CUMBRIA LSCB

CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

Serious Case Review

Child L

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1. Introduction

1.1 This serious case review was conducted under the statutory guidance of Working Together to Safeguard Children 2013[1] which states that a serious case review should take place "for every case where abuse or neglect is known or suspected and…a child dies". This review is about agency learning from the death of Child L.

1.2 Child L was born at 31 weeks gestation in May 2011. In the early hours of the morning in July 2011 he was taken to hospital by ambulance where he was pronounced dead by a consultant paediatrician at 08.47 aged 43 days. There were numerous medical reports into Child L's death which identified different injuries including a fracture to the skull, possible haemorrhage behind the eyes and possible subdural haemorrhage.

1.3 The guidance is clear that serious case reviews are a part of the learning and improvement framework that all local safeguarding children boards must have in place to identify learning from cases in order that local and national practice to safeguard children can continuously improve.

1.4 Reviews therefore must seek to:

- identify precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- understand practice from the point of view of the individuals and organisations involved at the time rather than using hindsight;
- be transparent about the way information is collected and analysed; and
- make use of relevant research and case evidence to inform the findings

1.5 The purpose of a serious case review is to conduct "a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children," (Working Together 2013, page 65).

[1] At the time of the incident and the consideration of the criteria for SCR, Working together 2013 was in place, however this has now been superseded by Working Together 2015

2. Terms of Reference

2.1 Cumbria Safeguarding Children Board Case Review sub-committee developed the following terms of reference for the review:

- The timeline was from the birth of the parents' first child in October 2009, until the date of Child L's death in July 2011.

The key questions centred on information sharing i.e. was information:

- *Shared appropriately?*
- *In a timely fashion?*
- *To all relevant agencies?*

i) In addition the following issues were explored:

- Risk Assessment
- Any issues for the older child
- Were any opportunities to intervene missed?

ii) To ensure a full picture, contextual information was used to provide a brief synopsis to establish the family history that Child L was born into.

3. Methodology

3.1 The review was conducted largely as a desktop exercise with a panel of experts to oversee the work.

3.2 Safron Rose from Reconstruct was the Independent Author. LSCB Member - Pam Hutton, who represents small voluntary sector organisations, was the Independent Chair of the Panel.

3.3 Agencies known to Child L's parents were asked to provide a chronology and these were integrated into a combined chronology. The following agencies provided a chronology:

- Cumbria Police
- North Cumbria University Hospitals
- GP Medical Practice
- Children's Services
- Cumbria Partnership Foundation Trust

3.4 The thorough desktop review commenced in November 2014. The purpose was to gather, evaluate and analyse all file material – both electronic and paper

records that covered the review period. The process was extended to relevant background information held on Child L's parents and his sibling (LS) who was 21 months old when Child L died.

4. Independence

4.1 An independent chair, Pam Hutton (representative of Voluntary Organisations in Cumbria on the LSCB) was appointed by the Safeguarding Children Board to chair the expert panel.

4.2 The lead reviewer was Safron Rose, a full time consultant manager and trainer with Reconstruct, a company providing child care training and consultancy to managers and staff throughout the United Kingdom. Reconstruct also supplies advocacy, independent reviewing officers, independent visiting and participation services to children in London and south west England.

4.3 Safron has over twenty five years' experience in child protection social work. She has been involved in a number of serious case reviews since 2010 – either quality assuring the work of Reconstruct's consultants, chairing review panels and producing overview reports. Safron has a Diploma in Social Work, a CQSW and she also qualified as a mental health social worker. She has held various operational and strategic roles and is a former Director at the NSPCC. Furthermore, she was a visiting lecturer on the Tavistock Centre post graduate Leadership Course (D66).

5. Panel

5.1 The expert panel met on two occasions between February and April 2015. The overview report was ratified at the Local Safeguarding Children Board meeting on 21 January 2016.

