



## OVERVIEW REPORT

## SERIOUS CASE REVIEW

## SIGNIFICANT INCIDENT LEARNING PROCESS

Child P

(age at death 2 years 4 months)

and

Child H

(age at death 7 months)

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## Introduction

- 1.1. In Spring 2015, two young children died in their homes in Dudley. They were unrelated and unconnected. In both cases no specific cause of death was identified.
- 1.2. Agencies had been involved with their families because of concerns about neglect of the welfare of the children. The then Chair of Dudley Safeguarding Children Board decided that the criteria for carrying out Serious Case Reviews under statutory guidance<sup>1</sup> were not met but, in accordance with the Board's Learning and Development Framework, a Thematic Review considering the background of both cases should be carried out applying the Significant Incident Learning Process (SILP) to ascertain whether there were lessons to be learned.
- 1.3. It was understood by staff commissioning the review that the decision not to carry out Serious Case Reviews was supported by the National Panel of Independent Experts on Serious Case Reviews and the Thematic Review was scoped on that basis at a meeting held on 1<sup>st</sup> October 2015.
- 1.4. OFSTED undertook an inspection of Children's Services in January 2016. The effect of the inspection was that it became extremely difficult for the reviewers to obtain vital information from staff. When the draft overview report was due to be submitted to the Serious Case Review Sub-group on 7<sup>th</sup> April 2016 the reviewers were presenting a report which still contained unanswered questions. It transpired that on that day correspondence between the board and the National Panel suggested only Child H's case had been notified to the National Panel of Independent Experts and the decision not to carry out a Serious Case Review by the then Independent Chair was challenged. However, the response received had incorrectly assumed the Board had made a decision in favour of carrying out a serious case review.
- 1.5. On 11<sup>th</sup> May 2016 the newly appointed Independent Chair of Dudley Safeguarding Children Board reviewed these decisions and decided both cases met the criteria for a Serious Case Review. The decision to undertake further work on the Thematic Serious Case Review was made. Due to staff turnover and internal capacity issues, the 'phase 2' work was not formally commissioned until 8<sup>th</sup> July 2016. For a similar reason, information vital to completion of the review was 19 weeks overdue. The draft Overview Report was submitted to the Board on 13<sup>th</sup> February 2017. Following further correspondence, the report was finalised in August 2017.
- 1.6. The Thematic Review looked beyond individual incidents or individuals and focussed on identifying, examining, and recording patterns or themes within the cases that are likely to apply in other circumstances.

## 2. Process

The thematic review was carried out applying the Significant Incident Learning Process. This involves agencies producing timelines and analytical reports of their involvement and encourages learning to be identified by the staff involved in the cases and so far as possible aims to involve members of the families affected by the incidents. The Terms of Reference for the review are set out in Appendix A.

Staff involved and the report writers were brought together at a Learning Event to discuss the reports, issues and themes emerging, focusing on Key Episodes identified from the reports. A Recall Day followed to discuss a first draft of the Overview Report. Staff from some agencies

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<sup>1</sup> Working Together 2015 Chapter 4

including Children Social Care were unable to attend the Recall Event. Arrangements were made for a meeting to take place separately with the writer of the Children Social Care Reports. During phase 2, a further professionals meeting was held in September 2016 to look at specific research questions following agencies producing and sharing Agency Questionnaires. One Agency Questionnaire was not submitted and a draft overview report was prepared highlighting the gaps in the review. It was agreed that the information was needed and that the report should not be signed off until a thorough review had been conducted.

The Reports provided by agencies are thorough and of a high standard. The Learning and Recall Events reflected careful consideration and a determination to learn. The recommendations made in the reports for their agencies if implemented are calculated to bring about change. These recommendations are set out in Appendix B to this report.

The Significant Incident Learning Process was led and the meetings were chaired by Ms Donna Ohdedar. David Spicer and Donna Ohdedar co-authored the Overview Report. We both have the qualifications, experience, suitability and independence to undertake reviews required by statutory guidance.

## **2.1 Family Involvement**

- 2.1.1. Attempts were made to involve members of the families to contribute to the process but they declined to do so. The mother of Child H asked to be informed in due course about the conclusions and recommendations.
- 2.1.2. Over the telephone Child H's mother also reported that Child H "had never been the same" since he had an admission to hospital with bronchial problems in 2015. This was discussed at the Recall Event and it was confirmed that there was no record of any such concerns having been brought to the attention of any health or other professional.
- 2.1.3. It was noted however that the hospital discharge letter did not suggest any follow up with the GP. This led to a discussion about advice given to parents when children are discharged from hospital and whether there should be a leaflet advising them in what circumstances to make appointments, particularly during the winter months.
- 2.1.4. The author of the Dudley Group NHS Foundation Trust Report agreed to look at the standard arrangements and consider whether there should be any changes to arrangements made to information and advice given to parents on the discharge of their children from hospital.

## **3. The Facts**

### **Child H**

- 3.1 There is very little recorded about Child H prior to the death, other than that the child slept in a bouncy chair. It later transpired that Child H was co-sleeping with parents. Recording of home visits suggests there was evidence of suitable age related toys were available for the children in the household and also evidence of warmth and affection in the interaction between adults and children within the family.
- 3.2 In Spring 2015, a 999 call was received by the ambulance service concerning a seven-month-old child, Child H, who was said not to be breathing.

- 3.3 The female caller originally stated that the baby had woken up in the cot. However, a man could be heard in the background who shouted "tell the truth" and the caller then said that Child H had been in bed with them and they had woken up to find Child H not breathing with blood coming from the nostril.
- 3.4 Upon arrival at the Accident and Emergency Department it was confirmed that he had died.
- 3.5 Home conditions were found to be cluttered, with sparsely furnished bedrooms and evidence of use of dried herbal cannabis in the adult bedroom. In the rear bedroom, the door was damaged by four dents.
- 3.6 A post mortem examination failed to identify a cause of death and the inquest recorded an open verdict.
- 3.7 At the time of death, Child H lived with mother, half-sibling, the mother's partner, who was the father of Child H, and an adult relative of the partner. On the night of the incident Child H's half-sibling was staying with the father.
- 3.8 It appears that Child H had a cot in the parents' bedroom in which there were stored nappies and clothing. The paternal relative was sleeping in the spare bedroom using the bed intended for Child H's half-sibling. The father had arranged pillows and bedding around Child H in the parents' bed.
- 3.9 After the death of Child H, child protection enquires were carried out in relation to Child H's half-sibling who was made subject to a child protection plan. This child continues to reside with Child Hs' mother, although there have been continued missed appointments and lack of engagement with services by mother. At the Recall Event, some practitioners were concerned that the plan had not been actioned appropriately since July 2015.

## Child P

- 3.10 Child P was described as a happy little child who had age appropriate toys in the home and liked playing alone or with siblings. As a baby, Child P was changed from formula milk to cow's milk, although not weaned. Workers were concerned that Child P was not eating any solid food and was seen infrequently by professionals, who were often told Child P was having a nap. On home visits, Child P was observed to be sleeping in a pushchair appropriately dressed.
- 3.11 In Spring 2015, a 999 call was received by the ambulance service. The male caller was very distressed and stated that 2-year-old Child P was not breathing. He passed the phone to a female who confirmed that the child had been taken out of the cot and laid on the bedroom floor.
- 3.12 Basic life support was carried out by the paramedics on the way to the hospital where it was confirmed that Child P had died.
- 3.13 A post mortem examination was not able to establish the cause of Child P's death, and the inquest recorded an open verdict.
- 3.14 At the time of death Child P lived with mother, two half siblings and the mother's partner who was not the father of any of the children.

- 3.15 The home conditions were reported to be very poor, unhygienic and potentially hazardous to young children.
- 3.16 This review received concerning information regarding the safeguarding response to Child P's death and the circumstances of the surviving children, who now reside with their mother. Evidence since the death of Child P shows that the concerning situation was continuing, with further house moves, another male in the family's life and continued lack of engagement with professionals. There was no indication that possible sexual exploitation had been addressed. The police were concerned about Child P's mother having an 'unfitting' relationship with a child who had been identified as at high risk of child sexual exploitation.
- 3.17 In the cases of both Child H and Child P it was impossible to conclude that from the circumstances known to agencies the specific circumstances of their deaths could have been predicted.
- 3.18 However, within the two households the concerns, priorities and capabilities of the adults were affected by their own circumstances. This resulted in the conditions that increased the risk of serious incidents or deaths of children not being recognised and acted upon by the adults responsible for their care.
- 3.19 Both households attracted the concern of agencies because of neglect. Improving the quality of life, health and development of children living in circumstances of neglect is important whether or not there is a risk of death or other serious incidents.
- 3.20 The Children Social Care Report correctly asserts:

*"Although, Child P's death is not attributed to any action by the Local Authority, (or any other agency or professional) there were a number of opportunities for agencies to take appropriate and timely action to safeguard Child P (and the two siblings)."*

3.21 And:

*"Whilst we cannot say whether Child H's death was or was not preventable we can say that a robust assessment would have provided a better picture of the children's developmental needs and parents' capacity to meet them. This in turn would have provided a solid evidence base for decision making and planning."*

## 4. Key Episodes: Child H

The review highlighted the following as the key episodes in Child H's case during the scoping period:

### 4.1 Antenatal Period

- 4.2 Antenatal care was considered routine, one feature being that Child H's mother received smoking cessation support. Whilst the GP records show Child H's mother took medication for depression during this period this information was not shared with the Health Visitor. When asked by the Health Visitor, Child H's mother gave no information suggesting she suffered from mental ill-health. She also failed to provide urine samples for routine tests. This was not proactively addressed and is not unusual. Routine testing would not reveal substance misuse unless the samples were sent elsewhere for analysis, although some

mothers may think it would. Health Visitors described Child H's father as uncommunicative, and that he had a "concerning medical history."

- 4.3 This is a key episode because it raises information sharing issues and provides a context for the referral which led to Children Social Care becoming involved.

#### **4.4 Referral leading to Children's Social Care Involvement**

4.5 Concerns were raised with Children Social Care by the owner of the property in which the family lived in Winter 2014. She reported poor home conditions, adult cannabis use and poor child care and described the property as "untidy" with no beds, and only 1 mattress. Two social work visits followed. The first confirmed the concerns. The second identified that the cluttered home conditions had improved. The mother mentioned her depression. Children and Young Persons Assessments were completed, although these produced identical assessments for each child.

4.6 Child H's mother reported that due to breathing related concerns, she took Child H to a doctor's surgery. She told police this was because Child H was becoming breathless during feeds. She stated being told that Child H had bronchitis, a chest infection and conjunctivitis.

4.7 Children Social Care involvement ended in early February 2015 when the case was closed with an expectation that an assessment under the Common Assessment Framework would be carried out. There was lack of formality and planning for this process and it did not take place. Some agencies believed it was to be undertaken by the Health Visitor and reports suggest it was proposed to involve the Children's Centre. There is no evidence of a "step-down" process being followed or of a lead professional taking this forward.

4.8 This is a key episode because it shows the level of agency activity in the period prior to Child H's death. The review considered whether there were opportunities within this period to recognise increased risk around Child H or to provide additional services to the family.

#### **4.9 Child H's death**

4.10 When Child H was found not to be breathing, parents called an ambulance. Upon arrival at the Accident and Emergency Department it was confirmed that Child H had died.

4.11 The Ambulance Service notified the Police and Children Social Care. The two agencies visited the family home and recorded in some detail the appearance of the property. In the Children Social Care Report, the team manager's opinion was recorded that the home conditions were significantly worse. Child H's half sibling, had been sharing a bed with the parents. The paternal uncle was sleeping in the sibling's bed. Child H had been sleeping in a bouncy chair. There was evidence of cannabis use.

4.12 This is a key episode because the agencies' responses to Child H's death and the safeguarding measures taken were considered by this review.

## 5 Key Episodes: Child P

The review highlighted the following as the key episodes in Child P's case during the scoping period:

### 5.1 Child P's Early Babyhood

- 5.2 Before Child P's birth, Children Social Care had been involved with the family due to two domestic abuse incidents and concerns about non-attendance for appointments. When Child P was only a few months' old, the Emergency Duty Team received information that an external family member had appeared in court in relation to sex offences. Child P's parents assured social workers the individual was not having contact with any of the children.
- 5.3 Also during this period, the Health Visitor saw two men leaving the family home. After this, the Health Visitor made 2 unsuccessful visits and requested a joint visit with the social worker. Children Social Care responded that they were unable to become involved on the basis that they understood the Health Visitor's concerns to be primarily around the family's failure to register with a GP or to have immunisations, neither of which are compulsory.
- 5.4 This is a key episode because it shows the information that was known to services in the early part of Child P's life and provides a context for the next period in which concerns escalated.

