practice in 2010 which itself led to an Improvement Notice being put in place. Many of the priorities for learning identified in this review relating to Children's

Social Care and the role of some other agencies in safeguarding children were fundamentally the same as those addressed by these ongoing processes. Had this not been the case, this Serious Case Review would have made a number of further recommendations.

7. Single-Agency Recommendations

The following recommendations were made by the agencies and endorsed by the Serious Case Review panel.

7.1 Calderdale Council Young People's Service (Youth Works)

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

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

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

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

7.2 Calderdale Children's Social Care

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

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

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

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

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

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

Additional Recommendation from Overview Report Author:

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

7.3 Calderdale Family Services Children's Centres

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

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

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

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

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

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

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

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

7.4 Calderdale and Kirklees Careers Service.

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

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

Recommendation 3: Review supervision recording and document retention

7.5 West Yorkshire Police

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

7.6 Yorkshire Ambulance Service

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

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

7.7 NHS Direct

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

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

7.8 Calderdale and Huddersfield Foundation NHS Trust

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

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

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

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

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

7.9 NHS Calderdale Provider Services

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

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

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

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

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

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

7.10 NHS Calderdale Commissioner

(Recommendations 1-6 have been made in relation to NHS commissioned provider services, Recommendation 7 in relation to NHS Calderdale Commissioner.)

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

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

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

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

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

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

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

8 Multi-Agency Recommendations

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

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

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

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

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

b) finalise the draft protocol between Children's Social Care and Adult Social Care in relation to working with families where there is parental Learning Disability. The information from this Serious Case Review to be used as an instructive case scenario to test the effectiveness of the protocol.

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

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

GLOSSARY

FAMILY:

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

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

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