

**LEICESTERSHIRE AND RUTLAND LOCAL SAFEGUARDING
CHILDREN BOARD**

**EXECUTIVE SUMMARY
OF A
SERIOUS CASE REVIEW**

CHILD H

Andy Smith - Independent Chair

Paul Tudor - Independent Overview Author

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PART 1: INTRODUCTION

- 1.1. In 2009 Child H died aged just over nine weeks. The child's father fell asleep in a chair and it is believed Child H suffocated. Both parents had a history of drug and mental health problems and were known to a number of different agencies. The Leicestershire & Rutland Local Safeguarding Children Board decided in November 2009 that a Serious Case Review needed to take place.
- 1.2. The purpose of a Serious Case Review is as follows:
 - a. to establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
 - b. to identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and
 - c. improve inter-agency working and better safeguard and promote the welfare of children.
- 1.3. The specific issues to be focused on in this Serious Case Review and therefore contained in the Terms of Reference are as follows:
 - a. The assessment and analysis of risk and the management of risk in the community
 - b. Communication between agencies and particularly the sharing of information about previous interventions/contacts with agencies
 - c. Decision making, particularly where this involves practitioners from different agencies, organisations, backgrounds and professions
 - d. The possibility of over-optimistic assessment and the criteria and opportunities for re-evaluating risk over time, including whether there was a lack of challenge to a prevailing view
 - e. Agencies' awareness of and response to:
 - Parental substance use
 - Parental mental ill health
 - Domestic abuse

- Parental learning difficulties
- f. Matters which may have affected the parenting capacity of either parent and how this information was, or might have been, assessed and shared with other agencies
- g. Multi-agency working.
- 1.4. The Serious Case Review has been conducted by an Independent Chair Mr Andy Smith, who is the Divisional Director, Social Care and Safeguarding in Leicester City. He has no connection with the Leicestershire & Rutland LSCB or the Leicestershire County Council.
- 1.5. He has led a Panel comprising the following:

Leicestershire & Rutland LSCB Board Manager (L&R LSCB)

Detective Chief Inspector, Leicestershire Constabulary

Safeguarding Lead Advisor, Leicestershire Partnership Trust

Chief Officer, The Bridge¹

Head of Service Locality Services, Children & Young People Services, Leicestershire County Council

Consultant Nurse Safeguarding Children/Designated Nurse Child Protection, NHS Leicester City

An Independent Author (Paul Tudor) has produced the Overview Report and this Executive Summary. Eleven Individual Management Reviews² have been submitted; and there has been a series of Panel meetings to analyse and debate them.

- 1.6. The Parents and maternal grandmother agreed to meet the Independent Author and a member of the Panel for interviews; their contributions have been most valuable and have been woven into the text of the Overview Report.

¹ The Bridge are a registered charity delivering a service to homeless and vulnerably housed people in the Borough of Charnwood, Leicestershire.

² Independent Management Reviews are the reports from individual agencies that are considered by the panel and the findings incorporated into the overview report.

PART 2: SUMMARY OF EVENTS

- 2.1. The mother of Child H had a previous child nine years older than Child H. At the age of twenty one months that child was the subject of Child Protection procedures. As a result, the long-term plan was for this child to remain in the care of a relative. This is still the plan.
- 2.2. On four occasions Child H's father displayed self-harming behaviour. On three of these occasions he was assessed by medical staff in his own right as an adult (on the fourth occasion he did not wait to be seen). However, there was little or no thought given by the involved agencies to him being a parent and the likely impact of his behaviour, firstly to his step-child and subsequently to his own young baby. In particular, the last and most serious episode occurred in close proximity to Child H and only a few days days prior to the baby's death.
- 2.3. Both parents led a chaotic lifestyle. They moved frequently, took illicit drugs, and were involved in low-level criminal activity. They used a lot of medical and drug treatment services.
- 2.4. In the light of these historic and presenting concerns, Children's Social Care carried out both Initial and Core Assessments³. There was a lot of Health, GP, Midwifery, Health Visiting and Community Drugs Team involvement. Also the family were well supported by The Bridge Tenancy Support Services; plus regular involvement of Children's Social Care and Police.

³ An initial assessment is a brief assessment to determine whether the child is in need, the nature of any services required, whether a further, more detailed Core Assessment should be carried out, and whether a Strategy Discussion and a Section 47 Enquiry should be undertaken.

The Core Group through the Child Protection Plan seeks to reduce the risks, or prevent the occurrence of further Significant Harm to the child, and safeguard the child's well being to the point where the child no longer requires a Child Protection Plan.

