

# Torbay Safeguarding Children Board

Serious Case Review

C 11

Executive Summary

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Working together to ensure every child stays safe in Torbay

## Introduction

1. This is a serious case review conducted in accordance with the Government guidance contained in *Working Together to Safeguard Children 2010*. It looks at the circumstances surrounding a baby (referred to as C11) who died in 2009 when six days old.
2. The death was investigated by the South West Peninsula Child Death Overview Panel (CDOP), which decided that although the cause of death was unknown, there were factors in the family circumstances that 'may have contributed to the baby's ill health, vulnerability or death'. The CDOP also noted that knowledge of the risks in this family was not effectively shared between practitioners working with the family. The chair of the CDOP recommended to the Independent Chair of the Torbay Safeguarding Children Board (Bob Spencer) that a serious case review should be held.
3. The Serious Case Review Sub-group of the Torbay Safeguarding Children Board established the following objectives for this serious case review:
  - to examine and critically appraise the awareness of safeguarding concerns, and the appropriateness of responses, by universal service providers catering for all members of C11s family;
  - to identify how well targeted services for individual children and the whole family related to universal service providers, in addressing any safeguarding risk factors associated with the children;
  - to appraise the robustness of current arrangements for escalating safeguarding concerns to the level of specialist services by universal or targeted service providers;
  - to evaluate the appropriateness of managerial oversight across all service levels (universal, targeted and specialist) regarding interventions to safeguard children and the effectiveness of quality assurance systems employed to evaluate practice;
  - to examine and evaluate the processes and procedures employed by the Rapid Response Team and the Child Death Overview Panel, with particular reference to the safety of siblings of a dead child; and
  - to generate practical recommendations for improving policies, procedures and inter-professional and inter-agency practises in relation to the above.
4. The serious case review process was managed by a panel that was independently chaired by Alan Wooderson, a former senior manager in social services and currently the chair of a neighbouring safeguarding children board. The overview report for the serious case review was written by Mike Craddock, an independent consultant who has previously worked as a senior manager in children's social care and as an Ofsted inspector of children's services.
5. Membership of the panel was as follows:
  - Safeguarding Manager Torbay Children's Services
  - Chief Inspector, Devon and Cornwall Constabulary
  - Head Teacher (LSCB representative for Torbay primary schools)
  - Designated Doctor Torbay Care Trust

6. In undertaking the serious case review the panel sought Individual Management Reviews (IMRs) from the following agencies:

Torbay Council:

Children's Social Care Services

Education Services

Torbay Youth Offending Services

Devon and Cornwall Police

Devon and Cornwall Probation Service

The National Health Service:

Brunel Medical Practice

South Western Ambulance Service NHS Trust

South Devon Healthcare Foundation NHS Trust

The Old Farm GP Surgery

Torbay Care Trust (Specialist Public Health Nursing Services)

NHS Plymouth as hosts of the Peninsula Child Death Overview Panel and the Peninsula Rapid Response Team

7. In accordance with the guidance in *Working Together to Safeguard Children 2010* a Health Overview IMR was produced by Torbay Care Trust.

8. A coroners' inquest was held and produced a narrative verdict concluding that the cause of death was unascertained, describing only the circumstances in which C11 died.

9. The baby's parents were asked if they would like to contribute to the serious case review but have chosen not to. There is ongoing Panel Chair contact through the completion of the review and publication process.

## Summary of Events

10. C11 was born in hospital and discharged home with the mother when 13 hours old. The baby was considered well and noted to have established feeding, on routine visits from the midwife. Early in the morning on the sixth day mother found her baby (who was sharing a bed with her) not breathing. Emergency services established that the baby had died.

11. C11 was the youngest of these parents' six children. The father had been previously married and had four adult children from this marriage. The family had moved to Torbay from another city in the region four years before C11 was born. The three oldest children had been on the then child protection register for a period of time in that city.

