Kirklees Safeguarding Children Partnership

Child K

Executive Summary

Version 2

Reason for this Review

This case was referred to Kirklees Safeguarding Children Partnership following the death of Child K on the 27th October 2019.
Child K was the third child born to mother and the second child of father.
Child K's siblings had been subject to CIN plans for six months prior to Child K's birth following concerns regarding who would care for them if mother received a lengthy custodial sentence for the offence of aggravated burglary.
Child K was found not breathing and an ambulance was called. Father attempted resuscitation. Child K was taken to hospital where she was declared dead. Mother later informed the police she and father had been drinking and had misused substances the previous night. Child K was found to have bruising to her back and overlay was suspected. This case has been subject to rapid review, Police investigation and Coroners Inquiry. The Police investigation has been concluded and the Coroners Inquiry concluded the cause of death as unascertained (history of co-sleeping).

Purpose of the Review

The aim of this Local Child Safeguarding Practice Review was for individuals and agencies to learn lessons about the way in which they work both individually and collectively to safeguard and promote the welfare of children. The review was conducted in such a way that it:

- Recognised the complex circumstances in which professionals work together to safeguard children;
- Sought to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Sought to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed .
- Made use of relevant research and case evidence to inform the findings.
- Consider how and what contribution may be sought from family members in respect of service delivery.
- Specifically considered ethnicity, religion, diversity or equalities issues that may be required; and
- Was able to develop a multi-agency action plan in light of the findings

Agency Involvement

The following agencies, identified as having been involved with Child K and Child K's family, were asked to provide a chronology and analysis of significant events during the agreed review period. The agencies were also asked to provide a list of practitioners and managers involved in the family's care.

- Kirklees Children's Social Care
- Police

- Calderdale and Huddersfield Foundation Trust
- Locala: Health Visitor Service / School Nurse
- Education
- SWANS
- CHART
- Greater Huddersfield CCG

Terms of Reference and Key Lines of Enquiry

Nicki Walker-Hall, an experienced Serious Case and Learning Lessons Review Author from a Health background was commissioned to undertake the review.

A narrative of events was developed by the reviewer. Two separate practitioner and two separate manager learning events, were held in January and March 2020 in order to understand the single and interagency practice in this case. The reviewer was able to gain an insight into the perceptions of the family and how the different agencies related to them.

The timeframe identified for the purposes of collating detailed information covered the period from 26.10.18, the start of the Child in Need for Child K's siblings, to 27.10.19 the date of Child K's death.

This review focused on the key themes for learning identified by the Case Review group; these have been identified under two broad headings as follows:
Sustaining services and support:

- The rule of optimism
- Child centred practice
- Supervision

Assessment of risk:

- Quality and timeliness of assessments (inc. Pre-birth Assessments and Child Protection Plans)
- Analysis in assessment and risk
- Quality and timeliness of decision making
- Contingency planning

Identified Good Practice in this Review

Some of the services involved with the family had clear remits and where this was the case they worked well. School and nursery staff were a constant for the children and they were very responsive to the children's needs referring concerns and taking part in safeguarding meetings and action plans.

Current senior managers have been in post for a longer period and this has now provided some stability. There has been a reduction in agency staff, all senior staff are now permanent. A positive is that a lot of staff who were previously in Kirklees have stayed and are providing stability.

CHART, having recognised that cases were being escalated but nothing appeared to be happening, took an internal decision and created their own social worker roles. CHART have since been trying to integrate these workers into CSC, but this has yet to be successful.

Learning from this Review

Learning point 1: The way drug and alcohol services were configured and the interface between drug and alcohol services and CSC heightened the risk that problematic drug use would go undetected and unaddressed in such a way as to increase risks to children.

Learning point 2: There was a lack of direct work undertaken with the children to understand their lived experiences and influence plans. The meetings were focussed on the adult's issues without clear recognition of the impact their behaviours were having on the children.

Learning point 3: There was a lack of evidence that the current supervision arrangements in place within CSC are effectively supporting frontline practitioners to manage their cases effectively.

Learning point 4: Accurate assessment of risk is dependent on the assessor being in receipt of all the information available across agencies and services and, on having the skills and input from those with additional knowledge. Currently some services are not included in requests to provide information when there are safeguarding concerns. Different agencies and services are carrying out single agency assessments of risk. It is not clear how these separate assessments of risk are being brought together to provide a clear multi-agency assessment of risk on which plans of action are based.

Learning point 5: The quality of the C&FA assessment was not challenged by the manager suggesting managerial oversight might not be robust. The reviewer has not been able to establish whether this is specific to this case or there is a wider issue.

Learning point 6: Where parents are preventing access to the children during a section 47 enquiry a further strategy meeting should be held to consider if further actions need to be taken.

Learning point 7: Within plans contingency planning was not robust. Consideration needs to be given to all potential crisis situations and a clear agreed plan of the actions to be taken.

Recommendations from this Review

Recommendation 1: KSCP to seek assurance from CSC and CHART that changes to service design and ways of working have improved communication, information sharing and risk assessing of parents who are misusing substances.

Recommendation 2: KSCP to seek assurance from CSC that:
• Age appropriate tools are being used with all children within assessments and on-going work, to understand the children's lived experiences and
• That all plans evidence consideration of the impact of adult behaviours on the child.

Recommendation 3: CSC to explore the effectiveness of supervision to its staff and explore whether there is scope for reflective supervision with an experienced supervisor who is not the SW's line manager.

Recommendation 4: KSCP and its partners to explore ways of ensuring information pertaining to risk, is provided by all relevant services and incorporated into safeguarding assessments and plans.

Recommendation 5: KSCP to seek assurance from CSC that the quality and timeliness of assessments is rigorously scrutinised by managers prior to sign off and acceptance. Where there are gaps in the assessment managers must evidence these have been challenged and addressed prior to sign off.

Recommendation 6: KSCP and its partners to review section 47 practice and procedures to ensure where enquiries are being impeded by parents that a further strategy meeting is held.

Recommendation 7: KSCP to seek assurance from CSC that all CIN and CP plans contain clear, specific contingency plans that relate to potentially foreseeable crisis situations.