Kirklees Safeguarding Children Board

Response to KMS Serious Case Review by Kirklees Safeguarding Board

NOT FOR PUBLICATION WITHOUT AGREEMENT BY THE BOARD

As the independent chair of the Kirklees Safeguarding Children's Board (KSCB), I am responding on behalf of the Board to the Serious case review conducted into the events surrounding the tragic death of KMS on the 30th September 2013. While the post mortem failed to establish a clear cause of death it is clear that this child sustained serious injuries while in the care of her parents. Both parents were charged and found guilty of offences relating to child cruelty and neglect.

The KSCB would like to express our condolences to the family of KMS for this tragic and untimely death.

The Board focused its review in understanding the events leading up to the death, from the perspective of multi-agency involvement with the family. The purpose of the learning Review was to identify lessons to be learnt from the case with respect to multi-agency practice, this stems from our stated objective of being a Board committed to learning and improving the way services are delivered.

Through undertaking the review the KSCB has accepted the learning that has emerged and has acted accordingly, this includes holding agencies to account in changing policy and practice where that is appropriate. Work on all of the actions identified were completed in June 2016.

Publication of this Serious case review was delayed as both parents lodged appeals in relation to the sentences that were given to them at the conclusion of the criminal trial. The Board was mindful of the guidance relating to parallel criminal processes and was keen to ensure that this work did not any way influence the judicial process, while at the same time acting upon the findings in a timely way as a result of this learning exercise.

The Board has also needed to consider the fact that an inquest into this KMS s death has also been on hold pending the appeal and conclusion of the criminal process.

Accordingly, the Board developed and distributed an interim learning the lessons summary, the key messages from which have been part of front line events highlighting learning from serious cases.

As the inquest is not yet concluded the Board will undertake further learning events with practitioners once a finding has been reached by the coroner.

The Board recognises that the criminal process and the knock-on impact to the inquest, have contributed to significant delay in sharing the findings in full. In addition, organisational changes and changes in personnel in contributing agencies has presented additional issues.

The death of a small infant whist in the care of her family is truly shocking and tragic. As a Board, we have sought to learn from this, while this has proved challenging at times particularly as a consequence of processes out of our control, as highlighted above, we

believe this report provides some significant findings to assist us in taking steps to safeguard other young children from harm.

Alongside system improvement work currently underway, I hope that this review and its findings will support organisations to improve practice and reduce the opportunity for such a tragedy to happen again.

Sheila Lock
KSCB Independent Chair