### 5.5 Escalating Concerns leading to an assessment

- 5.6 When the children were observed during a hospital appointment at the start of this period, this prompted an enquiry from the hospital to Children Social Care as to whether Child P's older sibling was subject to a Child Protection Plan. The children were observed to be "grubby" and an "uncle" was with them.
- 5.7 Within a month of this, the Health Visitor referred the case to Children Social Care. She had seen unknown males at the house. This led to the case being allocated for initial assessment. A Social Worker visited during each of the next two months. A decision was made by Children Social Care that there were no concerns and thus no further role for the service.
- 5.8 Over the next two months two anonymous referrals were made to Children Social Care about the children's welfare. Two Social Worker visits followed and a Child in Need Plan was recommended.
- 5.9 This is a key episode because the initial assessment conducted of the family circumstances was the first in Child P's lifetime and at the time it concluded there was no role for Children Social Care. It is significant that immediately after this, two anonymous referrals were made to Children Social Care.

### 5.10 Child in Need Plan

- 5.11 At the beginning of the Child in Need Plan period Child P was admitted to hospital due to vomiting. The consultant queried the mother's understanding in terms of how to feed Child P appropriately. The first Child in Need meeting followed quickly after this admission. During this meeting, Child P's mother was observed to be defensive, and not accepting of professional concerns.

- 5.12 6 weeks later the Children's Centre Worker queried possible lack of attachment between Child P and mother. However, at this time the next Child in Need meeting was cancelled due to health professionals being unable to attend.
- 5.13 A few days later consideration was being given to closing Child P's case as the mother's partner had been sentenced for kidnapping. On the same day, the Midwife reported Child P's younger sibling had been born and queried whether the mother and baby could return home. The Social Worker responded that there were no safeguarding concerns. The case was subsequently closed to Children Social Care.
- 5.14 This is a key episode as it shows the fast progression from Child P being treated as a Child in Need to professional opinion being that there were no safeguarding concerns and the case being closed, which seemed to be driven by mother's partner being sentenced to imprisonment.

### **5.15 Intervention Following Child P's Second Seizure**

- 5.16 When 16 months old Child P was taken by ambulance to hospital having had a seizure. The mother discharged Child P against medical advice because the siblings had been left at home with a male she did not know very well. The ambulance staff had been concerned about the conditions they observed in the family home. Also at this time information was received by Children Social Care regarding the unsuitability of another mother who was caring for Child P's two siblings. A social work visit revealed the house smelt strongly of urine but had been cleaned up by two maternal family members.
- 5.17 A month later an anonymous contact reported that Child P's mother had been witnessed slapping and dragging an older sibling along the road. Then a month after that two separate reports of concern about the children's welfare were received from sources close to the family. Two Children in Need meetings were held and a third cancelled as the mother refused to attend. The mother was engaging with the Children's Centre, Health and Housing and this led to the case being closed.
- 5.18 This is a key episode because the chronology shows an escalation of concerning evidence and two meetings having taken place at which there was an opportunity to stand back and consider the case/the evidence but the case was closed.

### **5.19 Threats to Kidnap**

- 5.20 Threats were made to kidnap the children. It was initially thought the threats were made by their mother's current and previous partner. Police requested a child protection conference as the appropriate course of action. However, in Children Social Care, the team manager recommended instead that a home visit should take place. The mother refused to disclose key information, suggesting it may have been other members of the family who made the threats and suggested she was safe as she had moved address. However, the new address was only 2 minutes' drive from the old address.
- 5.21 In February 2015, a neighbour reported numerous visitors to the family home and that the children had been heard crying at all times of the day and night. An unannounced visit revealed "no concerns" for the children. However, recording made subsequently described the social worker discussing with the mother having observed Child P's younger sibling "in the dog bowl", Child P's hand down the toilet and that the mother

had been harbouring a male wanted by the police. There was no evidence within recording that this was considered further.

5.22 During mid-April, the decision was made within Children Social Care to close the case.

5.23 This is a key episode because there is evidence that police recognised that the risk was escalating to the extent that the case should be considered as a child protection case but Children Social Care disagreed.

## 5.24 Child P's Death

5.25 Two days after the case was closed a man called an ambulance in respect of Child P who was reported to have been found dead in a cot.

## 6 Analysis by Themes

### 6.1 Assessments

6.2 In the two cases, a number of "Initial Assessments" were carried out by Social Workers and there were other circumstances that should have generated an assessment.

6.3 In Child H's case, the assessment completed for each of the children was identical, mainly making reference to Child H's half-sibling only or "the children". Also, it was adult focussed. Observations were recorded and although it is clear that the Health Visitor was spoken to there is nothing recorded regarding immunisations, attendance at appointments or whether Child H was meeting milestones. Furthermore, Child H's assessment provided a snapshot of the concerns and focussed specifically on the referral reports about the state of the property. "Family and Environmental factors" was the most detailed part of the assessment and was "cut and pasted" from recordings of the two visits to the family.

6.4 There were two occasions in which Child P was treated as a Child in Need when formal assessments should have informed plans.

6.5 The concept of the "Cumulative error" appears to have had a role in the shortcomings in these assessments. Each single factor in the chronology compounded the last so that the risk was multiplied, heightening the risk of severe harm.

6.6 The Children Social Care Report reflected that "there is a need for social workers and managers to go back to the basic principles of child protection work."

6.7 Research has emphasised<sup>2</sup> that assessments must be on a 'child by child' basis and must include a formal assessment of the parents' *capacity to change*. To understand the failure to provide safe, adequate and consistent standards of care requires interviews, observation, standardised measures, use of previous reports, and information from multiple informants. There is no recorded evidence that this approach was taken in either case.

6.8 In both cases the ability of parents to understand, and respond to, professional concerns was overestimated.

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<sup>2</sup> Social work assessment of children in need: what do we know? Messages from research Turney, Platt, Selwyn and Farmer, School for Policy Studies, University of Bristol; DFE Research Brief (March 2011)

6.9 There is no evidence that published materials<sup>3</sup> were considered or informed the assessment processes carried out or that if the staff had received training that the training informed practice or management of the cases.

6.10 Assessments were not timely and did not consider all that was known about the child and family; they were not informed by the child (age appropriately) and all those involved in the child and family's life. An analysis was lacking which made sense of what all the information gathered meant for the children in each case, identifying their needs and what needed to change or remain the same to improve their outcomes. As well as not being completed and authorised within an appropriate timescale, some assessments were insufficiently robust in that they failed to provide an evidence base for decision making that ensured the child's welfare was the focus.

### 6.11 Family History

6.12 The importance of understanding the family history has been reinforced by various publications of lessons from review processes and tools designed to assist with the process of assessment.<sup>4</sup>

6.13 Adults related to and involved with the children had histories of serious and persistent criminal activity involving drug abuse and violence but the impact of this on family functioning and prospects for the children was not included in assessments. Issues relating to the disclosure of police information and that held by the Probation Service are covered elsewhere in this report. Also, Child H's parents told the Pathologist that Child H's father's family "were known to Children Services previously." There is no evidence that this history was considered.

6.14 As a child, Child P's mother had been looked after by the local authority, but there is no evidence that her history or records were accessed and considered and this fact was not known or shared with the Health Visitor at any point. The Health Visitor became aware of it even though it was not documented in the main body of the record. Records show Child P's mother had a relationship with Child P's father as a child, but no ages were stated. It is not clear what is meant by this statement and this notification is not analysed in the main body of the records.

6.15 There is no evidence of the analysis of the lack of consistency in the lives of Child P and the siblings due to the numerous house moves and numbers of males being present short or long term in their lives.

6.16 The Police Report includes information held about the background of Child P's mother in relation to a background of committing violent offences, criminal damage and theft and regarding her diagnosis of attention deficit hyperactivity disorder. She had lived with her mother and step-father whose relationship was turbulent, characterised by several incidents of aggression and assaults, the first of which took place in her teenage years. She had lived in a Children's Home. In addition, there had been 73 recorded incidents involving the mother at various addresses during the scoping period, with numerous other logs and intelligence reports.

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<sup>3</sup> For example: DCSF Research Report RR023 (2009), OFSTED 'In the Child's Time: Professional responses to Neglect' March 2014, DFE 'Assessing Parental Capacity to Change When Children Are on the Edge of Care' June 2014

<sup>4</sup> For example: Analysing child deaths and serious injury through abuse and neglect: what can we learn? a biennial analysis of serious case reviews (DCSF Research Report RR023 (2009)), Reder and Duncan in *Lost Innocents: A Follow-up Study of Fatal Child Abuse* (Routledge. (1999))

- 6.17 There is no evidence that any of this family background was considered in any assessment process undertaken.
- 6.18 There was no evidence within the GP records that any formal assessment of either family was undertaken. Furthermore, there is no evidence in health records to indicate whether or not primary health care professionals were contacted to contribute to assessments.
- 6.19 Although it became clear after the deaths of the children that both families were previously known to Children Social Care this was not evident within the GP records. There is no documented account of any telephone calls from Children Social Care to gather any information from the GP practice. Also, there are no Child in Need plans or references to referrals within the notes.
- 6.20 In the GP's records, there was significant information regarding the mental ill-health and disabilities and difficulties in functioning of both mothers and drug use and the men involved.
- 6.21 Mental Health issues are covered specifically in other sections of this report.
- 6.22 The weaknesses identified in these cases are indicative of poor standards of practice within Children Social Care in general, as reflected in the Children Social Care Report recommendations regarding various forms of refresher training. However, the findings are more far reaching across other agencies.
- 6.23 The Children Social Care department does appear at this time to have lacked an awareness of the personal responsibility that social care workers have for their own professional development and for ensuring that they are equipped with the knowledge and skills to carry out their duties.

#### 6.24 **Complexity**

- 6.25 Cases involving child neglect are complex. In these cases, a combination of concerning circumstances brought together neglect of health, poor home circumstances and arrangements for care, domestic abuse, lack of cognitive ability, skills and motivation, drug misuse, mental ill-health, and deceitful, manipulative and collusive adults which added to the complexity.
- 6.26 The agency report writers found and reflected in their reports and in the discussions at the Learning Events that the complexities were not recognised and that the processes did not operate to bring together the information and knowledge held by individual practitioners – the familiar weakness of failing to understand the bigger picture.
- 6.27 Complexity of cases will only be understood and plans and services effective if information sharing, response to concerns, assessments and interagency processes operate to identify the relevant issues and analyse and evaluate the information with a focus on the impact on the children.
- 6.28 Child P's case was the more complex of the two. The length of time over which concerns persisted and the opportunities to understand the reasons for concern and respond were greater.

- 6.29 A further question from the terms of reference concerned evidence of use of a genogram to understand the complexity of the families.
- 6.30 There was no evidence of any agency preparing a genogram in either case individually or as part of interagency processes.
- 6.31 For the purposes of the review genograms were prepared setting out the relationships of people close to both the children who had died.
- 6.32 In both cases a genogram was important to understand the relationships between adults involved in the lives of the children.
- 6.33 During the review of Child P's circumstances, the genogram clarified the number of men involved and uncertainty and deception that had occurred about who were the fathers of each child and the roles and impact of members of the very extended family.
- 6.34 The Health Visiting and National Probation Services have recommended their future use.
- 6.35 In discussion, the author of the Children Social Care Reports stated that it was now understood that the Information Technology systems within Children Social Care can easily generate a genogram in a case. There is now an expectation that a genogram will be compiled and updated in every open case. This recommendation could be improved by an audit after 6 months within Dudley Children Social Care Services to ascertain whether the expectation that a genogram should be prepared and updated has been met and a report on the conclusions made to Dudley Safeguarding Children's Board.
- Recommendation 1.** Comments regarding genograms are equally applicable to other agencies involved in safeguarding children.

### 6.36 Fathers and Males

- 6.37 A large number of high profile child abuse reviews beginning in the 1980's refers to the lack of engagement with fathers and other males and the fact that in the main, assessments and planning focus on a mother's parenting capacity and place the onus of changing the situation on the mother - even when it is the father/partner whose behaviour has caused or contributed to the concerns.
- 6.38 The Overview Reports published in 2013 concerning the deaths of Daniel Pelka<sup>5</sup>, Keanu Williams<sup>6</sup> and Hamzah Khan<sup>7</sup> all addressed the "invisibility" of males in the assessment and planning process and the importance of having the "whole picture".
- 6.39 Assessments in Child H' and Child P's cases failed to recognise the importance of understanding the background, influence and impact of the men in the mothers' lives, rendering them flawed. At the Learning Event, it was suggested that this was a cultural norm across agencies in Dudley at that time.
- 6.40 Within GP records there was no reference to fathers or mother's partners within the children's notes in either of the cases. Child P's mother had 9 known partners in 4 years and had 3 children by 3 different partners in 3 years including the fathers of 2 of the children being closely related.

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<sup>5</sup> Coventry Local Safeguarding Children Board (2013).

<sup>6</sup> Birmingham Safeguarding Children Board (2013).

<sup>7</sup> Bradford Safeguarding Children Board (2013).