12. Following their move to Torbay the family had stayed in overcrowded conditions with a relative, then after a short period of time in homeless accommodation, were allocated social housing.
13. Both parents had difficult upbringings, both experiencing violence and sexual abuse. The father was involved in criminal activity from an early age and has numerous convictions for both property related and violent offences. Both parents have been involved in abuse of alcohol. On occasions one or both parents have been observed to be drunk whilst caring for the children.
14. There was evidence of domestic abuse from early on in the parents' marriage. The police responded to numerous incidents at the family home. Most of these involved an adult child from the father's first marriage. Although in most incidents violence was not directed against the mother, it was frequently witnessed by the children. The Probation Service was involved in the management of an offender who was bailed to live at the family home. The probation officer undertook risk assessments on the offender and the situation was managed through the MAPPA process.
15. The children in the family suffered many minor injuries. They were frequently seen at hospital A&E. None of the injuries were attributed to non-accidental injury. The review evidenced that one injury was associated with a domestic violence incident, others were not properly accounted for. Two older children were reported as missing from home on a number of occasions and at other times were seen out unsupervised and became involved in anti-social or criminal behaviour.
16. From school age the children all attended the same primary school. Teachers had concerns that the children were poorly clothed, suffered poor hygiene and appeared neglected. One of the children was incontinent and one had very serious dental decay necessitating tooth extraction at the age of six. One child exhibited sexualized behaviour. The behaviour of the older children became very difficult to manage and one of them was excluded from primary school. Secondary school was unable to meet the needs of the two oldest children and both received education services provided by the Education Other Than At School (EOTAS) service.
17. Two children were assessed for Attention Deficit Hyperactivity Disorder. The diagnosis was made in one, although for the second child the home circumstances were thought to be a significant contributory factor in his behaviour.
18. The two youngest children have been born since the family moved to Torbay. During the pregnancy with the first of these children the mother was observed to be abusing alcohol. A pre-birth assessment was commissioned, but was not started by the time the baby was born. Three days after

this baby came home from hospital the baby needed admission to the Special Care Baby Unit because of poor weight gain and jaundice, being discharged again soon after starting to gain weight. . The mother subsequently avoided assessment checks by the health visitor.

19. During the pregnancy with C11 the mother experienced repeated problems with her physical health eventually needing surgery. There was only one observation of her alcohol abuse during this pregnancy. C11 was born with a very low birth weight and very small head circumference.
20. Following the death of C11 the Peninsula Rapid Response Team carried out an investigation under the Child Death Review process(in line with national guidance). Although the serious case review has identified widespread concerns about the family these did not come to light at the time of C11's death. I. Consequently immediately following the death no consideration was given to the need for additional assessment of safeguarding risk to the other children in the family.
21. At a later stage in the process concerns became apparent to the Child Death Overview Panel (CDOP) so Children's social care was notified at that point, nearly a year after C11 died. Children's social care immediately called a child protection strategy meeting, which resulted in a core assessment being undertaken. By that time the Family Intervention Project was involved with the family and the core assessment identified that this was appropriate and should continue.

## Key Issues Arising from the Case

22. A number of significant issues arise from this case, none of which can be shown to have caused the death of C11, but many of these issues contributed to a failure by all agencies to work together to diminish the risks to the baby. The most significant of these issues are as follows:

### **The family environment**

23. The children were brought up in a family in which both parents smoked and were heavy drinkers. The father suffered from a range of physical ailments and there is no record that he had paid employment. Material conditions in the house were poor and the children were not well clothed. Violent arguments, frequently requiring attendance by the police, were common. The children were often inadequately supervised and became involved in criminal and anti social behaviour from an early age. They also suffered frequent minor injuries. Neighbours made several complaints about the children to the housing provider.

24. The significance of this environment is the impact that it would have had on the children's identity and self esteem and the expectations that professionals would have had of the children's potential to achieve satisfactory outcomes. It is noted that many professionals saw the family as 'typical of the area' and had lower expectations of standards of care, health, behaviour and attainment.

### **Information Sharing**

25. The family had contact with staff from 15 different agencies. A significant amount of information on the family was available from the city in which they had previously lived, where the children had been on the then child protection register. The family was also subject to a number of different assessment processes in Torbay, none of which made effective use of the available information and none sought to obtain any additional information from other agencies or pass on known information (within and between agencies).. .