PART 3: ANALYSIS OF AGENCY INVOLVEMENT AND THEMES

- 3.1. The management of the drug rehabilitation regimes and counselling of both parents were of a high standard and showed a good level of commitment. Also, the parents themselves reported positive and helpful interventions from the various Health services and particularly from the The Bridge Tenancy Support Service.
- 3.2. There was some very positive intervention before the birth of Child H (e.g. between the Community Midwife, the Specialist Midwife, the Social Worker, and a worker from the Community Drugs Team). Similarly there was very good multi-agency liaison in the management of the drug rehabilitation of both parents (GPs, Community Drugs Team, Pharmacy). There is also evidence of liaison between the Social Worker and the Bridge Tenancy Support Service and some contact between the Social Worker and the Health Visitor, and also the Social Worker and the Police.
- 3.3. However, these are examples of communication between agencies. This Serious Case Review has also revealed shortcomings in the communication within agencies, eg. Midwifery/Health Visiting/GPs. There were at least four occasions when multi-agency meetings should have taken place:
- Antenatally
 - Postnatally upon the discharge of mother and baby from hospital
 - The parental move to their own tenancy
 - The major incident a few days before the baby died

The fact that they did not take place represents significant missed opportunities to share information and to make a coordinated plan to safeguard the child.

- 3.4. The interventions of most of the agencies lacked a child-focus. The needs and demands of the parents (i.e. support for their mental health and drugs-related problems, involvement with the Police, etc.) were so high that the likely impact of their problems on their new baby was lost. Latterly and additionally, the likely impact on the baby of parental use of alcohol was also minimised.

PART 4: SUMMARY AND CONCLUSION

- 4.1. The mindset for all the agencies was that of Family Support. The analysis of the Serious Case Review (with the advantage of hindsight) is that the risks to the baby from parental behaviours and lifestyles were high enough to justify more rigorous interventions of a safeguarding nature. Whilst on many occasions there were appropriate reactions to events, there was very little proactive analysis, assessment or escalation of concerns.
- 4.2. Whilst there was a considerable amount of information-gathering, there was much less effective information-sharing and a complete absence of strategic planning on a multi-agency basis.
- 4.3. This Serious Case Review has drawn parallels with other recent Leicester City and Leicestershire and Rutland Serious Case Reviews; and one in particular dating from 2006 has many similar features.
- 4.4. Inevitably, this Serious Case Review also shows classic features regularly reported nationally:
 - the rule of optimism based on snapshot observations and too much credence given to self-reporting
 - the lack of respectful curiosity
 - the lack of historic context or research and therefore not making use or analysis of previous histories
 - a lack of an objective analysis of the couple's functioning as parents
 - at least four missed opportunities for coordinating a Strategy for the child's wellbeing and safety.

PART 5: RECOMMENDATIONS

- 5.1. A considerable number of individual agency recommendations have been drafted and agreed.
- 5.2. The multi-agency recommendations for the Leicestershire and Rutland LSCB are as follows (together with the rationale that lies behind them):

Recommendation 1

The Leicestershire & Rutland LSCB leaflet “Reducing the risk of harm to children in your household: Advice for parents who use drugs or alcohol” (2006) to be redrafted, reprinted and relaunched.

Recommendation 2

Guidance on the use of the leaflet to be commissioned from LPT by the LSCB.

Recommendation 3

In cases where there are one or more parents who give cause for concern while caring for a child in the light of their substance or alcohol abuse, all professionals must consider invoking a joint risk assessment which should then be shared with all relevant professionals.

Recommendation 4

The LSCB to issue guidance to all practitioners on the use of voluntary agreements⁴ with parents/carers.

Recommendation 5

When several agencies are involved, multi-agency meetings must be held in order to coordinate a plan for the child(ren) as per procedures.

⁴ These are informal written agreements between parents, carers and professionals working with families. These are voluntary in the sense that they are not legally binding.

Recommendation 6

Ensure that practitioners follow safeguarding procedures by using multi-agency meetings in order to enhance effective information-sharing.

Recommendation 7

The practice lessons from this Serious Case Review to be the subject of a specific dissemination training event and absorbed into ongoing multi-agency training programmes. Thereafter, an audit and analysis to be undertaken on the impact of this training on the practice of front line staff and their first line managers.

Recommendation 8

Specific training to be offered to the appropriate front-line practitioners on the impact of parental drug and alcohol misuse in the care of babies and young children. Again, this training must be followed by an audit and analysis of the impact of such training on the practice of front line staff and their first line managers.

Recommendation 9

All agencies to develop business processes to ensure that at the point of handover of a case from one worker to another, the family's history is discussed and understood; when a new worker is picking up a case, and there has been no opportunity for a handover, they must read, understand and absorb the history prior to intervention with a family; managers/supervisors must assist in this process.

- 5.3. These recommendations have been signed off by the LSCB Executive Group who have been given the authority to complete this task by the LSCB. The

Safeguarding Effectiveness Subgroup will monitor and audit progress on the recommendations.