- 6.41 There were also in health visiting records references to home visits when unknown males were in attendance at the property but no evidence of this being discussed. The potential for sexual exploitation of mother and the impact on the children was not analysed.
- 6.42 The Police held extensive histories regarding 5 men with close associations with Child P's mother.
- 6.43 The mother's partner at the time of Child P's death had a lengthy history of involvement with Police from 2001 onwards. He had 19 convictions from 30 offences and 2 cautions, which relate to assaults, public disorder, theft, drugs and offences relating to court/police/prison.
- 6.44 At the time of Child P's death, this man was living with the mother and her children, having recently been released from prison after a short sentence for theft.
- 6.45 During a police inquiry Child P's mother asserted that she was safe because she had a "new partner everyone is afraid of".
- 6.46 The Police had information about drug use by Child H's mother's partner and a close relative living with them. However, no link was made between Child H's mother and the information about these males. This was also an issue for information held by GPs involved in the case. The GP Communication Policy is "work in progress". An Information Sharing Agreement is being established with every GP practice. Clearly this would only have helped in Child H's case if the adults had been linked with Child H.
- 6.47 At the Recall Event, it was clear that apart from the Police, the background of these men was largely unknown and did not inform assessments or the work involved in the cases. The Police Report accepts that there was a significant under-recording of child protection concerns which resulted in limited information sharing with partner agencies. Action has been taken by West Midlands Police to ensure children's welfare is a priority whatever the area of activity undertaken by the police.
- 6.48 There was no attempt by Children Social Care to access information about the men during assessments and interagency processes. This gap led to links with important networks being missed, such as police offender managers, substance misuse services or adult social care.
- 6.49 It was also important for staff visiting the households to be aware of risks to their own safety.
- 6.50 At the Recall Event, it was acknowledged that there was insufficient curiosity about these men and their relationships to the children.
- 6.51 In health agencies discussions have led to work being done to review process prompts to inquire "about consanguinity" at pregnancy booking appointments and to address lack of enquiry by GPs.
- 6.52 Improvements that have taken place in Children Social Care in assessment processes should address the issue. The interest in men, their backgrounds and impact on children's lives was a more general issue of culture at the time and forms part of the Back to Basics work discussed in Section 7.

### 6.53 Information from Relatives, Neighbours and the Community

- 6.54 Assessments in both cases failed to identify why the households were chaotic or why on occasions conditions improved. Without this understanding plans were likely to be ineffective.
- 6.55 Close relatives of Child P contacted Children Social Care with serious concerns about the children and wished not to be identified. It was suspected by a Social Worker that these may have been the same relatives that cleaned up the household. They were assumed to be a resource available to mitigate the weaknesses of the mother.
- 6.56 Other Serious Case Reviews involving chronic neglect and serious incidents of maltreatment have warned against placing reliance on close relatives without speaking to them alone and thoroughly assessing their ability or willingness to be relied upon to mitigate the neglect or to blow the whistle in the event that circumstances deteriorate.
- 6.57 Assessing the potential should include researching their family and medical histories. Relatives involved in Serious Case Reviews have stressed how difficult they find it to report on their daughter or granddaughter or to express reservations at interagency meetings when the mother is present. Frequently no-one had spoken to them alone about these issues.<sup>8</sup>
- 6.58 There is no evidence that in Child P's case assumptions about the contribution actual or potential of close relatives tested. At the Recall Event, it was emphasised that in fact one relative had 2 carer jobs.
- 6.59 In November 2012, the Emergency Duty Team received information that an extended family member had appeared in Court in relation to sex offences. Between December 2012 and January 2013 three letters were sent to the mother inviting her to the Children Social Care office to discuss this. She did not respond or attend any of the appointments. (We refer in paragraph 6.175 to the information given at the Learning Event that the mother has great difficulty reading.)
- 6.60 Three months later the Team Manager decided that a home visit should be undertaken. The mother and an adult man present said that the extended family member had no contact with the children and the charges had been dropped. The Social Worker recorded that no concerns were identified. She felt that both had been open and honest with her. No further action was required and the case file was closed. No action was taken to check the accuracy of the responses.
- 6.61 In the event, the adults had misrepresented their relationship and the identity of the extended family member. The charges had not been dropped and the male relative was subsequently convicted and imprisoned. No assessment took place on the risks to the subject children or others in the community.
- 6.62 The Children Social Care Reports robustly acknowledge the weakness throughout in assessment and enquiry processes which raise questions about the practice in other cases.
- 6.63 We agree with the recommendations in the Children Social Care Report intended to address these weaknesses in basic practice.

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<sup>8</sup> See for example Executive Summary of Overview Report of SCR Concerning Children M1 and M2. Bridgend LSCB. 2010.

6.64 In Child H's case, a member of the community contacted Children Social Care about conditions in the property led to inter-agency consideration of neglect. A visit by the Social Worker found that conditions had apparently improved in the two weeks it took the member of the community to make contact with Children Social Care. However, no further contact was made with the member of the community to check out the assumptions that were made following this visit or to ascertain whether there was any additional information.

6.65 The Children Social Care Report comments that:

"The response from Children Services was timely a home visit took place within 24 hours of the referral. However, the intervention was ineffective as the failure to undertake a robust assessment resulted in what in the author's view was a poor outcome for the children."

"It is likely in light of what the mother reported during the first assessment visit that if the member of the community had referred the concerns when the visit was made to the property two weeks prior, that a Child Protection Enquiry would have been initiated."

6.66 During the Social Worker's visit the mother and her partner were angry stating that they believed a named relative had made the referral as he had threatened to do so. However, there was no enquiry into what might have influenced the relative to threaten this action.

6.67 We discuss the inadequacy of assessments in Section 6.1.

6.68 In Child P's case relatives contacted Children Social Care with concerns about the children and state of the premises but wished to remain anonymous. On several occasions Children Social Care received information anonymously from individuals in the community expressing serious anxiety about the welfare of the children. Sometimes it was suspected or known who was likely to be the referrer. They concerned serious allegations and were clearly from individuals with knowledge of the circumstances and activities in the property.

6.69 These concerns were not pursued with any rigor and elementary steps to enquire were not undertaken. When the identity of the referrer was known no feed-back or checking of factual issues or conclusions following assessments took place. Although the reasons for this are not recorded, the impression is given that because they were anonymous or from a family member or likely to be from neighbours, the accuracy was in doubt and they were more likely to be malicious.

6.70 Evidence and experience suggests that this is not likely to be the case. While some malicious complaints may be made when there are already concerns about the welfare of children such contacts are more likely to understate concerns and express them sufficiently to generate some action. They may make tentative contact or report minor issues, to generate inquiry when actually, more serious issues are occurring.<sup>9</sup>

6.71 In any event, the motive for making and the source of a referral should not impact on the thoroughness of the inquiries.

6.72 The importance of considering the relevant information known to the community has been increasingly emphasized following high-profile reviews and research dating back to 2003.<sup>10</sup> Reports of Serious Case Reviews, Domestic Homicide Reviews, Child Practice Reviews

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<sup>9</sup> Proceedings of a Symposium on risk assessment in child protective services National Centre of Child Abuse and Neglect Cicchelli (1991)

<sup>10</sup> Report of the Climbié Inquiry (2003); Executive Summary of Overview Report of Serious Case Review of Concerning Children M1 and M2: Bridgend Local Safeguarding Children Board (2010); Overview Report of Serious Case Review: Hamza Khan; Bradford Safeguarding Children Board (2013); Overview Report of Serious Case Review: Daniel Pelka; Coventry Safeguarding Children Board (2013); Overview

and research confirm that even when neighbours or other members of the community do contact child protection agencies often the information they share is given a low status and the importance is downgraded.<sup>11</sup>

6.73 In 2012 a substantial research study into social care provision for children, provided “a rare insight into the experiences of neglected children” over a period of five years, examining the responsiveness of parents and children to social care support and their progress. The researchers commented that:

“It was noticeable that referrals from neighbours and relatives were often discounted or ignored.”<sup>12</sup>

6.74 Working Together to Safeguard Children 2013, which was current at the time these cases attracted concern, repeated guidance<sup>13</sup> in previous versions which is reproduced in Working Together 2015:

19. Anyone who has concerns about a child's welfare should make a referral to local authority children's social care. For example, referrals may come from: children themselves, teachers, a GP, the police, health visitors, family members and members of the public.

21. Feedback should be given by local authority children's social care to the referrer on the decisions taken. Where appropriate, this feedback should include the reasons why a case may not meet the statutory threshold to be considered by local authority children's social care for assessment and suggestions for other sources of more suitable support.

6.75 Earlier versions of Working Together to Safeguard Children spelt out that:

“In the case of public referrals, this should be done in a manner consistent with respecting the confidentiality of the child.”

6.76 Statutory regulations and guidance prohibit some decisions concerning Children Looked After by the local authority being taken without considering relationships with adults who are not members of the household but likely to have regular contact with the child and the nature of the neighborhood in which the home is situated and resources available in the community to support the child and parent.<sup>14</sup>

6.77 At the Learning Event, a Team Manager was very clear that she would not expect social workers to contact neighbours during enquiries or assessments or to go back to them following a “referral”. This appeared to be a widely held approach to practice.

6.78 It is important that when enquiries and assessments are being carried out there is careful identification of what needs to be known and how to source of that information. Where that source might be a neighbour or other member of the community rather than a professional

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Report of Serious Case Review: Child T (Poppy Widdowson) North East Lincolnshire Local Safeguarding Children Board (2017); What research tells us: Dr Karen Broadhurst, Professor Sue White, Dr Sheila Fish, Professor Eileen Munro, Kay Fletcher and Helen Lincoln (2010);

<sup>11</sup> Effective Working with neglected Children and Their Families – Linking Interventions to Longterm Outcomes: Elaine Farmer and Eleanor Lutman (2012; Jessica Kingsley) Farmer and Owen 1995; Munro 1996; 1999)

<sup>12</sup> Case management and outcomes for neglected children returned to their parents: a five-year follow-up study: Elaine Farmer and Eleanor Lutman, School for Policy Studies, University of Bristol; Research Brief DCSF (2010)

<sup>13</sup> Working Together to Safeguard Children 2013 Chapter 1: Assessing need and providing help: Paras 19 and 21; HM Gov.(2013)

<sup>14</sup> See for example: Provision for different types of placement - decisions to place a child subject to care order with a parent: para 18 and Schedule 3 Part 4. The Care Planning, Placement and Case Review (England) Regulations 2010.

it is inappropriate to practice on the basis that they will never be approached by any professionals.

6.79 This is therefore an area that has attracted careful consideration by the Board of guidance, procedures and training arrangements to ensure that the legal obligations and principles concerned with carrying out enquiries and reaching sound judgments are met.

6.80 It is recognised by Dudley Safeguarding Children Board partners that for any agency only to have regard to such information only when by chance those with the information report it, is inappropriate, and that on occasions it might be necessary to proactively approach possible sources of information held by relatives or members of the community.

6.81 This is a skilled area of practice that requires care in its application, taking account the implications and likely impact on children, families and professionals and the form and extent of such enquiries must be considered on a case by case basis, considering principles of confidentiality, data protection and proportionality.

6.82 In Dudley, a Multi-Agency Safeguarding Hub has been established and the approach to these issues in individual cases referred into the Hub can be discussed and agreed. The appropriate practice can also be addressed within supervision.

6.83 Clearly, where members of the community or relatives hold information that should reasonably be reported to agencies, it is preferable that they recognise that they have a responsibility and make such a report.

6.84 An emphasis of the recently published Government Advice on Child Sexual Exploitation has encouraged making links with communities so that those who do not necessarily "work with children" also make a contribution to tackling child sexual exploitation.<sup>15</sup>

6.85 Considerable work has been done in Dudley to address communication with the public and encourage members of the community to take an active interest in safeguarding.

#### **6.86 Common Assessment Framework**

6.87 Professionals across all agencies during discussion agreed that during the scoping period and still at the time the practitioner events took place in 2016 there was a lack of robust understanding and elements of confusion regarding the Common Assessment Framework. It is understood that work undertaken by Early Help will help to resolve this.

6.88 Children Social Care closed Child H's case expecting that a Common Assessment Framework involving the Children's Centre would be carried out. The dynamic between one agency recommending that another undertakes a Common Assessment Framework was discussed at some length as part of this review. This revealed that the lack of a robust process around Common Assessment Frameworks was an issue for this review.

6.89 A Common Assessment Framework had been recommended in January 2015 but this had not been progressed by the time Child H died. There is no evidence in the GP records that a Common Assessment Framework was due to be undertaken which would suggest that the GP had not been contacted for any information.