26. This meant that no single agency was able to assemble a holistic picture of what it was like to be a child in this family. . In addition, when multiagency plans were attempted through the common assessment framework and pre birth assessment chance of success was limited by inexperience of the lead professional, lack of clarity about responsibility for implementing plans and the above information sharing problems

### **Compliance with Safeguarding Procedures**

27. Even though the review identified that this case had a significant number of current and historical risk factors. these were rarely seen (as they arose) as sufficient to trigger formal child protection processes. This appears to be due to a failure to develop a comprehensive picture of the risks faced by the children and appeared compounded by a belief, held by many practitioners who had contact with the family, that the parents were cooperative. Generally this belief was supported by very limited evidence and agencies tended to ignore signs to the contrary, such as large numbers of missed appointments.

28. On occasion when professionals felt a threshold for formal child protection referral had been reached and a referral was made, it was either not accepted, not actioned appropriately or not followed up. There was no consideration of historical information.

29. There is evidence that staff in children's social care, education, health and youth offending services were either inexperienced or unfamiliar with child protection policies and procedures. Some staff lacked confidence in their use and consequently did not access supervision or feel able to challenge decisions made or actions taken by other agencies.

### **Assessments of Risks and Needs**

30. In assessing the needs of the children and the risks they faced there were repeated failures to make proper use of the historical information available, or build a comprehensive picture of life in the family. A variety of assessment processes were undertaken but these were poorly linked and rarely properly completed. Only one care plan for the children was developed by children's services and the aim of this was to close the case. Other agencies, notably schools and youth offending services, developed plans but these were focused on specific behavioural problems and did not consider the wider family issues that may have contributed to the behaviour.
31. The Common Assessment Framework (CAF), which was initiated by the primary school, should have provided an opportunity for agencies to share information and develop joint plans for the family based on cooperation with the parents. It appears that the CAF was not well understood by staff in some agencies and was poorly managed. While there are strong advantages to working in cooperation with parents, it is very important that the degree of parental cooperation is properly evaluated. In this case it was not.
32. Much of the assessment work was based on the needs of the parents and lacked a clear focus on the needs of the children. Although signs of neglect were observed in the children, practitioners failed to focus on their needs and gain an understanding from them of what life was like. Incidents involving the children failed to be seen in a wider family context and no analysis of the possible causes of their behaviour was undertaken. The children received a significant number of minor injuries, which were viewed as accidental. Although there is no evidence that injuries were deliberately caused the pattern of injuries being an indication of a parental failure to safeguard the children was not considered.
33. Two of the children were diagnosed as suffering from Attention Deficit Hyperactivity Disorder (ADHD). In one child the diagnostic process was slightly inconclusive, but in reaching the diagnoses there was no proper consideration of the family background and its possible influence on the children's behaviour. Following the diagnosis agencies were more inclined to absolve the parents of responsibility for the behaviour of the children.
34. In pre- and post-natal assessments of risks to the two babies in the family, the maternity services failed to make use of information that was available in the health community. The second baby was under a different midwifery team to the first baby and this team was not aware of information held by the first team. Information held by the GP was not available to hospital staff. Concerns held by the health visitors and school nurses were not shared with the GP. Information about the role of alcohol in A&E attendances was not made available to the GP or other hospital staff. The ambulance

service made a referral to Torbay Children's Services, which was good practice, but this was not acted upon.

35. There was awareness amongst some agencies that the parents were, at the least, problematic users of alcohol. This use of alcohol seems to have been accepted by practitioners who appeared to make efforts not to be judgmental. No agency considered the possible damaging effects on the children of their parents' alcohol use and no agency considered referring the parents to alcohol misuse services. Tolerance of the parents' misuse of alcohol is a significant feature of this case.
36. Several of the interventions in the family focused on the anti-social or criminal behaviour of the older children. Youth offending services workers spoke to the children about their behaviour and discussed the consequence of the behaviour but did not consider the circumstances in the family that might have contributed to this behaviour.

### **Advice to Parents**

37. Some agencies gave advice to the parents, but this was frequently in written form. The school was aware that the father was illiterate but no other agency seems to have considered this as an issue. Consequently the effectiveness of the provision of written advice may have been limited. This was likely to have been particularly significant in advice given by maternity services about the care of a new born baby. It is known that advice about co-sleeping with a baby was given. It is not known if the parents understood this advice, and they did not act on it.