5.2 The Expert Leads Panel comprised of:

Title	Organisation
Panel Chair	LSCB Member
Senior Manager	LSCB
Designated Nurse	Clinical Commissioning Group (CCG)
Lead General Practitioner (GP) for Safeguarding Children	CCG – Primary Care
Senior Manager, Child Protection	Children's Services

Title	Organisation
Named Nurse Safeguarding & Protection	Cumbria Partnership Foundation Trust (CPFT)
Detective Superintendent	Cumbria Constabulary
Lead Midwife, Safeguarding	North Cumbria University Hospitals Trust

6. Confidentiality

6.1 Working Together to Safeguard Children 2013 clearly sets out a requirement for the publication in full of the overview report from serious case reviews

"All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case."[2]

7. Family Involvement

7.1 Child L's Mother (LM) was informed of the serious case review. However the Expert Leads Panel agreed that it would not be possible to include her in the process due to police enquiries which were also underway during the review period.

7.2 The Final Draft of the report was shared with LM at a meeting with the Expert Leads Panel Chair on 27 May 2016, and her views have been reflected in this final version of the report.

8. Parallel Processes

See 7.1

[2] Working Together to Safeguard Children 2013 p71

9. Time Scales

9.1 The serious case review commenced in May 2014 after being "stalled" in February 2014, due to there being very little agency involvement with Child L at the time of death. This was an erroneous decision due to a mis-interpretation of the criteria for a serious case review.

9.2 In May 2014, the incoming chair of the LSCB reviewed this decision, as part of a wider review of previous serious case decisions between 2011- 2014. The decision was then reversed by this LSCB chair who commissioned this review.

10. Dissemination of Learning

10.1 Learning from this case will be shared through the LSCB Business Group, who will take responsibility for translating the learning, where appropriate, into changes to practice and procedures as well as disseminating key messages to all staff through learning and training opportunities and through the LSCB's communication channels.

11. Race, language and culture

11.1 Child L's parents are white British, their first language is English and there was no reference to a specified religion in the case files.

12. Background Information

12.1 As Child L tragically only lived for six weeks, the Expert Leads Panel agreed that the review should concentrate on Child L's parents, their parenting of Child L's sibling, as well as Child L's short life.

Child L's Mother (LM)

12.2 LM, Child L's mother was born in May 1989. Cumbria Children's Services became involved with the family in August the same year, due to her parents' inconsistent, poor parenting and drug abuse. At times LM was subject of a child protection plan (1989, 1992 – 1994, 1998, 2001) due to neglect. LM was distressed to learn about the early involvement of Children's Services with her family. She said she had no previous knowledge of this prior to reading the overview report.

12.3 She told her social worker that during her childhood she was in effect caring for her mother and older brother who had significant learning difficulties. She had a very close relationship with her grandparents who provided respite for her at their home. However her circumstances deteriorated and in 2002 aged twelve the local authority obtained an interim Care Order and LM became a looked after child. During her period in care LM was involved in criminal activity and anti-social behaviour which culminated in her being remanded into secure accommodation in 2002 for a period of eighteen months for very serious offences.

12.4 In 2007 the Care Order ended and LM left care to live independently. It was reported that her behaviour settled and she established a stable lifestyle with support from her extended family.

12.5 During 2009, aged 20, whilst pregnant with her first child LS she returned to live with her mother because the flat she was renting had damp which she felt was unhealthy for a new born baby.

Child L's Father (LF)

12.6 Little is known about LF, who was born in July 1981. He was not known to Children's Services prior to the birth of child L's sibling, LS. He has been known to the police for minor offences in 2003 and 2005.

12.7 He has two older children, a boy and girl with whom he has no contact. LM claimed not to know of the existence of these children.

Parent's relationship

12.8 LM and LF had been in a relationship for approximately eighteen months when their first child LS was born in September 2009. LM was aged 20 and LF aged 28 at the time.