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<sup>15</sup> Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation; Department for Education (February 2017)

- 6.90 There was no evidence of a step-down process being followed, nor of a lead professional taking forward the Common Assessment Framework process.
- 6.91 At the Recall Event, a discussion took place about the Common Assessment Framework (replaced with Early Help Assessment) arrangements which were said to be insufficiently robust with a lack of clarity about who is to be involved, who is the lead professional to drive it forward and what are the expected timescales. There is poor administrative support. A central team with responsibility to monitor these assessments did not receive information about all those carried out.
- 6.92 An audit of Common Assessment Frameworks was carried out 18 months prior to the Learning Event but inquiries about this indicated that the work had not progressed as the Quality Assurance officer had since left the authority. An audit has since been carried out relating to Early Help Assessments. It is hoped that the development of Early Help services and support will ensure and secure significant improvements.
- 6.93 A single agency report recommendation suggested "For all practitioners to assess home conditions using a recommended tool to be utilised across all agencies." We have been informed that training on the Graded Care Profile has taken place, was well attended and at the time of publication has been implemented across the partner agencies in Dudley.

#### 6.94 **Neglect**

- 6.95 In both cases concerns arose because of chaotic and poor conditions within the homes and neglect of the children's welfare. The recognition of the need to address neglect was reflected in the approach taken to both cases and the work undertaken.
- 6.96 Working with neglect and achieving significant improvements is difficult. The concerns in Child P's case were chronic and in both cases the involvement of agencies brought about only short-term improvements with no change in the underlying circumstances. The circumstances of the deaths of the two children could not have been predicted but the likelihood of serious incidents occurring is greater in neglectful households.
- 6.97 The adverse consequences of neglect are well understood and there has been a significant body of research and guidance published. This learning has informed the process of the review and the identification of themes.
- 6.98 In Child P's case decisions were made to close the case without consideration as to whether the risks to the children had been minimised and whether it was safe to do so. One hypothesis raised by current Children Social Care staff was that workers over identified with Child P's mother, and continued to view the mother as a Looked After Child. Child H's case was also closed prematurely.
- 6.99 Plans in the two cases failed to require workers to maintain a focus on the child and their needs throughout assessments and interventions. The children were not given a voice, and there was no evidence that their behaviour and interactions with others was observed. Such a focus would have improved understanding of the impact of neglectful care on their lives and potential and it would have provided a benchmark for measuring progress. The consensus of practitioners across agencies was that this weakness reflected a culture that prevailed across agencies at that time.
- 6.100 The reports confirmed that although there were occasions on which physical descriptions of the children were made by practitioners there was little comment on the

children's presentations, their interaction or demeanour, which may have contributed to an understanding of what life was like for them or how adults were interacting with them.

- 6.101 There was little analysis of what was observed or the impact of actions undertaken in response. Essentially, the voice of the child in both cases was either not heard or, if/where it was heard, it was given insufficient weight.
- 6.102 In Child P's case, there was no analysis of the impact of the mother's relationships on the children nor any analysis regarding the males with responsibility for parenting.
- 6.103 Child P's mother disclosed that her current partner had been sentenced to imprisonment for 2 years. There is no indication that this prompted any consideration of what the impact would be for the children in the household.
- 6.104 During supervision meetings with Social Workers and their managers when decisions were made to close a case, there was no reflection or consideration of the impact on each child or clarity about how risks had been minimised. Assessments did not focus on individual children.
- 6.105 The Police Report concerning Child P comments that contact with the mother by police officers lacked a child-focussed approach and consideration of the effect that individuals or the circumstances of incidents may have had on the children.
- 6.106 Following an inspection by Her Majesty's Inspectorate of Constabularies which highlighted a lack of awareness by officers regarding the importance of considering "the voice of the child", action was taken by the force. Officers were provided with training in respect of their role in the safeguarding of children and there have been numerous training packages and force initiatives recently to increase the knowledge of West Midlands Police staff around child protection issues. Encouragingly, it was reported at the Recall Event that there has been training arranged specifically for staff working within the Intelligence Department to emphasise that they "must think children".
- 6.107 The interagency processes, which in the case of Child P included Child in Need meetings, failed to focus specifically on the impact on the children and what was necessary within appropriate timescales to impact on the adverse consequences.
- 6.108 Discussions at the Learning Events confirmed that despite the considerable activity and obvious concern among professionals there was little evidence of focus on the experiences of life and the impact of their environment for the individual children or of what life was like for the children 24 hours a day, seven days a week and the likely impact of the neglect upon them in the short and long term.
- 6.109 Discussion with the author of the Children Social Care Reports suggested that the documentation in place to support practice and provide triggers to ensure relevant issues receive attention is adequate and does require consideration of individual children. However, unless there is a clear understanding about the purpose and importance of those triggers the documentation will become an administrative requirement rather than an aid to ensure good practice.
- 6.110 The Children Social Care Reports address poor case recording and the need for refresher training for social workers on Child Development.
- 6.111 Many of the common weaknesses in working with neglect that have been highlighted by research were evident i.e. failure to gather information about the family's past history,

their relationships and functioning, viewing each concern in isolation, not maintaining up to date chronologies, and the "rule of optimism" each played a role.

6.112 An Ofsted thematic report of evaluations of reviews published in 2011 found that practitioners underestimated the fragility of babies<sup>16</sup> and emphasised the need to reflect that vulnerability to very serious harm through inter- and intra-agency processes and communication.

6.113 In March 2014 Ofsted published "In the child's time: professional responses to neglect". One of its key recommendations was that Local Safeguarding Children Boards should ensure that the training provided for front-line practitioners and managers enables access to contemporary research and best practice in working with neglect.

6.114 This is reinforced by the requirement in Working Together to Safeguarding Children 2015<sup>17</sup> that Social workers and managers should always reflect the latest research on the impact of neglect and abuse and relevant findings from serious case reviews when analysing the level of need and risk faced by the child. This should be reflected in the case recording.

6.115 Whilst Dudley Safeguarding Children Board did disseminate the OFSTED recommendations, there was no evidence of a clear steer on the actions required to ensure improvement in practice and then to test the impact of this. There is no evidence that the body of knowledge regarding the impact of neglect or the practice and management skills required were considered or applied in either of these cases.

6.116 Information Technology resources make it easier now than at any time to ensure that practice is underpinned by consideration of research and Serious Case Review findings. In 2015 the University of Huddersfield established a Web-Based Register of all completed and ongoing child protection research in the UK.<sup>18</sup> The NSPCC Library has copies of all Serious Case Review Reports published and will also undertake literature searches. Local Safeguarding Children Boards must now make readily accessible on their websites Reports of Serious Case Reviews for a minimum of least 12 months.<sup>19</sup>

### 6.117 **Neglect Strategy**

6.118 Clearly the absence of an overarching plan or Neglect Strategy within the scoping period is significant in these cases. It would appear from records that the Dudley Safeguarding Children Board was aware there was a gap across the staff groups of the understanding of indicators for neglect and the impact of long term neglect. There was also work within individual agencies to improve understanding of neglect and the response to it, but this was not driven or monitored by the Board.

### 6.119 **What is the current position on neglect strategy?**

6.120 The Board approved a Neglect Strategy in July 2016, the implementation and governance of which is being overseen by the Children and Young People's Alliance.

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<sup>16</sup> Ages of Concern: learning lessons from serious case reviews 2011: A thematic report of Ofsted's evaluation of serious case reviews carried out in England from 1 April 2007 to 31 March 2011.

<sup>17</sup> Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children; Chapter 1: Research and SCR findings. HM Government (March 2015)

<sup>18</sup> <http://www.hud.ac.uk/hhs/research/ukrcpr/>

<sup>19</sup> Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children; Chapter 4 Serious Case Review Checklist. HM Government ((March 2015)

6.121 The new threshold framework was rolled out to practitioners from May 2016. This included information about the Multi-Agency Safeguarding Hub and Single Point of Access which is hoped will improve responses. The Safeguarding Children Board is also receiving data regarding the impact of these new service developments.

6.122 The Board received two audit reports carried out by staff independent of the partnership during 2016 and continues to receive routine performance data regarding contact and referrals to the Multi-Agency Safeguarding Hub. OFSTED monitoring is in place and scrutinises the Multi-Agency Safeguarding Hub as well as other Children Social Care systems and processes.

6.123 Board members collectively and individually will be responsible and accountable for ensuring that this work progresses and that appropriate arrangements are in place to ensure that there is a significant impact on practice.

6.124 The lack of a strategy for neglect and response to recommendations made in previous serious case reviews and national reports and guidance suggest it is likely that weaknesses identified in this review will have been apparent in the approach to other cases. While it is probably impractical and unrealistic to expect that every case involving neglect is reviewed, the Board should take some action to ascertain whether there is a need to take significant action to review individual past cases. **Recommendation 2** The Board has identified neglect in its business plan as a themed area on which to focus and will monitor the implementation of the strategy and periodically undertake case file audits to test the impact.

#### 6.125 **Previous Serious Case Review**

6.126 Two years before the deaths of Child P and Child H, Dudley Safeguarding Children Board and Sandwell Safeguarding Children Board jointly published the Executive Summary of a Serious Case Review carried out by the two Boards concerning the death of Child C. She was an 18-month-old girl who died at home in Sandwell and despite extensive forensic testing, it was not possible to establish the cause of death.

6.127 The key Issues identified in the report arising from the case were:

- Protocols and Practice in Managing Neglect: essential that practitioners use assessments of risk to develop plans that include clear and measurable targets for improvement.
- Role of Partners: no evidence that mother's partner's role in respect of the children was researched or understood by those practitioners. SSCB and DSCB need to satisfy themselves that existing guidance is sufficiently robust in this area and that all practitioners recognise the imperative of engaging male partners in the assessment process.
- Disguised Compliance: despite occasional optimism that Mother was showing signs of improved co-operation and engagement, there was no discernible improvement even in the face of considerable input and activities by professionals.
- Families Who Avoid Professionals: Such situations need to be robustly assessed and given sufficient weight in the findings of assessments.
- Voice of the Child: opportunities to hear the 'voice of the child' were missed and resulted in incomplete assessments.

6.128 The report emphasised the need for improved communication between agencies, thresholds and timing of intervention, implementation of agreed protocols for escalating

unresolved concerns about children and the importance of frontline staff being adequately trained in safeguarding children issues.

6.129 The recommendations accepted by Dudley Safeguarding Children Board included:

*Recommendation 1:*

*That DSCB and SSCB take urgent steps to satisfy themselves that: procedural guidance in the area of neglect is robust and reflects latest research; and the training programme to support that guidance is reaching all relevant personnel.*

*Recommendation 3:*

*That SSCB and DSCB:*

*Review their procedural and practice guidance to ensure that it robustly promotes the participation and engagement of fathers and other male partners in any assessment process; and  
Review their multi-agency training programme to ensure that this issue is adequately promoted.*

*Recommendation 4:*

*That DSCB and SSCB undertake a review of existing guidance in respect of disguised compliance by parents/carers, to ensure it reflects current research. This review should also include an audit of current practice to establish practitioners understanding and compliance with the guidance, and the training that underpins this practice.*

*Recommendation 5:*

*That DSCB and SSCB review existing guidance to ensure that assessments of families who persistently avoid contact with professionals give appropriate weight to that non-compliance. Evidence that guidance is widely known and understood by practitioners should also form part of this Review.*

*Recommendation 7:*

*That DSCB and SSCB commission or undertake quality assurance measures to satisfy themselves that:*

*Existing training programmes adequately emphasise the importance of canvassing the views and feelings of all children, and taking account of that information in safeguarding assessments; and*

*Practitioners across all partner agencies have accessed relevant training in this area and can demonstrate their awareness of its significance.*

The report stressed that:

*“All of these issues have been identified in previous Serious Case Reviews, both locally and nationally, and the challenge is for the two LSCBs concerned to ensure that they become embedded in local practice.”*

6.130 It is very disappointing and of serious concern that the issues arising and weaknesses identified from the review of the deaths of Child P and Child H are so similar to those identified in the Serious Case Review concerning Child C.

6.131 Some staff who attended the Learning Events were aware of and referred to the Child C Serious Case Review but no-one attending was able to identify any steps taken to implement the recommendations.

6.132 However, this review has established that there were clear arrangements for implementing and monitoring the implementation of the Serious Case Review recommendations at the time. There was evidence of monitoring of the implementation of action plans by the Serious Case Review Sub-Group and members of the Safeguarding Children Board. There is also a suggestion that the then Independent Chair of the Board met senior officers to ensure evidence would be provided to demonstrate actions taken for their implementation.

6.133 However, there is no evidence that the lessons from that Serious Case Review and any actions taken to implement the recommendations had any impact on the practice in relation to the neglect of Child P and Child H.

6.134 All partner agencies have individual and collective responsibility and accountability for ensuring that the implementation of recommendations is carried out effectively and that national findings and recommendations are considered and implemented and have the intended impact to improve practice **Recommendation 3.**

#### 6.135 **Sudden Infant Death Syndrome**

6.136 Much has been learnt about why some very young children die suddenly.<sup>20</sup> Babies living in households where drugs are taken, sleeping on their fronts, in very warm rooms, experiencing passive smoking or in beds with adults are accepted as being at increased risk of sudden deaths.

6.137 The Post Mortem Report for Child H highlighted that there were risk factors of "cot death" present – "baby born prematurely, parents smoking and smoking of cannabis and co-sleeping".

