Kirklees Safeguarding Children Partnership

Child A

Executive Summary

Version 1 August 2019

Reason for the Serious Case Review

This Review was triggered by the death of Child A, who was nearly nine weeks old when she was found lifeless by her father in her parent's bed. At the time of instigating the review, it was suspected that Child A's death may have been caused by an overlay. This has not been substantiated as the post-mortem was inconclusive. At the time of writing this report no criminal charges had been brought against Child A's Mother or Father. Child A's siblings were subject to interim care orders and unlikely to return to their parent's care.

While the circumstances of Child A's death are inconclusive, the family were previously known to local statutory agencies for incidents of domestic abuse between parents and neglect of older siblings. As a result, the KSCB took the decision to conduct a Local Child Safeguarding Practice Review to identify learning for local agencies.

This Child Safeguarding Practice Review has not identified any actions that may have been taken by professionals to prevent Child A's death.

Agency involvement

The following agencies have provided information:

- Children's Social Care
- West Yorkshire Police
- North Kirklees Clinical Commissioning Group
- Mid Yorkshire Hospital Trust
- Locala
- South West Yorkshire Partnership Foundation Trust
- Community Rehabilitation Company
- Kirklees Neighbourhood Housing
- Schools

Agencies that identified significant background histories on family members pre-dating the scope of the review provided an account of that significant history.

Reviews of all records and materials that were considered included.

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

Two Learning Events for practitioners and managers who had worked with the family (or who could contribute to learning) were held in April 2018. The outcomes from the Learning Events were twofold:

- Practitioners and managers were able to share their experiences of working with the family and contribute to the information provided by agency chronologies i.e. understanding not just 'what happened' but 'why it happened'.

- Practitioners and managers were able to contribute to discussions about what improvements in policy and practice might be required.

Terms of reference and Key lines of enquiry

The KSCB Serious Case Review Workstream agreed the scope of the SCR. The workstream also considered key lines of enquiry which were:

1. The quality of assessments and decision-making during your involvement with the family during the specified period – specifically relating to family engagement?
2. Was the family history given appropriate consideration during decision-making?
3. Is your service responsible for assessing home conditions and does this include routine checking of the bedrooms?
4. To what extent was your agency aware of the history of neglect of the children and domestic abuse within this family?
5. Was there any evidence of ongoing neglect or domestic abuse within the family e.g. children not being taken to school and/or appointments?
6. Was consideration given to whether or not a pre-birth assessment was indicated prior to MM's birth?

Key Practice Episodes (KPE) are identified during the review process to capture key incidents and/or ongoing issues that warrant further analysis. These episodes are usually times when an incident triggers the involvement of a number of professionals; there is an event that is significant to understanding the way that the case developed and/or was handled; and/or there is a recurring issue for the family.

In this case, the independent reviewer identified six key practice episodes that warranted further exploration:

1. Closure of the Child in Need plan – January 2016.
2. Support for Sibling 2 – January 2016 to June 2017.
3. Multi-agency response to domestic abuse incidents – September to October 2016; December 2016; December 2017
4. Home conditions – September 2016 to February 2017.
5. Pregnancy with Child A – March to October 2017.
6. Police incident at 1:00am on 01/01/18.

Learning from this Serious Case Review

Learning has been given in this review in the form of learning points for agencies to consider. It is the responsibility of individual agencies to respond to these learning points by outlining what actions they will take to address any learning they feel pertains to their practice.

Learning point 1: If children have recently moved schools, the previous school should be invited to multi-agency discussions around safeguarding children.

Learning point 2: Relevant housing providers should be routinely invited to multi-agency discussions around safeguarding children.

Learning point 3: Consideration should be given to de-escalating to a Team Around the Family plan if low level concerns still need to be addressed when a decision is made to close a Child in Need plan

Learning point 4: Children's social care should explore how their expectations around child contact should be communicated to parents and professionals. This should include clear consequences for failure to adhere to agreed contact arrangements, recommendations for professionals in other agencies to record/flag the arrangements for supervised contact; and a clear process for reporting breaches to contact arrangements.

Learning point 5: Some parents may be intent on securing a medical diagnosis for a child's behavioural problems and consequently ignore advice from professionals about behaviour management. A consistent, multi-agency response should be given to parents in these cases to ensure that children receive an appropriate, authoritative parenting approach.

Learning point 6: An authoritarian parenting style is likely to exacerbate behavioural problems in children.

Learning point 7: Exposure to domestic abuse may cause behavioural and emotional problems in children. Professionals should clear about the research that supports this and evidence the work done with parents to increase their understanding of the impact of domestic abuse on their children.

Learning point 8: 'ASK CAMHS', the initial point of contact for those who have concerns about a child or young person's emotional or mental health, should assist professionals in in providing clear, consistent advice to parents about obtaining appropriate support for children.

