



Serious Case Review
(CHILD A)
EXECUTIVE SUMMARY

February 2009

Introduction

- 1.1** This Executive Summary reflects the findings from a Serious Case Review which was undertaken to consider the professional involvement of a range of agencies with a family of mother, father and two children who were both under 5 years of age at the time of the family's arrival in Cambridgeshire approximately 3 years ago. Two further children were later born to the family, although the youngest child tragically died when just a few days old in early 2008. At the time there were professional concerns regarding the cause of the baby's death. These concerns were not only based on the lack of an identified cause of death but also because there was a history of significant concerns within the family in the past.
- 1.2** The mother had been convicted of an offence against a previous older child, no longer living with the family, and another baby had also died about a year before the family arrived in Cambridgeshire. This earlier death was identified as a result of natural causes. These incidents had occurred in other parts of the country where the family had previously lived, although by the time they arrived in Cambridgeshire, it had been considered by previous health workers and social workers, that the parents were now appropriately and satisfactorily caring for their children.
- 1.3** Following the baby's death in Cambridgeshire, there was an initial police investigation, and both parents were interviewed in respect of the death, although these investigations did not ultimately lead to criminal proceedings. Also at this time, Interim Care Orders were granted on the baby's three older siblings. These children were eventually rehabilitated after a period of approximately 6 months, to their parents.
- 1.4** As part of the Cambridgeshire Local Safeguarding Children Board's commitment to learn and develop inter agency child protection practice, this Serious Case Review was undertaken in order to establish the facts of the handling of the case and to analyse the professional involvement with this family. The purpose of the Review was to identify and recommend any relevant changes to professional practice, and to improve the ways in which the different agencies in Cambridgeshire work together to safeguard children and young people.

Case Review Process

- 2.1** Each agency that had some direct involvement with the family was required to undertake an Individual Management Review, to look openly and critically at individual and organisational practice as it related to their involvement with this family. In undertaking this, each agency was required to produce a chronology of its contact with the family. Those managers conducting the Individual Management Reviews were not directly concerned with the services provided for the children or family, or the immediate line manager of the practitioners involved.
- 2.2** Selected representatives of the Safeguarding Board and senior managers of key agencies within Cambridgeshire were brought together to form a Serious Case Review Panel to collate the information provided from the Individual Management

Reviews and then to analyse the professional practice and inter agency working as it related to this family. The Panel was chaired by the Independent Chair of the Cambridgeshire Safeguarding Children Board, and an independent consultant, with extensive experience in safeguarding children, was the author of the Overview Report and the Executive Summary.

Case Details

- 3.1** At the time of the family's arrival in Cambridgeshire, there was considerable concern about the way in which the two children presented during an occasion when the family attended the local hospital. The children's behaviour appeared very disturbed, and the parents were hostile, and reluctant or refused to give any information about their family history. An agreement was made with the parents that the children would remain at the hospital for the weekend whilst further assessments were undertaken, but when they tried to leave with the children, the police were called and the children were placed under police protection and remained in the hospital.
- 3.2** With the agreement of the professionals involved at the time, the children returned to their parents after two days, and a social work initial assessment was undertaken. The background information in relation to the mother's previous offence, and the death of the previous child, became known to the social work team. The outcome of the assessment was that the case was closed with no concerns identified about the two current children in the family.
- 3.3** Although there was one occasion when concerns were raised about possible neglect of the children, and the hospital expressed concerns about parental aggression and refusal to cooperate or take health advice regarding the children, particularly at the time of birth of the two youngest children, none of these led to further direct involvement by children's services social care staff. The health visiting service also considered that there was no reason to provide any additional support to the family. By the time the older children attended school and nursery locally, the school saw no reason to refer the family because of child protection concerns.
- 3.4** It was not until after the death of the youngest baby that the police and children's services (social care) became involved as a matter of urgency to investigate the cause of death of the baby and to assess any risk to the older three children. Concerns were heightened because there was the potential of some similarity regarding the mother's previous offence against her older child and the death of the new baby. It was identified that this infant went from being a healthy baby to a seriously ill baby very quickly, and died, although the underlying cause for the death could not be determined. After extensive investigation the cause of death remains unknown. No blame could or should be attributed to the parents. Medical and social work assessments were undertaken in respect of the three siblings and based upon these and other professional opinion, after a period of foster care, it was eventually considered appropriate for the children to be returned to their parents.