6.138 Standard operating procedures for Midwives and Health Visitor's require mothers and fathers to be advised about these risks. Were adequate warnings and advice given by the health staff?

6.139 The written material left with the parents clearly identifies the risks. The records indicate that this was reinforced by health staff in discussions with the mother and the other adults in the household. They stated that smoking took place outside the house. The mother was offered but refused smoking cessation services. The mother was given a thermometer and advised on appropriate room temperatures.

6.140 It is clear that not only were warnings given but they were understood.

6.141 When the mother called emergency services when she found that Child H was not breathing she lied about the circumstances and initially claimed Child H was found in his

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<sup>20</sup> See for example a report on Birmingham cases Investigating Unexpected Child Deaths: An Audit of the New Joint Agency Approach; Garstang, DeBelle, and Auket: Child Abuse Review volume 24, issue 5 (2015) pp 378-384.

cot before being prompted by the male present to “tell the truth”, that is that Child H had been sleeping in bed with the adults.

- 6.142 There is evidence within the post mortem report which suggests it is also possible that the adults misled staff about the extent to which smoking took place in the household. There was small amount of cannabis shown in Child H's blood which may have arisen from passive smoking.
- 6.143 If it had been apparent that a parent had slept with Child H under the influence of alcohol or drugs they may well have been prosecuted.<sup>21</sup>
- 6.144 In December 2014, the National Institute for Health and Care Excellence (NICE) updated national guidance to clarify the association between co-sleeping and Sudden Infant Death Syndrome.
- 6.145 Unfortunately, the guidance and the press release issued by NICE on 3 December 2014 – “Empowering families to make informed choices on co-sleeping with babies” - lacks the directness required concerning such a serious risk. It permits parents to weigh up the possible risks and benefits and decide on sleeping arrangements that best fit their family.”
- 6.146 Parents are therefore to be told they can make an informed decision to expose their infants to increased risk of a premature and unnecessary death.
- 6.147 This is not helpful for community health professionals attempting to impress upon households such as those in which Child H lived the importance of avoiding behaviours that increase risks.
- 6.148 In a survey involving 600 parents 46% said they lied to their GP or Midwife or Health Visitor about whether they “co-slept” with their babies.<sup>22</sup> **Recommendation 4**
- 6.149 At the Recall Event, there was discussion about whether there should be more and stronger advice given locally to parents when a baby is discharged following birth and thereafter. Practitioners discussed whether a leaflet could be provided specifically on these issues. Also, the importance was noted of recording not only that advice was given but that so far as possible that the reasons underpinning the advice were understood where applicable.
- 6.150 Factors such as depression, mental ill health and learning disabilities may influence the practice and suggest a need for repetition and emphasis. Amendments made recently to ‘The Red Book’ which is left with parents at their home contain a requirement that Health Visitors undertake a safe sleep assessment. This was not a requirement during the scoping period for Child H, although formed part of best practice. In Child H's case, the family's change of GP resulted in a new Health Visitor assuming the previous one had undertaken this assessment. We welcome that agency's recommendation to audit whether the red book's new requirement is being implemented robustly.
- 6.151 There was general agreement that professionals can only give advice and monitor the circumstances. The responsibility is that of the parents. Both written and verbal indications from staff involved in Child H's case suggest there was no evidence available to staff to

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<sup>21</sup> Children and Young Persons Act 1933 s1(2)(b)

<sup>22</sup> Reported in Sunday Times 13 March 2016

suggest that the adults would have deliberately disregarded the advice they had been given.

### 6.152 **Cannabis Use**

6.153 The adults close to Child H and to Child P used cannabis.

6.154 There appears to be a weak association between drug use generally and Sudden Infant Death Syndrome particularly in the context of co-sleeping, but very little specifically relating to cannabis.<sup>23 24</sup>

6.155 But what might be the impact on the welfare of children in a household in which drugs are routinely misused, where dealing might also take place, particularly in the context of concerns about the neglect of the children?

6.156 Research is clear that parenting capabilities may potentially be affected<sup>25</sup> The Clinical Commissioning Group Report comments that:

“Substance misuse can have an impact on parental capabilities and whilst it is not clear from the records if the adult’s substance misuse was problematic, it should still have raised concerns when seen in conjunction with the other parental issues, namely domestic abuse, mental health issues and poor home conditions. Again, however, this was not evident within the parental GP records. There is also no evidence of any involvement with substance misuse services in any of the adult’s records.”

6.157 At the Learning and Recall Events, Health Visitors for Child P confirmed that they had no evidence or knowledge of drug use and had not been informed about the misuse. Police held extensive intelligence concerning drug misuse and if the network had been more curious about family life this information may have been unlocked. It is hoped the recommendation made within a serious case review in Dudley regarding Health Visitors reviewing medical notes should change this approach in future.

6.158 Where drug use is a feature of the family environment as a minimum there is likely to be a lack of routines and a focus on drug acquisition. The interests and welfare of children are likely to be a low priority. Practitioner discussions suggested that local practice at the time was to rely heavily on involving family support workers. **Recommendation 5**

### 6.159 **Domestic Abuse**

6.160 Any child/young person who lives in a home where domestic abuse is taking place is personally at a higher risk of direct abuse. Some estimates suggest that between 45 and 70% of children exposed to domestic violence are also subject to physical abuse. The social, emotional and psychological impact of violence upon women can seriously affect their parenting capacity. Research has consistently shown that a high proportion of children living with domestic violence are themselves being abused, either physically or sexually, by the same perpetrator.<sup>26</sup>

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<sup>23</sup> Maternal cannabis use in the sudden death syndrome. Scragg, Mitchell, Ford, Thompson, Taylor, and Stewart published online: 2 Jan 2007 DOI: 10.1111/j.1461-2227.2001.tb00256.x

<sup>24</sup> Maternal and Paternal Recreational Drug Use and Sudden Infant Death Syndrome. Klonoff-Cohen and Lam-Kruglick. Arch Pediatr Adolesc Med. 2001;155(7):765-770. doi:10.1001/archpedi.155.7.765.

<sup>25</sup> Cannabis and Mental Health; Royal College of Psychiatrists (June 2014)  
<http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/cannabis.aspx>

<sup>26</sup> Walby and Allen (2004) Mullender et al (2003, 2005)

- 6.161 Studies indicate that child witnesses to domestic violence are, on average, more aggressive and fearful and more often suffer from severe anxiety, depression and other trauma-related symptoms. They live with constant anxiety and may be at a higher risk of alcohol or drug abuse, experience cognitive problems or stress-related ailments and have difficulties in school.<sup>27</sup>
- 6.162 Recent national developments include the publication in January 2016 of a report concerning nineteen children killed over a decade by known domestic abusers allowed contact with the children by courts.<sup>28</sup> In December 2015 the Home Office issued statutory guidance concerning the implementation of section 75 Serious Crime Act 2015 which created a new offence of controlling or coercive behaviour in intimate or familial relationships.
- 6.163 The Police Report highlights that in 2012, within the 49 recorded incident logs which involved the mother there were numerous incidents of domestic abuse. Within the response to the concerns, including whether appropriate notifications were made, in Child P's case the consideration of the impact of Domestic Abuse was not effective.
- 6.164 In Child H's case, there were no reports of domestic abuse but damage to doors in the house was not explained and, after Child H's death, neighbours said they heard arguing and noise. Midwives and Health Visitors routinely ask asked questions about domestic abuse. Child H's mother did not disclose abuse.
- 6.165 At the Recall Event, it was suggested that these issues and how far to pursue them are matters of professional judgement and professional curiosity but are not the focus of work. At the Professionals' Meeting, there was a consensus that the culture in Dudley at the time lacked professional curiosity generally. Also, even when identified, it was thought staff may be uncertain how to address Domestic Abuse. **Recommendation 6**
- 6.166 **Mental Ill Health & Disabilities**
- 6.167 Mental ill-health in adults was feature of both cases and concerned the mothers and the men close to them.
- 6.168 Child H's mother was asked about her mental health by the Health Visitor as part of the post-birth assessment 3 weeks after Child H was born. She gave no information suggesting that she suffered from mental ill-health, despite having been prescribed medication for depression which despite an increasing dose she felt had been ineffective.
- 6.169 Child H's mother disclosed to the GP that she was prescribed antidepressants since Child H's half-sibling was a baby but this information had not been shared with the Health Visitor.
- 6.170 Likewise, key information was held in GP records of Child P's mother concerning mental health issues, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder and domestic abuse. The complexity around sharing such information is acknowledged. However, barriers were not overcome and this information was not accessed by other professionals or considered within assessments or in deciding on appropriate services or evaluating their impact.

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<sup>27</sup> Silvern et al (1995) (1998)

<sup>28</sup> Nineteen Child Homicides; Women's Aid 20 January 2016

- 6.171 At Children in Need meetings, Attention Deficit Hyperactivity Disorder was discussed and Child P's mother was encouraged to go back to the GP. Again, there was no communication with the GP who was unaware of the status of the case. Adults with Attention Deficit Hyperactivity Disorder are more likely to experience more interpersonal and relationship difficulties. Break-ups are more common. The risk of drug and substance abuse is significantly increased in adults who have not been receiving medication.<sup>29</sup>
- 6.172 Child P's mother's diagnosis of Oppositional Defiant Disorder was also significant in that symptoms include negative and disruptive behaviour, often to people in authority. There are persistent references in the records to Child P's mother refusing to engage with services, missing appointments and declarations that she "did not have to" do whatever she was advised.
- 6.173 There was a lack of support for a mother with Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder which would be likely to result in her struggling with concentration and organisation. There is no evidence that she was advised to consult with mental health services, nor was engagement with Adult Social Care services explored as a possibility. There is no recording suggesting workers knew how her conditions were managed, let alone assessing the impact of this on her parenting capacity.
- 6.174 Knowing this background would clearly have affected the practice and communication with Child P's mother and should have been considered within any assessment carried out, in particular when trying to understand why she did not take advice or agree to access supportive resources. The Housing Officer, who had successfully secured greater engagement, was not involved by the professional network to share strategies for working with Child P's mother. This was a missed opportunity.
- 6.175 At the Learning Event, it was confirmed that in addition Child P's mother was either unable to or has great difficulty with reading and writing.
- 6.176 These issues had the potential to impact on the ability to parent and how best to communicate with Child P's mother. However, practitioners noted an absence of any assessment of these impacts. This was considered to be cultural in terms of the lack of professional curiosity that was the norm in Dudley at the time accompanied by the shortcomings in assessments which were a feature of practice then. Reviews of medical notes during pregnancy was the subject of a recommendation in a serious case review undertaken in Dudley in 2015. It is hoped a positive impact is being derived from this.
- 6.177 There is no evidence that either of the mothers received added support for their mental health issues whilst pregnant. Women who have suffered from mental health issues or received treatment from mental health services in the past should receive specialist advice as they have a high risk of becoming unwell after childbirth (RCPSYCH 2012).<sup>30</sup> There is also very little information available within the GP records regarding psychiatric input during the pregnancies or any evidence of a discussion between the midwives and GP's involved around their mental health and wellbeing.
- 6.178 At the Recall Event, it was emphasised that perinatal mental health is different from that within the general population and is a specialist area of practice. The point was made also that with the provision of adult services the patient or client have to want to engage and that without co-operation mental health is difficult to assess.

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<sup>29</sup> Harpin: The effect of ADHD on the life of an individual, their family, and community from preschool to adult life: Arch Dis Child 2005;90:i2-i7 doi:10.1136/adc.2004.059006

<sup>30</sup> RC Psych (2012) Mental health in pregnancy:

<http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/mentalhealthinpregnancy.aspx>

- 6.179 There is no evidence that Child H's GP was contacted in relation to the mother stating she had post-natal depression. Furthermore, no efforts were made to ascertain whether mother or father were known to mental health services as part of the assessment process.
- 6.180 In Child P's case, initially maternal mental health issues were raised following one of Child P's sibling's birth. Child P's mother stated she was low in mood and felt paranoid due to her partner at the time using hard and soft drugs. The Health Visitor ensured that mother had a GP appointment but there is no follow up documented in the records. Maternal mental health does not appear to be referred to again in the children's records therefore presuming that no further concerns were identified.
- 6.181 The Clinical Commissioning Group Report emphasises the need to access all available records for relevant information about health and to check and if necessary contradict assertions or claims made by adults. It is now clear that the fact that Child H's father stated that he was schizophrenic and used cannabis to self-medicate could not be verified from the GP records. However, further checks were never made. This is likely to be attributable to the fact that Child H's mother was not linked to her partner as a couple or as living with a relative, all being in the same household with a young baby.
- 6.182 There is growing evidence that people with serious mental illness are more likely to use cannabis. Also, evidence shows that those who use cannabis particularly at a younger age, have a higher than average risk of developing a psychotic illness.<sup>31</sup>
- 6.183 At the Learning Event, it was emphasised that provision of perinatal mental health is not addressed in the national contract for health services. Locally steps are being taken to develop a Perinatal Mental Health Service through a Dudley Group of professionals a business case has been put together. Lower level cases are dealt with by Primary Care and acute vulnerable women by services commissioned by NHS England. However, a substantial cohort of women (it was estimated about 300 per annum) fall between these 2 levels. Discussions at present concern the need to develop the service and capture the "mid-section" of cases. **Recommendation 7**
- 6.184 A further development arises from the need for adult and children's safeguarding services to be co-ordinated. Dudley Safeguarding Children Board and Dudley Safeguarding Adults Board have introduced twice yearly joint Board meetings to address issues which overlap both Boards in order to ensure a more joined up approach. It is expected that the mental health of adults and child welfare will be considered at these joint meetings.
- 6.185 Accessing information about the mental health backgrounds of adults caring for children should improve if the arrangements to address weaknesses in assessments are addressed as discussed above.
- 6.186 The Board will no doubt be interested in understanding how the government's five-year strategy to help new and expectant mothers <sup>32</sup> is assisting with improving provision in Dudley **Recommendation 4**

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<sup>31</sup> Cannabis and Mental Health; Royal College of Psychiatrists (June 2014)  
<http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/cannabis.aspx>

<sup>32</sup> Times 11 January 2016 p12.

