A Lessons Learnt Review in Calderdale

Child P

This briefing has been produced to provide practitioners and managers with the key learning from cases that have been considered and discussed at the Calderdale Safeguarding Children Board Case Review sub group.

A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. Although this case did not meet the criteria for a SCR, it was agreed to undertake a review of services that had been provided to the child and family prior to the death in order to:

- establish whether there are lessons to be learnt 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,
- to improve inter-agency working and better safeguard and promote the welfare of children.

It therefore looked at lessons that can help prevent similar incidents from happening in the future.

For information visit calderdale-scb.org.uk

What was the story?

- Child P died aged 10 weeks – Sudden Infant Death (SID). Found by Father in Moses basket unresponsive. History of snuffly cold.
- Post-mortem undertaken – revealed old fracture – Non-accidental Injury (NAI). Skeletal survey of sibling revealed old fracture. Unsubstantiated accounts provided by parents.

Background:

- Child P born in ambulance. CONI[1] offered but declined
- History of Domestic Violence from previous partners.
- Mother 18 weeks pregnant before booking with Child P.
- At time of death, family were staying with Maternal Grandma.
- Previous referrals made to CSC by Paternal Grandparents relating to Neglect. Investigated by CSC via core assessment but unsubstantiated and no further action taken. No concerns re: parenting. Case closed late 2013.
- Referral made to Early Intervention panel by Health Visitor late 2014 for a Family Link worker and Housing Support. Child P died before actioned.
- Mother took appropriate action to leave violent partner when in an abusive relationship
- Mother engaged well with Health Visitor who was a consistent figure

Other Factors:

- Sibling has a club foot (Talipes) and received physio during 2013/14. This may have been a contributory factor to the fracture and/or disguised the fact that a fracture was present
- The sibling was involved with speech and language services – this could indicate difficulties in establishing the child's voice or an opportunity to enhance
- Police did not bring any formal charges regarding the injuries to Child P or her sibling
- Second opinion required re: coroner's report and forensic pathologist
- At the time of Child P's death, the family were living in overcrowded conditions. Maternal Grandma was dominant and controlling. Unclear of her role with the children.
- The role of the Father's in the lives of the children is unclear

1 CARE OF THE NEXT INFANT (CONI) – Offered to parents and close relatives of those who have suffered a sudden and unexpected death of a baby – in this case baby of paternal cousin. Care of Next Infant (CONI) programme, supports families before and after the birth of their new baby. CONI is available through many hospitals and community health centres and involves health visitors, midwives, paediatricians and GPs

Overview and Analysis (using the Strengthening Families Approach)

Strengths and Protective Factors

Mother took action to leave a DA situation
Parenting was assessed as safe and effective
Mother was observed as attentive to the baby's needs and demonstrated emotional warmth
Mother was engaging well with the Health Visitor
Mother attempted to be assertive with landlord to make improvements to the home (but without effect) and moved out of unsuitable property
Both parents receptive to advice and support and presented as open and honest.
Child P had been seen in different environments (clinic and at home)

Risk/Harm/Danger

History of Domestic Abuse from previous partners
Post mortem revealed healed fractures
Evidence of sibling having healed fracture
Some inconsistencies in attending medical appointments when pregnant with this Child.

Grey Areas

Role of current partner
Parents' experiences of being parented themselves
Extended family relationships and socialisation within community

Complicating Factors

Sibling had club foot (Talipes) - toe walker -disguised or contributed to fracture?
CONI offer was rejected
Speech and language delay of sibling
Routines compromised by living situation - family in overcrowded conditions for over 10 weeks
Maternal Grandmother controlling and coercive - family and professionals - imposed restrictions in home e.g. bathing and financial restrictions
3 children under 5 to different fathers
DA by 2 previous partners
Smoking in the home. Dogs

Voice of the Child

Very young baby – positive interactions observed with Mum
Sibling's voice potentially compromised by language delay

Analysis

Unexplained healed fractures

Stressful and compromised living arrangements

3 children under 5, 2 with additional needs

Role of partner and extended family members unknown

Mother has taken protective action to distance herself from abusive partners and unsuitable living arrangements

Conclusion

- There were no indicators of abuse or neglect other than stress associated with overcrowding and the parents' relationship with Maternal Grandmother
- Some inconsistency re: engagement with agencies during pregnancy
- The issues identified in referrals were addressed
- The Risk Indicator Tool applied retrospectively did not highlight any new needs or risks

Learning for Professionals and Multi-Agency Working

1. Be aware of and use relevant tools to assess risk and inform decisions
2. Revisit assessments when circumstances change, using relevant tools
3. Consider historical context and implications for future and current needs/risks

Relevant Tools and Multi-Agency Responses for this case include:

SAFE LIVES Dash risk checklist
Family Group Conference
MAPLAG and Domestic Abuse Hub
Professionals Meetings
Assessment of Neglect Tool especially Home Conditions/Emotional Neglect
Pathway for Working with Resistant Families
Continuum of Need and Response

For more information about Serious Case Reviews visit:

http://www.calderdale-scb.org.uk/professionals/serious-case-reviews/