12.9 LS was born two weeks premature and as a result transferred to the Special Care Baby Unit due to low birth weight and feeding problems. She was discharged home on 11 October 2009 to LM's care who was still living with her own mother.

12.10 LM moved to her own tenancy in January 2010.

13. Child Protection Concerns

13.1 In September 2009, the day after LS's birth the community midwife (CM1) made a referral to Children's Services due to tensions in the relationship between LM and her own mother which were observed by nursing staff in the delivery suite. During LM's labour, her mother asked CM1 for prescription drugs. She was also aggressive toward her daughter.

13.2 An initial assessment was completed on 7 September 2009 and a strategy discussion was held the following day. These actions led to completion of a core assessment on 23 November 2009 to see what support could be offered to LM. The assessment concluded no further action was required because the relationship between LM and her own mother was stable and supportive and the home conditions were no longer a cause for concern. The case was closed.

13.3 On 3 December 2009 Children's Services received a referral from the NSPCC concerning alleged drug use at maternal grandmother's home and concern about the welfare of LS, who was eight weeks old at the time. An unannounced visit was made on 14 December 2009 but the family was not in. A second visit was made on 22 December 2009 during which LM denied any drug use in the household. The social worker observed LS to be a bright and alert child. Children's Services concluded that the concerns were unsubstantiated and the case was closed.

13.4 On 1 March 2010 the police were called to an incident at the home address of LM. An argument had occurred between LM and LF who fell and cut his face during the altercation. It was recorded that no offences were disclosed. LS was present but she did not witness the incident. A referral was made to Children's Services who made telephone contact with LM on 2 March 2010. LM explained that LF had arrived at the house drunk and she had shouted at him to leave. She said that their relationship was over but LF would not accept this. LM asked the police to remove LF's belongings.

14. Narrative of Events surrounding Child L's death

14.1 On 12 February 2011 she was seen by community midwife (CM2) for a booking appointment. She was seventeen weeks pregnant at the time, which was considered late for the first appointment.

14.2 There were no identified problems during pregnancy or delivery although she did not attend several antenatal appointments (which included follow up visits to missed appointments), some of which were due at the hospital. The community midwife at the time did not consider this to be a problem because she was still able to provide clinical care during home visits, some of which were unannounced. However in accordance with the Perinatal Institute for Maternal and Child Health guidelines, mother's failure to attend hospital appointments did not meet the required standards. There was no record of the community midwife complying with the missed appointment guidelines.

14.3 Child L was born prematurely at 31 weeks in May 2011 and was admitted to the Special Care Baby Unit where he received respiratory support. Child L was discharged home to his parents' care on 30 June 2011.

14.4 Prior to discharge Child L was examined by three consultants on six separate occasions. During one examination a possible heart murmur was detected, which was again noted on the day of discharge but it was not considered to be a cause for concern and he was assessed as fit for medical discharge.

14.5 Child L was seen at home on 1st July 2011 by the health visitor where he was observed to feed well and was putting on weight. During this visit LM informed the health visitor that she and LF were having difficulties in their relationship but they had decided to stay together for the sake of the children.

14.6 Child L died at home in July 2011 at 43 days old. Medical experts concluded that he died from cardiac arrest which on balance of probabilities was secondary to some form of head injury.

15. Analysis

15.1 The analysis of this review was based on desk top research and interviews with professionals known to the family. The information focused on each child protection episode and took account of research on the following themes:

- Avoidant Families
- Risk Assessment
- Domestic violence

i) Furthermore it is cross referenced with the key questions set out in the terms of reference i.e. was information shared:

- Appropriately?
- In a timely fashion?
- To all relevant agencies?

ii) In addition:
- Were any opportunities to intervene missed?

15.2 In situations where a baby who has an older sibling has died, it is necessary to examine the care that the sibling received from their parents and professionals to assess whether there were any warning signs that may have indicated that the deceased child was at risk.

15.3 There were three child protection episodes during the timeframe of the review; each one relating to LS. These were assessed against the questions listed above.