## 6.187 **Non-engagement**

- 6.188 In both cases, professionals in health services were concerned about the mothers' engagement with their services. Appointments were missed and health checks for the children and immunisations not arranged. In Child P's case, there were long periods during which the children were not registered with a GP.
- 6.189 The Children Social Care response to these concerns was to assert a parent could choose not to register with a GP or have children immunised, which is clearly correct in law. However, a pertinent question during assessment would be whether the approach by the parent reflects a carefully reached decision, alongside the network attempting to make other arrangements to ensure surveillance of health needs. In this case lack of attention, ability or motivation to make appropriate arrangements may have been the drivers.
- 6.190 The Housing Report sets out the persistent attempts that the housing worker together with the Health Visitor made to impact on the poor standards. The Report notes that the mother only appreciated interventions that involved doing something for her. Examples of this included arranging house moves, sorting out arrangements to deal with chronic debts and loss of benefits. While suggestions that she make changes, or take action herself led to her avoiding contact or becoming aggressive, to the extent that staff became nervous of visiting alone. This report includes the only reference to the mother receiving a Disability Living Allowance and a Personal Independence Payment. The reason why she qualified for payments or what impact it would have on her cognitive abilities or functioning was not considered within any assessment.
- 6.191 The Housing Worker and Health Visitor were keen to take part in interagency processes and were disappointed when these ceased. Upon case closure no reason was given by Children Social Care when there could be no confidence in the issues that had given rise to concern having been addressed.
- 6.192 Discussions at the Recall Event concerned what impact the attitude of a parent can have on the services that are offered.
- 6.193 Child P's mother was manipulative - engaging with some services and not with others. She was reluctant to get help for Attention Deficit Hyperactivity Disorder. The Health Visitor advised referral to her GP but could not make the referral without her co-operation. She could not be forced to seek advice. Disability living allowance benefits were stopped because she failed to complete forms or attend for assessment. The likely impact of Oppositional Defiant Disorder on the attempts made to persuade her to engage with services was not part of the assessment.
- 6.194 The parents of Child H while appearing to understand advice failed to act on it.
- 6.195 Previous Serious Case Reviews locally and nationally have consistently identified that families who persistently avoid contact with professionals, or who prevent their children having such contact, may present a serious risk to the children's safety and welfare.
- 6.196 It is encouraging to note the Board approved guidance on this topic following a serious case review in 2013 and audits of understanding and awareness were undertaken.
- 6.197 The Ofsted publication "In the child's time: professional responses to neglect", (March 2014) recommended that local authorities should:

“ensure that social workers have specialist training and supervision to enable them to exercise professional authority and challenge parents who fail to engage with services, particularly when their children are subject to child protection plans; this process should be subject to robust, regular management oversight and practice audit.”

6.198 The Children Social Care Reports include recommendations that staff in the department should receive an intensive programme of training to raise the standard of practice.

#### **Recommendation 8**

6.199 The mother of Child H failed to provide a urine sample during either of her pregnancies. It was not possible to insist that she did so. It is not clear whether the reason for not providing a urine specimen was discussed with Child H's mother by the Midwife. It was not seen as particularly significant by the Midwife.

6.200 Testing is not concerned with identifying substance misuse, although some mothers think this. Unless sent elsewhere for analysis the samples would not show up substance misuse.

6.201 It is not unusual for pregnant women not to provide regular urine samples. In a busy clinic, the Midwife might not query this and might inadvertently overlook a possible safeguarding concern. It was confirmed that there is no recommendation made by NICE in relation to this issue.

6.202 Discussion included whether there should be a system whereby after a number of missed samples the issue is addressed more proactively. It was felt that there are learning points for staff concerning the relevance of urine testing and an increased awareness of reasons why a urine specimen may not be provided.

## **7 The Safeguarding Response**

### **7.1 Barriers**

7.2 The barriers to providing an adequate safeguarding response included a lack of professional curiosity at critical points. Also, assessments which were adult focussed and did not consider what life was like for the children or their individual needs were a barrier within Children Social Care. Although the historical information was included (some more than others), this was not then used to inform the analysis and a professional judgement that was child focussed and addressed the risks for the children or the concerns apparent from the referral.

7.3 This was accompanied by a lack of forensic approach and management oversight. At the point when the case was referred to Children Social Care, there was no evidence of management oversight considering why the assessment was required.

### **7.4 Communication Between GP and Health Visitors**

7.5 Health Visitors could not be relied upon to be familiar with the GP records during the scoping period. However, Social Workers assumed that all health information would be accessed and disclosed by the Health Visitor.

- 7.6 This is a serious issue and is well documented<sup>33</sup>. In discussion, the Children Social Care Report author commented that she had “audited hundreds of cases” and that “GPs were not contacted routinely.” The GP had not been made aware that Child P had died or the processes taking place and was seeing other family members.
- 7.7 There is evidence of the development a GP Communication Policy and an Information Sharing Agreement with each GP Practice. This will enable information to be shared daily regarding changes of status of children in certain categories. GPs will also be able to use a form to refer children to safeguarding leads. The Board will want to be assured of the impact these developments are having.

## 8.0 Quality of Decision Making and Plans

- 8.1 A pre-condition for an effective plan is a thorough assessment and this was lacking in the two cases. Also, the inadequacy of interagency processes is highlighted within this report. Given that these two elements were present it follows that plans were likely to be flawed. There were no interagency plans formulated to address effectively the risks to and needs of the children in these cases.
- 8.2 In addition, plans were made by Children Social Care without the benefit of contributions from all relevant professionals or with opportunities to question or challenge their effectiveness. There was a lack of clarity regarding benchmarks of “what the protected child will look like”. There were no contingency plans to address circumstances if even vague objectives were not met. The opinion of practitioners who contributed to the review was that these were not isolated cases and that these were the standards in operation locally at that time.
- 8.3 The plans failed to set out clearly what was required, by whom and when. The standards expected were not precise or measurable. There was no reflection of why standards in the households fluctuated so dramatically. It is hoped that the action by Dudley Safeguarding Children Board to develop a strategy and training programme to address neglect would impact positively on these issues.
- 8.4 The approach to and content of plans has been addressed by government in regulations and guidance and has attracted judicial comment and criticism in reviews and inquiries. The “how, who, what and when”<sup>34</sup> and why were left unclear. Contingencies for withdrawing support or taking further action were not indicated.<sup>35 36</sup> These are particularly important in cases of child neglect where often there is no single event that ‘triggers’ matters escalating. Realistic timescales were missing to ensure the children were not subjected to long-term neglect.

## 9 Supervision

- 9.1 Good management impacts significantly on outcomes for children in any case. However, OFSTED and others highlight the need for it more specifically in neglect cases to avoid drift and delay.

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<sup>33</sup> The Victoria Climbié Inquiry Report. Paras. 12.26 and 12.29 TSO (2003)

<sup>34</sup> Richards J in R(AB & SB) v Nottingham CC (2001)

<sup>35</sup> The Protection of Children in England: A Progress Report in 2009, Lord Laming

<sup>36</sup> In the child's time: professional responses to neglect, March 2014, OFSTED

- 9.2 In Child H's case, there was no evidence of supervision on the case file in Children Social Care. This is of additional concern as Child H' was a case in which neglect was suspected.<sup>37</sup>
- 9.3 In Child P's case, oversight was not robust, with team managers failing to provide challenge to workers and establish clear contingencies. Decision making, including within supervision, was adult focused. There was virtually no reference to the children or whether specific issues have been addressed, no rationale provided for decision making so the author did not get a sense of what life was really like for the children.
- 9.4 The Children Social Care Report author identified the lack of an up to date chronology and robust supervision as a key omission at various critical points. It was felt these two elements could have pulled all the concerns highlighted above together, possibly leading to a Core Assessment being undertaken. A contingency plan could have been developed that if Child P's mother did not engage within a specified period of time that consideration would be given to initiating a Strategy Discussion with Police and Health to consider a Child Protection Enquiry and Initial Child Protection Conference.
- 9.5 The Children Social Care Report states that this was not unusual practice in Dudley at that time. The author had audited many cases where management oversight is either not present or is limited at the commencement of the Children Services involvement. Team managers failed to ensure that their management footprint is evidenced on the case file from the point of allocation until the case is closed including regular supervision, providing a rationale for decision making and giving direction.
- 9.6 We are pleased to note that there are 3 separate recommendations regarding supervision in the Children Social Care Report.
- 9.7 Research, guidance and serious case reviews suggest all open cases must have an up to date supervision recorded on the case file. The Victoria Climbié Report published in 2003 recommended that Directors of social services must ensure that the work of staff working directly with children is regularly supervised. It also recommended that Directors of social services must ensure that senior managers inspect, at least once every three months, a random selection of case files and supervision notes. The accreditation arrangements for Knowledge and Skills: Practice Leaders and Practice Supervisors will no doubt have an impact, but this issue is not only relevant for social services staff and managers.
- 9.8 Earlier statutory guidance emphasized the need for effective support and supervision<sup>38</sup> for all agencies. This was required to include scrutinising and evaluating the work carried out, assessing the strengths and weaknesses of the practitioner and providing coaching development and pastoral support.
- 9.9 The Children's Centre Report indicates that the service has adopted a practice of ensuring "2<sup>nd</sup> pair of eyes" and focuses on robust evidence to support judgments.
- 9.10 The Police have monthly reviews of their cases carried out by a supervisor alert to children's interests.
- 9.11 Housing have senior staff who hold monthly meetings with supervisees, shadow them on visits and ensure robust handover of case responsibility. However, it is significant that

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<sup>37</sup> (Farmer et al Case Management and Outcomes for Neglected Children returned to their Parents: A Five-Year Follow-up Study 2010.)

<sup>38</sup> Working Together to Safeguard Children DSCF (2010) paras 4.58 to 4.55

the officer involved at the time was supervised by 5 different managers during the scoping period, which affected the level of confidence of that officer to challenge, both the mother personally but across the network.

9.12 Health Visitors have Team Leaders with specialist training with enhanced skills in particular areas and checks on practice in a way that is expected to avoid a tick box approach. In Child P's case, however, the Health Visitor felt with hindsight she may have been more challenging of Child P's mother and felt the fact that she did not have a team leader at the time may have contributed to this.

9.13 More generally, faced with manipulative and uncooperative mothers most workers will benefit from supportive and pro-active supervision. At the Recall Event, it was clear that not all staff within health organisations receive supervision.

9.14 It is important that Dudley Safeguarding Children Board is aware of the arrangements in each agency. We invite the Board to seek assurance on these arrangements to support the other workstreams within its improvement framework.

## 10 Challenge and Escalation

10.1 Safeguarding Children Board partners individually and collectively have a responsibility for the healthy functioning of the child welfare system. This accountability can only be effective if there is a willingness to raise and comment on issues of concern relating to the functioning and approach of partner agencies and a willingness to listen and take seriously concerns when they are raised by other agencies. This review has examined why the weaknesses identified and the concerns expressed about approaches within Children Social Care had not been raised and addressed by partner agencies within the Dudley Safeguarding Children Board. There is evidence to suggest partners did not feel that constructive challenge was welcomed or effective.

10.2 During the scoping period, the Board lacked support in the form of a business infrastructure, and this affected how well its members understood their roles and accountabilities. It was recognised and commented upon by partner agencies that there have been significant changes in management, leadership and governance arrangements within Dudley Safeguarding Children Board and this has led to a more positive and responsive environment.

10.3 All members of the Board have responsibility and accountability which include ensuring recommendations from serious case reviews are effectively and promptly implemented. Lay Members are full members of the Board and with Lead Members for Children's Services have particular roles to play in challenging professional practice and agencies. During the scoping period, no induction document was in place to guide and support members as to how their role works in practice. There are now robust induction and peer support processes in place for all members of the Board. The Board may wish to consider on an on-going basis how these developments have impacted on and improved the culture of challenge within the Board and make it less likely, for example, that urgent recommendations from serious case reviews are not effectively implemented, despite processes being in place. **Recommendation 9**

10.4 There is now clear evidence of the Board having clear and robust arrangements for implementing and monitoring implementation of Serious Case Review recommendations, and monitoring of the implementation of Action Plans by the Serious Case Review Sub-Group and members of the Board.