Learning point 10: Professionals should advise parents of any concerns regarding their children and/or gain parents' consent for someone from children's social care to contact and offer support (unless doing so would put the child at risk)

Learning point 11: Victims may retract statements or disclosures regarding domestic abuse. The reasons for this are varied and complex, but fear of the consequence of disclosure and ongoing feelings for the perpetrator are likely to be contributory factors. Retractions should not be seen as evidence that abuse has not occurred and may be indicative of ongoing contact between the victim, the perpetrator and their children.

Learning point 12: Social workers should challenge parent's 'programming' children's responses to social workers questions and explore the reasons behind this with parents.

Learning point 13: Children being 'programmed' by their parents should warrant further exploration and social workers should speak directly to the children, without the presence of their parents, to explore their wishes and feelings.

Learning point 14: Coercive control has a detrimental impact on victims and may affect their capacity to assess risk and appropriately safeguard their children. Victims should not be expected to take sole responsibility for keeping their children safe from perpetrators, particularly when perpetrators have parental responsibility for their children.

Learning point 15: Social care should not use the police evidential test as a basis for determining whether or not an assault took place.

Learning point 16: Professionals should be mindful that an initial report of domestic abuse is likely to be accurate, and subsequent retractions are likely to be false.

Learning point 17: Perpetrators of domestic abuse, particularly those with parental responsibility for their children, should be directly spoken to about the impact of their abusive behaviour children and included in the assessment process/safety plan for children.

Learning point 18: Social work assessments should respond to new and emerging information, even when new information contradicts what was previously known or believed to be true. Managers should provide supportive challenge to ensure that social workers respond appropriately to conflicting information.

Learning point 19: MARAC provides an opportunity for information regarding the assessment and management of risk to be shared. Agencies in attendance must ensure that information shared at MARAC is appropriately acted upon.

Learning point 20: The use of a visual home conditions assessment tool may be useful to enable professionals to share a collective, objective understanding of what constitutes acceptable home conditions.

Learning point 21: Several agencies now employ routine enquiry in relation to domestic abuse. If the case history and/or responses to the enquiry indicate historic domestic abuse, the current risk posed by violent partners/ex-partners should be explored.

Learning point 22: How can we improve the offer of support to pregnant women who are struggling to cope but keep agencies at arm's length?

Learning point 23: MYHT should explore electronic and/or duplicate copies of mothers' maternity notes.

Learning point 24: Police should consider how to ensure responding officers check on the safety and welfare of children when they are called to an incident.

Learning point 25: Police to explore what information/history can be shared with responding officers before they attend an incident.

Learning point 26: Children's social care to ensure assessments of risk to children include a thorough exploration of the ongoing, cumulative impact of coercive control on victims and children.

Learning point 27: Key frontline professionals should continue to assess risk, and provide support for victims and children, post-separation in recognition of the increased risk posed by perpetrators during this period.

Learning point 28: Written agreements are not effective tools for managing risk and their use should be avoided. Where considered necessary, written agreements should, at a minimum, be clear about the duration that they are in force; the ways in which agreement will be monitored; and the consequence of breaking the agreement. Any written agreement should be shared with all parties with parental responsibility and shared with universal services that are likely to remain in contact with the family after children's social care withdrawn their intervention.

Learning point 29: Children's Social Care assessments should consider the history of the case and ensure that any historical concerns i.e. home conditions, suitable sleeping arrangements for children etc. are explored during the re-assessment process.

Learning point 30: Children's Social Care ensure that children subject to social work assessments: are spoken to alone; are given the opportunity to comment on the assessment completed by social workers; and are asked if they agree with the outcome of the assessment.

Good practice identified in this review

The Police information that was shared with health and social care included information about the home conditions and the presentation of each child, which is considered to be good practice in assisting social care with their decision making.

The decision to close the Child in Need plan may have been appropriate, given the stability that the family had achieved. Mother appears to have demonstrated to professionals that her relationship with Father was over, and that she recognised the impact of domestic abuse on her children. Furthermore, professionals at the meeting noted marked improvements in behaviour management and establishing consistent routines.

However, it may have been prudent to either invite the previous school to the meeting or keep the Plan open until the current school had received relevant records from the previous school and had time to get to know the children and consider their behaviour in the context of their history. It is also unfortunate that no one from Kirklees Neighbourhood Housing was invited to attend the meeting, despite requests from the allocated Stronger Families Consultant to be involved in any multi-agency meetings around the family.

It appears professionals at the Child in Need meeting clearly communicated that Father was to continue to have supervised contact with his children.

The Probation Officer was proactive in seeking information about Father's contact with his children. If information about the necessity for supervised contact had been shared, there may have been an opportunity for Probation to explore this with Father and do some exploration around his relationship with Mother.