### **After the Death of C11**

38. Following the baby's death the case became subject to the South West Peninsula Child Death Overview Protocol. Immediately following the death the case was investigated by the Rapid Response Team. Team members visited the family, sought information from the agencies that they knew to have been involved with the family and made referrals for health support. This did not include Children's Social Care. None of the agencies contacted raised any concerns about the family's previous history or any risk factors. Torbay Children's Services were contacted by the police, but were informed that there were no concerns and consequently did not get involved. The failure by the Rapid Response Team to inform Children's Social care was contrary to the protocol and meant a missed opportunity to further consider the safety or wellbeing of the other children in the family.
39. The subsequent meeting of the Child Death Overview Panel took place nearly a year after the baby had died. That meeting had the benefit of a written report from the GP who had analysed the historical information in his records and identified and had identified serious concerns about the children. Following this meeting Torbay Children's Services immediately held a strategy meeting and

undertook a further core assessment to ensure that the other children in the family were safeguarded.

### **Conclusions and Lessons Learned**

40. The reasons for the death of C11 are not known. It is known that C11 was co-sleeping with the mother, that the mother was a smoker and had drunk alcohol on the night the baby died. It is also known that there were a number of other interacting risk factors, including the father's abuse of alcohol, domestic violence, neglect and possible abuse of the older children. Co-sleeping with a baby does not pose a known risk of harm to the child unless there are other risks present in conjunction with the co-sleeping. Significant risks exist when a parent has used alcohol or drugs. The mother's use of alcohol and many of the other interacting risk factors were known to most of the agencies involved in this case, yet there is no evidence that the potential dangers to the baby were considered in the plan to discharge C11 from hospital when the baby was 13 hours old. The failure to consider the risk factors in the plan to discharge the baby from hospital stems directly from the lack of awareness of these factors by those responsible for the discharge plan.
41. The failure of inter and intra agency information sharing in relation to this family and the failure to analyse the interacting risk factors resulted in the baby going home from hospital to a potentially dangerous environment without adequate safeguards being in place. The death of C11 cannot be attributed to these failures, but it is reasonable to expect that had the maternity services been fully aware of the home circumstances, additional safeguards could have been put in place that would have reduced the risks to the baby.
42. The children were subject to a significant number of risks, including parental alcohol abuse, domestic violence, physical neglect, criminal and anti-social behaviour, school exclusions, many unrecognised. None of these in isolation was sufficient to trigger child protection processes, but as a combination of interacting risk factors made it likely that the children would achieve poor outcomes. No agency gave proper consideration to these factors.
43. The pressures faced by the intake team in Torbay Children's Services meant that thresholds for child protection work were high. As this case was not seen to reach the child protection threshold there was no formal multi agency planning and information sharing process. Use was made of the Common Assessment Framework but it appears that the plans lacked clarity and were incomplete. Some key agencies were not invited to participate and responsibility for implementation was unclear.
44. There is no evidence that actions or omissions by any agency contributed to the death of C11. However there was a joint failure by all agencies to share and make use of information about the

children in this family. This failure was particularly marked within health. The organisation as a whole possessed sufficient information to analyse the risks to C11, yet this information was not collated and made available to the practitioners responsible for the baby's discharge from hospital. The failure to share information was compounded by a failure of individuals or teams to make use of all the available information to assess the risks to all the children in the family. The assessments undertaken in children's social care, which should have led to appropriate care plans, were inadequate, and in common with other agencies failed to take account of the views of the children and assumed a higher level of parental cooperation than was supported by the evidence.

## **Recommendations**

45. Each of the IMRs produced a series of recommendations, which are included in the action plans. The shortcomings in the NHS have been well identified in the Health Overview IMR and the recommendations to address these are comprehensive and appropriate and are therefore not replicated here. In addition to the individual agency recommendations, the following recommendations are made either to strengthen the individual agency recommendations or to highlight the need for a joint agency approach to address a particular issue.