## 11 Holiday Periods

- 11.1 When Child H's Health Visitor made a referral to Children Social Care, it appears likely that the holiday period contributed to the delay in the safeguarding response. The agency report author concluded the likelihood that supervision would have taken place over the Christmas and New Year break was small.
- 11.2 The Report reflects careful analysis of contacts and progressions to referral and assessment. Between the 22 and 23 December prior to the Christmas break the teams would have been extremely busy. Although there is no evidence that this had an impact on the timeliness of response, the proximity of the holiday period contributed to what appeared to be haste to close the case and in failing to keep the children at the centre of the assessment.
- 11.3 The services available out of hours and the impact on decision making in the period approaching and during weekends and statutory holidays has been an issue of concern repeatedly identified in Serious Case Reviews and inquiries.<sup>39</sup> The chief executive of each local authority with social services responsibilities is required to ensure that specialist services are available to respond to the needs of children and families 24 hours a day, seven days a week, as opposed to out-of-office-hours teams.<sup>40</sup>
- 11.4 Managers have a responsibility to ensure that an effective service is delivered and staff have a personal responsibility arising from contracts of employment and professional codes to alert managers to any circumstances that indicate that the service will not be delivered effectively.
- 11.5 At the Recall Events, the discussion included reference to a "bulletin" that had been sent out recently about when offices were closed and the alternative contact numbers. This issue does not only concern social care services. Across agencies there was a consensus that personal annual leave should be raised and agreed with supervisors with proper arrangements for cover and handover.

## 12 Information Sharing

- 12.1 The Police Report identified failures by officers to make referrals and share information about domestic abuse incidents. In Child H's case, known males were not linked with the mother. In Child P's case, there were three separate police intelligence logs submitted during November 2014 which related to the mother's previous address and information that she was suspected to be growing cannabis. More similar intelligence was logged after she moved to a different address. There is no record that Children Social Care or other agencies were aware of this intelligence.
- 12.2 Awareness-raising about the significance for child welfare of domestic abuse and misuse of drugs has underpinned the West Midlands Police's action to robustly address this issue. All staff within the Intelligence Department have received training on their responsibility to identify child welfare concerns and the need to ensure that appropriate referrals have been made.
- 12.3 The GP practices were unaware of the previous history, referrals and concerns around neglect until after the deaths of both children. They would have been unable to take these into consideration during any consultation. There is also no evidence of discussion

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<sup>39</sup> See for example the Executive Summary of the Overview Report of the SCR carried out by Bridgend SCR concerning Child O (2012)

<sup>40</sup> The Climbie Inquiry, 2003

or communication between the Health Visitor and the GP in either case. From reviewing the GP records, it is not apparent that there had been concerns for both families. There is also no evidence that the GPs had been contacted when referrals had been made for both children to Children Social Care.

- 12.4 The Clinical Commissioning Group Report notes that the GP as a member of the Primary Care Team will often have information that would be beneficial to any information gathering process.
- 12.5 From completed chronologies in the case, prior to the scoping period for the review, it was clear that Child P had been known to Children Social Care since soon after birth in relation to two domestic abuse incidents. The Report highlights as good practice that the GP practice had recorded these in the notes and in the problem summary which meant that any clinician reviewing the case would be aware of them.
- 12.6 At the Recall Event, it was emphasised that the GP responsible was not aware that Child P had died when seeing other family members. The case was transferred to a new health visitor in October 2014 due to a change of GP. There is no documented evidence that there was a verbal handover with the new Health Visitor.
- 12.7 There was, however, good information exchange between the Housing worker and Health Visitor in Child P's case.
- 12.8 The other reports give examples of weaknesses in sharing information; delay in feedback between Health Visitors and Social Workers; no information regarding past history or home conditions was shared with the Children Centre; not making colleagues aware of house moves; failure to share information from Child P's mother who stated that the father of one of the children had been charged with causing Actual Bodily Harm, kidnap and witness intimidation and was serving a prison sentence.
- 12.9 There were indications of uncertainties and confusion about information sharing and incorrect assumptions about the barriers to sharing information that led to an inappropriate culture developing - a persistent theme that has led to repeated national guidance on the issue. From discussions at the Learning Event it appears that staff are uncertain about when information can be shared unless there are clear child protection concerns.
- 12.10 In Child P's case, a Social Worker reported that Police had refused to disclose information about adults as these were "Child in Need enquires, not Child Protection". This is a serious issue. Despite a well-established acceptance of the importance of good communication, weaknesses have persisted.<sup>41</sup>
- 12.11 Working Together 2015 continues to emphasise that:
- "Serious Case Reviews (SCRs) have shown how poor information sharing has contributed to the deaths or serious injuries of children."
- 12.12 National guidance intended to improve practice has regularly been issued, the latest in March 2015.<sup>42</sup>

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<sup>41</sup> The Victoria Climbié Inquiry Report. TSO (2003)

<sup>42</sup> Sharing Information: Advice for practitioners providing safeguarding services to children, young people, parents and carers, HM Government (2015).

- 12.13 The approach adopted suggests that a Child in Need case is treated as requiring a less rigorous application of process than a Child in Need of Protection. Within health organisations it was suggested that Child in Need is treated as less serious. The Named Nurse does not review Child in Need cases whereas if Child Protection is involved she does.
- 12.14 A Child in Need includes one who is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, even a reasonable standard of health or development or whose health or development is likely to be significantly impaired, or further impaired, without the provision of services.<sup>43</sup>
- 12.15 If the services are not provided or are ineffective the child will be likely to suffer significant harm. A proper assessment requires accessing all the information relevant to forming a judgement.<sup>44</sup> Agencies to whom Section 11 Children Act 2004 applies have a statutory duty to discharge their functions with regard to the need to safeguard and promote the welfare of children. This includes partner agencies and those commissioned by those agencies. These agencies are unable to carry out this statutory duty without access to the relevant information. The duty includes sharing and acquiring and considering the necessary information to form appropriate judgments about how to exercise their functions to safeguard promote the welfare of children – not only to contribute to child protection processes.
- 12.16 The Dudley Group NHS Foundation Trust Report expressed concern having made referrals to Children Social Care that consistent feedback on action and decisions made was not received. Arrangements have been made to disseminate information about the Single Point of Access which it is hoped will improve the approach and consistency to sharing information and responding to referrals. Dudley Safeguarding Children Board has arrangements in place to review the effectiveness of the Single Point of Access.
- 12.17 If the approach to sharing information is not sound, it is likely to have an impact on inter-agency processes. For example, Child in Need meetings took place without any input from health practitioners as the social worker was reported to have stated she was unaware of who the Health Visitor was.
- 12.18 At the Recall Events, there was considerable anxiety about the approach to interagency working and processes with criticism of Children Social Care for the lack of explanation for cancelling Child in Need meetings and closing cases without expressed reasons or consultation.
- 12.19 It was also suggested that minutes of Children in Need meetings are not consistently received. We anticipate the Board will wish to satisfy itself that inter-agency processes take place effectively. Administrative support for inter-agency processes should be ensured and an audit regarding promptness of circulation and adequacy of minutes would inform where any gaps lie.
- 12.20 Discussion of the issues generated a healthy determination that “In future I would escalate it higher.” One agency sought to recommend that “Children Social Care to liaise with all agencies involved prior to closing any case e.g.: Child in Need.”

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<sup>43</sup> s17(10) Children Act 1989.

<sup>44</sup> Lord Laming in The Protection of Children in England: A Progress Report (2009)

- 12.21 In Child P's case, the Police asked for a Child Protection Conference to be convened but Children Social Care refused to do so. It does not appear that other agencies were consulted. The issue was raised with senior staff but the decision was not changed. It was considered by current Children Social Care staff that the mindset at that time was that this case concerned medical neglect, the mother had cooperated, Health Visitors were making visits and the Police were aware of the family. The case, it was suggested was only "seen at surface level".
- 12.22 This raises the issue of where the responsibility should lie for deciding whether an inter-agency process takes place and how appropriate it is when a partner agency feels strongly that a conference should take place not to convene the meeting. A benefit of a conference is that it involves experienced child protection professionals uninvolved in the case who are more likely to identify weaknesses in the approach.<sup>45</sup>

## 13 Good Practice

- 13.1 There were elements of practice which made a difference in these cases and there is equal learning to be derived from these as from shortcomings in practice. The network as a whole was able to reflect on the persistence of the Housing Officer who worked with Child P's mother.
- 13.2 Good inter-agency working was apparent between Child P's Health Visitor and the wider network in her approach to referring the case and then following up. She attended GP practice meetings to share information and exercised curiosity when she watched a male leaving the property and alerted Children Social Care.
- 13.3 There was good co-working between the Housing Officer and the Health Visitor. Also, the Children's Centre offered joint visits, showing good inter-agency working.

## 14 Improvements Already Implemented

- 14.1 There have been a lot of developments since the scoping period for two reasons. The first is that this review has taken longer than it should have to complete. However, the second is more positive and it is that Dudley is on a journey of improvement. This journey was under way at the time of the OFSTED inspection.
- 14.2 The developments of most relevance to this review have been mentioned within this report. These are the introduction of the Multi Agency Safeguarding Hub and the Single Point of Access. These are still early in implementation and there is some way to go. The work around communication with GPs will, it is hoped, also secure improvement. The Unborn Baby Network is also an encouraging development, providing an opportunity for multi-agency discussion of certain cases.
- 14.3 The Back to Basics Training module, offered to Social Workers is a significant development which, it is hoped will make a difference. We take a similar optimistic view regarding the Resolving Professional Differences Protocol, which we hope will be instrumental in changing the culture in Dudley, if arrangements are made for it to reach all levels, including the front line. Building confidence is in operation and will only be successful if accompanied by appropriate oversight and support.

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<sup>45</sup>See for example the Executive Summary of the Overview Report of the Serious Case Review of the Circumstances Concerning KaB (dob 13.12.1994) and KiB (dob 10.03.2012) who both died in a house fire on 18.09.12. South East Wales Safeguarding children Board January 2015

14.4 Workforce changes to enhance leadership and capacity, the re-launch of the Resolution Policy and the Graded Care Profile are all worthy of note. It is expected that the impact of the work of the Improvement Board will be significant.

## 15 Conclusions and Lessons Learned

15.1 In both cases it was impossible to conclude that from the circumstances known to agencies the specific circumstances of the deaths could have been predicted. The cases have facilitated a thematic review which is intended to assist the board identify areas which may arise or have arisen in other similar situations.

15.2 The assessments that were undertaken in relation to both cases under review were inadequate for a variety of reasons. The number of "initial assessments" was striking, as was the lack of assessments in circumstances which required one to be carried out. In both cases assessments were adult focussed. In Child H's case, the assessment seemed to take a snapshot of concerns. This review has highlighted where robust assessments, analysis, planning and review were found to be lacking. This was confirmed by an OFSTED inspection in January 2016. In Child P's case, each development in the case compounded the last so that the risk was multiplied. Workers over identified with Child P's mother, who continued to be seen as a Looked After Child.

15.3 It appeared that practice was incident led in both cases with a lack of overview with the result that the level of risk was not recognised. In both cases assessments failed to take account of the family history, and there was no evidence of information being gathered in one place for reflection and debate. There was no evidence of use of a genogram in any agency. These deficiencies were described as being "the norm" in Dudley. It is encouraging that these areas form part of the "Back to Basics" work undertaken with Social Workers.

15.4 The complexity of factors contributing to the risk to Child H and to Child P was not always fully appreciated, and this no doubt results from deficiencies in practice highlighted above. Poor information sharing, response to concerns, assessments and interagency processes prevented the complexity from being recognised and responded to. The review reveals not a situation in which specific instances of underperformance from any single agency are to be highlighted but a fundamental systemic failure.

15.5 A striking feature of the cases was the failure to incorporate males in assessments. This had an enormous impact on professionals' ability to understand what life was like for the children in these two cases. Described as culture and practice at that time, this factor was identified by OFSTED and is now the subject of improvement work.

15.6 Professional curiosity was lacking on many occasions, resulting in information from the community and relatives not being incorporated into assessments and brought within the professional networks. Child P's relatives were considered to be a protective factor without sufficient assessment and an over optimistic view of parental ability to effect change prevailed. The workers' over identification with the mother and failure to maintain child focus contributed to this optimism.

15.7 The issue of substance misuse was largely overlooked and this was no doubt made more difficult by parental non-engagement in both cases as well as some agencies failing to make the connection between the adults and the children who were residing together. But where the issue was recognised it was not treated with sufficient seriousness.