Episode 1

15.4 The hospital midwife's referral to Children's Services in September 2009 was decisive and correct in the circumstances. The referral was timely (prior to LS's discharge home) and Children's Services acted swiftly to assess the situation.

15.5 Community midwife1, the Police and LM's Pathway worker all contributed to the initial assessment, which indicates that information was exchanged between professionals to inform the process. Information included details of the inadequate parenting LM received from her own parents and her time as a looked after child with the local authority. The assessment noted that little was known about LF and therefore his role within the household needed to be understood in terms of his potential for protection as well as any adverse effect he may have had on the safety of LM and their child.[3]

15.6 The initial assessment appropriately identified the following risk factors:
- Maternal grandmother's drug use
- Past neglectful environment at maternal grandmother's house
- Volatile relationship between LM and her mother
- LM and her mother refusing to work with Children's Services

15.7 Representatives from Health, Police and Children's Services all attended the Strategy Meeting on 8 October 2009. Evidently the hospital midwife had informed community midwife 1 of their referral as community midwife 1 was able to attend the meeting, which was good practice. However the main problem identified at the meeting was maternal grandmother's volatility. The

[3] Learning from Serious Case Reviews Bandon et al., 2008

plan was for LM and LS to live temporarily with maternal grandmother. It was recorded that there were no concerns about LM's parenting ability or the conditions at maternal grandmother's home. At that point in time, the latter was based on the appearance of the sitting room during visits by community midwife 1, which was not thorough or satisfactory. Despite knowing that there were concerns about the home environment in the past, professionals did not look around the property. No mention was made of LF, or LM and her mother refusing to engage with Children's Services, which is worrying because it suggests that these factors were no longer considered to be risk factors that required assessment. Furthermore, it is difficult to understand how the family would engage in the assessment as a result.

15.8 The aim of the core assessment was to consider the parents' ability to safely care for LS and to look at the family situation in more detail and analyse the level of need and/or risk faced by LS, with a view to providing support to LM. Pathways, community midwife 1 and the health visitor service were identified as the multi-agency network contributing to the assessment, which was relevant given their recent and on-going involvement with LM.

15.9 It was recorded that LM did not want the social worker to visit her mother's home and that she did not believe that her mother would cooperate with the assessment. She did not think that there was anything wrong with the home conditions. The assessment concluded that both parents felt well supported by their respective family and friends. They appeared to have gone through a troubled period early on in their relationship but this had settled down since LS's birth. There was no evidence of a volatile relationship between LM and her mother, in fact the relationship was judged to be mutually supportive and the home conditions very good. LM's history in care was taken into consideration and the conclusion drawn that she had established and maintained a stable lifestyle since leaving care in 2007.

15.10 In the author's view the following issues were not rigorously addressed during the assessment which is a concern:

- Maternal grandmother's drug use
- Maternal grandmother's lack of involvement in the assessment
- The impact of mother's experience as a child on her capacity to safely parent

15.11 Consequently it is hard to understand how the assessment was thorough and how the analysis of family dynamics informed risk assessment and decision making. The role that every member of the household played in

caring for LS was not considered; in the case of maternal grandmother it was unknown what risk her drug taking posed or what support she could provide to her daughter as a first time mother in light of the neglectful parenting she had experienced. In the past, maternal grandmother had been a poor role model who lacked parenting capacity.

15.12 It is debatable whether the family fully cooperated with the assessment process. Consequently in all likelihood the professionals experienced disguised compliance whereby the parents appeared to agree to plans and to co-operate with professionals, but in reality their commitment was superficial and designed to placate, obscure and disguise their lack of compliance.[4]

Episode 2

15.13 There was very limited information recorded about the anonymous NSPCC referral to Children's Services in December 2009. The referral was received on 3 December 2009 and an unsuccessful unannounced visit made seven working days later. Children's Services did not act with sufficient urgency given the delay in visiting to assess the environment in which a vulnerable new born baby was living. The recent hospital referral and subsequent assessments do not appear to have heightened the agency's concern.