46. A previous serious case review (Child A) in Torbay examined the circumstances around a child who received serious injuries in the autumn of 2008. The events in that serious case review were occurring at the same time as the events in this one. The recommendations and action plans from the previous serious case review had not been published before C11 died. However it is worth noting that many of the findings in the earlier SCR are replicated in the case of C11. The most relevant of these were:

- Inadequate information sharing between agencies resulted in a failure to develop a comprehensive multi agency analysis of the risks to child A either before or after his birth.
- There was a lack of clarity about the appropriate decision making framework for this case, with the result that key decisions were made without the benefit of multi agency input or scrutiny.
- Assessment and planning appeared to be influenced by the notion that the parents were cooperating with professionals. This notion was not supported by the evidence.
- Supervision of front line workers lacked sufficient rigour and challenge.
- Concerns about risks to child A were identified at an early stage. There was a significant lack of urgency in assessing these risks, which meant that by the time he was allowed to live with his parents unsupervised, the risks had not been properly assessed.

The recommendations and action plans from the previous serious case review could not have been implemented at the time C11 died, but they reinforce many of the issues identified now.

47. **Recommendation 1.** The TSCB should take steps to ensure that all the recommendations and actions from the previous Serious Case Review (Child A) have been implemented and expected outcomes achieved and evidenced.

**48. Recommendation 2** In view of the Ofsted unannounced inspection of contact, referral and assessment arrangements within Torbay children's services in May 2010, The TSCB should seek evidence from Torbay Children's Services of the outcomes achieved as a result of the action plan developed in response to the Ofsted inspection.

The TSCB must be confident that the following areas for development and priority action, which were identified by Ofsted and which are also themes arising from this case, have been satisfactorily addressed:

- Clear thresholds for access to social care services...are not always appropriately applied.
- Some child protection cases are allocated to, or assessed by, staff who are not qualified social workers.
- ...children's views are not consistently reflected in the assessment process.
- Communication with partner agencies on the progress of assessments is inconsistent.
- The quality of assessments and subsequent care planning are inconsistent and lack a clear focus on outcomes for children and young people.
- There is a significant delay in the transfer of some cases between the referral and assessment service and other social care teams, which results in a drift in the work with some cases and severely limits the capacity within the team.
- Most social workers are currently carrying excessive case loads. A significant number of cases are awaiting completion of assessments, recording of information, or management decision.
- Managerial oversight and case planning...are of poor quality, insufficiently robust and not consistent.
- Staff supervision .... is not compliant with council requirements. Supervision is not sufficiently regular, clearly documented, or providing appropriate professional challenge.
- In some cases the response to child protection referrals does not meet statutory guidance and does not ensure that some children are adequately safeguarded. Timescales for the completion of some assessments are poor.
- Some assessments do not demonstrate a clear analysis or evaluation of risk to the welfare and safety of children. The outcome of assessments and managerial oversight on some child protection cases are not recorded on case electronic records or in case supervision. It is therefore not always possible to establish whether these children are safe.

**49. Recommendation 3** Torbay Children's Services must ensure that staff are enabled to use a suite of assessment tools to accurately assess the risks to children arising in specific circumstances including parental alcohol abuse, neglect and domestic violence.

50. **Recommendation 4** The TSCB should take steps to raise public and professional awareness of the dangers for children of parental alcohol abuse.
51. **Recommendation 5** The TSCB should seek a response from partner agencies to the Joint Guidance on the Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services (DCSF/DH/NTA November 2009) and must ensure that appropriate inter agency protocols are in place in order that the children of drug and alcohol abusers are protected from harm and their welfare needs are met.
52. **Recommendation 6** The TSCB should review its training programmes in the light of the analysis contained in the Far South West Peninsula CDOP Annual Report (June 2010) and the issues arising from this serious case review, to ensure that practitioners in all agencies are aware of the significance of interacting risk factors, including historical factors, and recognise the risks posed to children in families in which no single factor places a child at risk of significant harm, but where a combination of factors may be dangerous.
53. **Recommendation 7** The TSCB must ensure that it has a robust process for monitoring the implementation of actions arising from the Serious Case Review Overview Report and the individual agency and Health Overview IMRs, and that it receives regular reports with evidence of outcomes achieved.