- 15.8 Similar comments apply to the issue of domestic abuse. It was not recognised in Child H's case until after death. There was no effective consideration of the impact of this on Child P and the siblings. It seemed to raise insufficient levels of concern even when evidence was brought to the attention of the professional network.
- 15.9 Poor information sharing played a role with a lack of awareness among agencies which never gained an understanding of the importance of mental ill-health and disabilities for these two mothers. Missed appointments were not considered in the context of these issues, with a professional mindset that lacked the curiosity to gather information and assess this important element. Such an assessment may have helped professionals find ways to engage better with both mothers and support them better to effect improvements.
- 15.10 Parental non-engagement with professionals had the effect of blocking interventions, particularly in Child P's case. Management oversight was lacking at this time across some agencies and this did not help practitioners overcome this barrier. Poor communication between Health Visitors and GPs presented a similar barrier, with Social Workers acting on an incorrect assumption that all health information will be accessed by Health Visitors.
- 15.11 When the Housing Officer in Child P's case considered challenging the lack of progress being made, perceptions of power and status prevented this. With management oversight lacking, there was not the support to carry this through. Safeguarding is everyone's responsibility, and lack of follow up from agencies who felt strongly about the situation contributed to the safeguarding response being inadequate.
- 15.12 The Police failed to understand impact on children of domestic abuse and drug misuse and so did not make referrals. The GP had no knowledge of many of the concerns; the home conditions in Child P's case were not known to the Children's Centre and there was significant delay in feedback between Social Workers and Health Visitors. There were indications of uncertainties about the barriers to sharing information, with an inappropriate and overly restrictive culture developing. It is hoped that improved awareness of the Single Point of Access will improve the approach and consistency to sharing information and responding to referrals.
- 15.13 We were asked to consider systemic issues and explore the reasons why there were these shortcomings. This led us to explore whether the Safeguarding Children Board was undertaking work in respect of the role of partners, disguised compliance, families who avoid professionals and the voice of the child during the scoping period. It was also important for us to examine why learning activity flagged for the Board two years before had little or no impact on practice in these two cases.
- 15.14 All of these questions, and also repeated attempts to understand how the Safeguarding Children Board was approaching neglect at the time were finally responded to fully, albeit after queries being raised as to the relevance of our questions. It now appears that the reason for the delay was simply a lack of capacity in house to complete the work. This has been a striking feature of this review and is the reason for the enormous amount of delay in bringing it to a conclusion. We have learned that some of this work was being undertaken at Board level, but it was not having the desired impact on practice on the ground. Reasons for the loss of organisational memory may well have included the enormous amount of staff turnover in Dudley at the time.
- 15.15 There is no doubt that achieving sustained improvement in neglect cases is difficult, as these cases demonstrate. However, if the voice of the child is not at the centre of

assessments, as was the case here, it is impossible for intervention to focus on their needs. In Dudley this has been recognised, and the Early Help Strategy, the Neglect Strategy, the threshold framework, the Multi Agency Safeguarding Hub and the Single Point of Access are all designed to effect improvement.

15.16 In undertaking this review, we have been fortunate to experience openness and transparency from practitioners involved at the time and from agency report authors, who have been committed to helping us to understand why events unfolded as they did. We acknowledge that this has been difficult due to turnover of staff and we extend our thanks to those who have assisted.

15.17 We hope this report will act as a reminder regarding accountability, for those who have a key role in ensuring arrangements are in place for safeguarding children. Safeguarding Children Board members, Chief Officers, the Lead Member for Children's Services and the Lay Members on the board play a role in ensuring national guidance and serious case review recommendations are implemented. This review's conclusions and recommendations should be brought to their attention.

15.18 Pockets of good safeguarding practice were identified, with individuals demonstrating tenacity and persistently offering opportunities for these families to engage and benefit from the support of agencies. It was clear that the Housing Officer, the Health Visitors and the Children's Centre were working collaboratively in Child P's case and this was noted during the review.

## **16 Recommendations**

### **Recommendation 1**

Dudley Safeguarding Children Board should consider requiring the preparation and consideration of an up to date genogram to be a requirement at all interagency meetings concerning a child's welfare.

### **Recommendation 2**

Dudley Safeguarding Children Board should arrange for an audit to be carried out of a sufficient number of cases to form a judgment on the impact of the Neglect Strategy.

### **Recommendation 3**

Dudley Safeguarding Children Board should urgently carry out a review of the arrangements for timely completion of serious case reviews and for ensuring effective implementation of the recommendations of Serious Case Reviews and other learning review processes and the monitoring by the Board of the impact of implementation on practice.

### **Recommendation 4**

Dudley Safeguarding Children Board should recommend to NICE that it reviews the guidance on co-sleeping to emphasise that adults should not co-sleep with their infants

### **Recommendation 5**

Dudley Safeguarding Children Board should consider the priority given to the issue of substance misuse within improvement work including for the Neglect Strategy and associated training.

**Recommendation 6**

Dudley Safeguarding Children Board should consider whether the current guidance, procedures and training sufficiently address the need for curiosity regarding domestic abuse and the practice to address risks to children.

**Recommendation 7**

Dudley Safeguarding Children Board should arrange for a report to be prepared on the arrangements being made; (i) to ensure more effective consideration of mental health issues within assessments of the needs of children, (ii) for addressing mental health needs of adults caring for children and (iii) the impact of the five-year funding strategy to help new and expectant mothers and their mental health needs.

**Recommendation 8**

All partner agencies should report to Dudley Safeguarding Children Board on the arrangements that they have in place to ensure that staff are enabled to exercise professional authority and challenge parents who fail to engage with services.

**Recommendation 9**

Dudley Safeguarding Children Board should keep under review whether the culture and environment encourages and supports raising concerns about the exercise of Board functions, and whether all those with roles in calling the Board to account have an understanding of the duty upon them.

**Donna Ohdedar**

**August 2017**

**David Spicer, LLB, Barrister**

# DUDLEY SAFEGUARDING CHILDREN BOARD



## THEMATIC SIGNIFICANT INCIDENT LEARNING PROCESS

### Appendix A

## Terms of Reference

#### CASES INVOLVED

Child P  
(age at death 2 years 4 months)  
and  
Child H  
(age at death 7 months)

## SCOPE

The review will focus on a general theme of young children that have died in neglectful circumstances although the cause of death was found to be non-ascertainable. The review will focus on the learning that arises from an analysis of two separate cases.

Where an agency had involvement in both cases, there will be two timelines of significant events, but one questionnaire which answers the TOR, and uses the two cases to illustrate the analysis of practice.

Time period on which agency reports shall focus:

**Child P:** 16 October 2012 to 16 April 2015

**Child H:** 1 January 2014 to 10 April 2015

## LEARNING AND IMPROVEMENT FRAMEWORK

Dudley Safeguarding Children Board has a learning and improvement framework which is used to guide the way in which reviews will be conducted in Dudley. The guiding principles below are central to the approach taken in Dudley.

Serious Case Reviews and other case reviews should be conducted in a way in which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks 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; and
- makes use of relevant research and case evidence to inform the findings.

(Working Together to Safeguard Children Chapter 4 para 11, March 2015)

## AGENCIES INVOLVED

<b>Child P</b>	<b>Child H</b>
1. Dudley Metropolitan Borough Council Children Social Care.	1. Dudley Metropolitan Borough Council Children Social Care
2. Halesowen Children's Centres.	2. Halesowen Children's Centres
3. West Midlands Police Force.	3. West Midlands Police Force
4. Dudley Clinical Commissioning Group (General Practice).	4. Dudley Clinical Commissioning Group (General Practice)
5. Dudley Group NHS Foundation	5. Dudley Group NHS Foundation

Trust. 6. Black Country Partnership Foundation NHS Trust (Health Visiting). 7. National Probation Service. 8. Staffordshire and West Midlands 9. Community Rehabilitation Company. 10. Bromford Housing Association. 11. West Midlands Ambulance Service NHS Foundation Trust.	Trust 6. Black Country Partnership NHS Foundation Trust (Health Visiting) 7. Blowers Green Nursery 8. The Wordsley School
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Where an agency is considering both cases, they will provide an analysis of practice, using examples from each case to illustrate the analysis made.

### **ORIGINAL TERMS OF REFERENCE**

1. How well did practitioners recognise and understand the complexity of factors contributing to the risk to the children including neglect from parental behaviours such as substance misuse, domestic abuse?
2. What were the barriers to providing an adequate safeguarding response?
3. Were the voices of the children heard, (including an understanding of the children's lived experiences)?
4. How were the family histories incorporated into assessments?
5. To what extent did practitioners "Think Fathers"?
6. How did practitioners approach challenge and/or escalation and what was their level of knowledge around the processes for these?
7. What was the quality of information sharing including the making of referrals?
8. Analysis of the quality of decision making. Was there evidence of use of genogram or an understanding of the complexities of the families?
9. Were the responses to families timely and were the interventions effective?
10. What views do family members have on what might have made a difference?

### **FURTHER AREAS TO BE CONSIDERED ADDED DURING THE REVIEW**

Reflecting on the integrated chronology and the key practice episodes identified:

1. How did agencies assess and support a mother with Attention Deficit Hyperactivity Disorder?
2. Describe Child P's contact with services and address "why" things happened e.g. the professional mind set and working culture or environment at the time.

3. What revised recommendations can be formulated to address the issues that will have greatest impact on reducing the likelihood of similar failure in the system?

# DUDLEY SAFEGUARDING CHILDREN BOARD



## THEMATIC SIGNIFICANT INCIDENT LEARNING PROCESS

### Appendix B

## Agency Recommendations

### CASES INVOLVED

Child P  
(age at death 2 years 4 months)  
and  
Child H  
(age at death 7 months)

## **Black Country Partnership NHS Foundation Trust**

Escalation process to be embedded in Health Visiting and School Health Services

For evidence of voice of the child to be documented in all child records  
For professionals to be curious and challenge unknown people within the home during visits and record the information.

Practitioners to ensure analysis of contacts is evident in the child record, professional curiosity is executed and challenge is applied where needed.

Genogram's to be included for all cases as standard information above universal services and to be reviewed when new information is identified.

All information is reviewed and pertinent information is recorded in the main body of the record. E.g.: DA notification received stating mother is a LAC child- this information is required in the main record.

For practitioners to assess home conditions using a recommended tool to be utilised across all agencies.

Any clinic attendance request to parents by practitioners must be followed up to ensure this was undertaken

Verbal handover to be given by current practitioners to new practitioners if a child is above universal services.

Supervision to be in place for all practitioners on all cases above universal services.

To ensure attendance at all child protection core groups and case conferences

To ensure a care-plan is in every child's record and is updated following every contact with the child/family.

## **Dudley Clinical Commissioning Group**

Children who miss appointments should be followed up

That GP's are aware of the impact of parental behaviours such as domestic abuse, substance misuse and mental health on the wellbeing of children.

Communication between GP's and HV's is improved in relation to vulnerable children

## **Dudley Metropolitan Borough Council Children Social Care**

Management Oversight is robust in closing cases.

Assessments include all adults in the household.

All assessments include appropriate lateral checks.

The voice or lived experience of the child is evident in all assessments.

Training on improved understanding about males in the household.

Refresh training on working with parents.

In line with CSIB Improvement Plan – Supervision.

Improvement Plan. Continuity of Service over holiday periods.

Children's services to consider a process to feedback following a referral as per Working Together 2015.

## **Dudley Group NHS Foundation Trust**

Learning from these cases to be incorporated into midwifery in-house training days and be communicated in departmental meetings

Lack of urine specimens for routine testing to be addressed by specific discussion with the pregnant woman and reasons for this documented.

Staff need to consider the significance of the role that fathers play in families.

Staff need to consider the significance of parental issues e.g. mental health and domestic abuse on their ability to parent their children and incorporate into the documented assessment.

## **West Midlands Police Force**

Offender Management training need identified regarding recognising and recording CA matters.

**West Midlands Ambulance Service NHS Foundation Trust**

None

**Bromford Housing Association**

None

**Halesowen Children's Centres**

Processes for Family Support including paperwork, engagement and supervision should be robust

Step down and step up processes are robust between specialist and early help

Strategies are in place for managing risks during remodelling

Access to CCM for Managers of Family Support Services so previous history of children is established.

**National Probation Service**

Consideration to be given to initiation of no contact conditions with co-accused whilst in HMP

Genogram to be completed and information fully incorporated into oasys where possible

All children to be cited in oasys – the two children living in Wolverhampton were missing from the original assessment

**Staffordshire and West Midlands Community Rehabilitation Company**

All Probation Practitioners to ensure they undertake a prompt home visit for safeguarding purposes in line with IC 01/2013 – Staff Responsibilities in Respect of protecting children from harm.

PSO1 to undertake an OASys refresher course.

All relevant Agencies to share relevant convictions and allegations at the earliest opportunity to safeguard children in a timely manner.

All Sandwell Probation Practitioners to improve their ORA Adult Custody Licence Practice

All Sandwell and Dudley Probation Practitioners to ensure they record safeguarding decisions and discussions in Service User case records.