Kirklees Safeguarding Children Partnership

Child E

Executive Summary

Version 1 October 2019

Reason for this Review

On 30th August 2018, KSCB were informed of the death of Steven, a 4 month old baby, on 23rd August 2018. The death was suspected to be an overlay. A historic bruise on Steven's chest was also noted which was thought may be innocuous or may have been indicative of a broken rib. Steven had been subject of a pre-birth assessment as Joanne's previous children had been "removed" and were in the care of their father. Both of Steven's parents were known to have mental health difficulties and concerns in relation to alcohol misuse. The pre-birth assessment concluded that the family should be supported on a Child in Need plan. This plan ended on the 9th July 2018.

Purpose of the review

At the time of writing this review it is not known whether any police action is being taken in respect of Steven's death. The pathologist has ultimately determined Steven's death as unascertained.

In any event, Safeguarding Practice Reviews are not written to determine causes of death or to assign blame to either family members or practitioners involved with or previously involved with the family, but to seek to understand the child's life, experience of services and whether anything can be learnt to improve practice and prevent future harm to other children.

In 2018, KSCB commissioned 3 Safeguarding Practice Reviews, all on children aged 2 and under. When the notification of Steven's death was received it was clear that there were many similarities to these 3 cases and the emerging learning coming from it. As such the specific purpose of this review is as follows:

1. To act as complementary learning to those other reviews and to identify learning that mirrors that of the Kirklees Cases Child A, Children B+C and Child D and whether Steven's life and death can deepen our understanding and response to that learning.

2. To understand the multi-agency response to Steven, Joanne and Mark to ascertain if any learning can be gained to strengthen future practice

3. To identify learning that differs from those other 3 reviews and highlight this for the agencies involved.

Agency involvement

The following agencies have provided information:

- Children's Social Care
- West Yorkshire Police
- North Kirklees Clinical Commissioning Group Mid Yorkshire Hospital Trust
- 2 Local GP Practices
- Locala
- South West Yorkshire Partnership Foundation Trust

- CAFCASS
- CHART

Reviews of all records and materials that were considered included;

- Electronic records
- Paper records and files
- Patient or family held records.

This review differs from those usually commissioned by KSCB for a number of reasons. Firstly, its similarity to other reviews already in the process of being written meant that much of the learning and the context of safeguarding practice in Kirklees has been identified and, as such, it was felt that commissioning another "full" review would be repetitious. Further it would take longer for a full review to be completed and any action needed from additional learning would be delayed.

This review has not arranged Practice Learning Events which seek to engage first the practitioners involved in the case and then the senior managers of the involved agencies. Again though highly valued parts of most reviews these learning events take time to organise and it was felt would not add much more to the understanding than had already been gleaned from previous Practice Learning Events on the other cases. This author has however had the option to contact agencies to clarify events where necessary.

Key findings explored in this review

The first 3 findings below are linked to the findings of 3 other concurrent reviews undertaken in Kirklees.

Finding 1 – Workforce understanding of the risks of domestic abuse, particularly the risks associated with post separation are poorly understood

- Victims of domestic abuse are given the responsibility of keeping their children safe from the perpetrators of abuse without an assessment of their capacity to do so
- Perpetrators of violence, though identified as the source of risk to children, are not directly worked with to address concerns
- Relationships characterised by domestic abuse and between people with alcohol, substance and mental health issues rarely end without periods of reconciliation and contact.

Finding 2 – Clear, up-to-date records and effective, comprehensive information sharing are the foundations on which effective child safeguarding practice are built

Finding 3 – The support arrangements post Child in Need are not clear and co-ordinated and the circumstances under which Children's Social Care may want to consider re-opening a Child in Need case after the closure are not specified to the agencies who remained in contact with the family

The following findings are additional to those found in other reviews

Finding 4– For those agencies primarily addressing parental issues, child safeguarding does not appear to feature in their assessments, decisions or direct work.

Finding 5 – The safe sleeping advice, given consistently to mother, was not effective in reducing the risks to Steven

Finding 6 – The risk of a return to problematic alcohol use by mother was not understood, assessed or managed.

Reflective questions raised by this Serious Case Review

1. How is the workforce understanding of domestic abuse and the effective application of this knowledge into practice be evidenced?

2. What does "acting protectively" mean in the context of domestic abuse?

3. How can practitioners move from a description of events or recording a narrative given by parents to a truly analytical assessment?

4. What barriers do practitioners face to effective, comprehensive information sharing and keeping clear up-to-date records and how can these be overcome?

5. What are the best practice expectations of all agencies in relation to de-escalation of cases?

6. Should the closure of a Child in Need case be done in the context of a multi-agency discussion?

7. How can practitioners who are providing an "adult facing" service ensure they are routinely asking questions about and assessing the safeguarding needs of any children of or in contact with their client?

8. What role does the Mental Health in Families team play in facilitating closer working relationships between SWYPFT and Children's Social Care?

9. How can we respond effectively to parents who are presenting in mental health crisis on multiple occasions?

10. How do adult facing organisations such as Adult Mental Health Services ensure that the opening and closing of cases are appropriately flagged to Children's Social Care when the client is a parent?

11. How effective is the safe sleeping advice given to new parents? Should a tiered or different approach be considered when working with parents who have identified as having additional needs and being at higher risk?

12. What assessments or direct work is prompted (or should be prompted) with a parent who has identified previous alcohol or substance misuse issues?

13. How are the adverse childhood experiences of parents taken into account and explored when assessing parenting capacity?

14. How confident is the workforce understanding of relapse, how to identify this quickly and intervene effectively?

Good practice identified in this review

1. Safe sleeping advice was given on 4 separate occasions and by 2 agencies

2. Routine enquiries were made about domestic abuse by midwifery and health visiting services.

3. Upon receipt of the information in relation to Joanne's older children being subject to a CAFCASS assessment the Midwife made an immediate and appropriate referral to Children's Social Care

4. Joanne's health visitor and mental health team developed good relationships with Joanne, who felt able to share information with both sets of professionals

5. The Police response to domestic abuse incidents and Mark's mental health crises was swift and appropriate

6. Domestic abuse incidents were referred appropriately to MARAC

7. Considerable intervention was provided by SWYPFT to both parents

8. The pre-birth assessment was completed in good time and ensured that a birth plan was in place

9. A clear and recorded rationale for closing the Child in need case was given by the social worker who also sought guidance from her manager in relation to the case

10. Upon case closure the social worker gave detailed advice about facilitating safe supervised contact