Main Findings

- 4.1** Given the available information about the family background, then the downgrading of concerns after the first intervention triggered because of concerns about the older children, by both the social work team and the health visitor, was premature. This family had just moved into the area and had a background which, in respect of their capacity to parent their children well, gave rise to concerns. However, there was a fairly positive assessment report from a previous local authority which was viewed as supporting evidence that there were no current child care concerns. This positive information was selectively used, and appeared to fuel a rule of optimism by professionals.
- 4.2** Although it was believed by social care that the health visitor would monitor the family situation, this was not formally arranged and did not take place. In these circumstances it appears that the social work team did not fully access or use all relevant background information before making a decision to close the case. In addition the health visiting service should have conducted their own risk assessment of the children, but failed to do so.
- 4.3** A formal child protection enquiry should have been undertaken following the children being made subject to police protection soon after their arrival in Cambridgeshire. To not have done so suggested that the concerns had been downgraded too readily and without a thorough investigation of all the aspects of possible risk.
- 4.4** An anonymous referral which was made some months later to children's services social care regarding the children potentially being left alone was not dealt with in line with procedures and went unaddressed. A dangerous assumption was made that the anonymous referral was likely to be malicious.
- 4.5** There were some good examples of efficient information sharing between agencies in Cambridgeshire regarding the family's background, which meant that most of the professionals working with the family had a reasonable and early understanding of past concerns. There were some occasions however when information was not effectively retrieved or sought and one particularly occasion when a police national data base check failed to reveal the mother's offending history
- 4.6** Overall, background information was not fully collated and analysed by key professionals to inform new assessments of parenting capacity and of any risks to the children.
- 4.7** There was a failure by professionals, apart from those within the school, to engage the father in their work with the family, even though he was very involved in the day to day care of the children. A overstrong maternal focus has often been found to be a feature of work undertaken with families where there are children in need, or children at risk of significant harm, and this tended to occur in this case. This had the potential of undermining the quality of assessments of risk and the understanding of family functioning.

- 4.8** As part of normal practice, the background records to be used by health practitioners in their daily work with this family, were summarised, although this inappropriately led to the omission of significant child protection data from these records, thereby adversely affecting the health professional's ability to respond in the most appropriate way to the parents and children.
- 4.9** School staff informed the parents if they had concerns about the children, and these led to appropriate changes in parenting taking place. In this way the parents appeared to respond to a consistent approach, and to clear expression of concerns, and generally the school and nursery rarely saw evidence of the hostility that was sometimes portrayed by the parents to other professionals.
- 4.10** At the time of the baby's death, the hospital did not follow procedures to immediately inform the police, and this delay until they were informed the next morning, potentially compromised the criminal investigation which then ensued.
- 4.11** Whilst there was some acknowledgement of the impact that the family's racial, cultural and linguistic background may have had upon their ability to work with professionals, and to settle into the local community, there was little evidence that these issues were analysed or pursued sufficiently as part of the understanding of family functioning
- 4.12** There were occasions when there was conflict or disagreement between agencies about the way in which the case was being managed, and about the level of risks to the children. These disagreements were not effectively resolved at the time when the relevant professionals should have addressed their dissatisfactions by escalating the matter through the management hierarchy.
- 4.13** It was not until the death of the baby that professional intervention with the family reached the child protection threshold. Appropriate actions then followed. Prior to this, there was no evidence that the children suffered significant harm. Despite this more informed assessments and better collation and analysis of past information and concerns should have led to a family support service being provided and would have prevented the concerns that were clearly identified being too readily downgraded by professionals.

Summary of Recommendations

- 5.1** When a family move into the area following a history of child protection concerns in their previous locations, then assessments of current levels or risk must be linked with full and detailed information obtained from the previous authorities. No final assessment of risk or parenting capacity should be concluded until such past information has been fully identified and analysed.
- 5.2** A mechanism needs to be established to ensure that an inter-agency professional's meeting is instigated following the arrival in the area of a family with previous child care concerns, or when a parent/carer is considered may pose a risk to children. Such a Child in Need meeting can be established by any key agency involved with the family.

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- 5.3** A Strategy Meeting and the instigation of a child protection investigation should automatically follow the use of police protection powers to protect children.
- 5.4** Agencies must devise appropriate systems and management support mechanisms to assist their front line staff in taking all necessary steps to engage the male carer/father, when working with child care concerns within a family.
- 5.5** The new Cambridgeshire Safeguarding Children Board’s “Child death protocol” must be disseminated in a manner which ensures that all relevant agencies and their staff have a full understanding of how to deliver the protocol within the context of their agency practice. The Child Death Overview Panel should consider the lessons from this Serious Case Review and consider any implications for future practice.
- 5.6** The Safeguarding Board should ensure that its constituent agencies ensure that their staff understand and have the confidence to instigate escalation procedures when inter agency conflict threatens to compromise appropriate and safe child protection practice.
- 5.7** The summarising of child care records on behalf of GP surgeries must be undertaken by appropriately trained staff who are able to recognise risk factors in respect of safeguarding children and young people.
- 5.8** All agencies should ensure that issues in respect of a family’s racial, cultural, linguistic and religious identity are consistently addressed by their staff as part of any assessment or plan of intervention.
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February 9th 2009