15.14 The presenting problem related to issues at the home of maternal grandmother and yet she was not interviewed despite the fact that she had been a known drug user in the past. LM denied any drug use in the household which was accepted. All rooms in the home were viewed which was good practice. However the decision to close the case was based on a very partial assessment comprising solely of the unannounced visit which was unsatisfactory. Multi-agency checks were not made and consequently there was no proper investigation into the alleged concerns and therefore there was a lack of understanding of the potential risks and severity of harm to LS. In the author's view there was an eager readiness to accept LM's explanation without an objective oversight of LS's safety and welfare in the household.

15.15 Given LM's history of involvement with Children's Services and related care history it is reasonable to assume that she had a detailed working knowledge of Children's Services interventions including the assessment process.

[4] Beyond Blame (1993), Reder, Duncan and Gray

Professionals have described her as pleasant and plausible. Therefore she may have been very aware of the assessment process and perhaps told professionals what they wanted to hear and presented as cooperative. Research shows that disguised compliance by parents include those who present as engaging and compliant, whilst minimizing harmful behaviours to their child. The result is professionals do not see the reality or impact of the lack of cooperation or compliance.

15.16 What appeared to be good parental engagement could have masked the potential risks of harm to her child and led to a lack of professional concern and involvement. Children's Services was aware that LM was living with her mother temporarily as the plan was for her to secure her own tenancy as soon as possible. In the author's view it would appear that her need for housing possibly overshadowed the safeguarding needs of her child. Furthermore LM's apparent compliance during the unannounced visit possibly deflected the focus away from the referral's allegation of harm. Babies are particularly vulnerable in this type of situation.

15.17 During the core assessment, LM had expressed concern about Children's Services visiting her mother's home. She said her mother would not cooperate with the assessment which was an indication of her mother's likely hostility toward professionals whom she probably viewed with suspicion and criticism.

Episode 3

15.18 The domestic violence incident on 1 March 2010 was the first reported episode to the police, who completed a referral which was faxed to Children's Services the next day, which was good practice. The notification system was effective in alerting Children's Services to the fact that LS was present at the time of the incident; even though her parents claimed that she did not witness the incident. The referral prioritised the risks to LS so that her safety and needs were not overshadowed by her parents' issues.[5]

15.19 The matter was dealt with by a duty social worker in the then Access and Advice team who telephoned LM to discuss the referral. The incident did not progress to an assessment and no further action was taken on the basis that LM had ended her relationship with LF who had left the home and moved in

[5] Stanley, N.et al Children and families experiencing domestic violence: Police and children's social services' responses NSPCC 2009

with his parents. LM was judged to have taken appropriate action to prevent further risk to LS. It was reported that the social worker would have assessed the recent case history which would have been available electronically and the decision to close the case would have involved management oversight.

15.20 As stated previously it is most likely that LM viewed Children's Services with suspicion given her childhood history and it was unlikely that she would have engaged with services had they been offered as a means of support. Given the circumstances of domestic violence, she may well have feared Children's Services removing LS from her care if she were deemed incapable of protecting her.

15.21 However once again the decision to close the case was based on a limited assessment as multi-agency checks were not made and information was not shared to alert other professionals to the factor of domestic violence between the parents and the potential risks to LS. Furthermore, decision-making does not appear to have taken account of the increased risk as a result of the parents' separation. For some time now research has evidenced that incidents of domestic violence continue and can increase at the point of and following separation. It is concerning to note that the lack of information exchange meant that no agency was monitoring LM and LS during this vulnerable period. In this case the known risks for care leavers and their ability to appropriately parent were not considered.

16. Conclusion

16.1 Whilst Child L's death was a terrible tragedy it is clear that his death was neither predictable nor preventable. This review has been about agency learning and has considered the involvement of professionals working with the family, seeking to identify if anything more or different could have been done to understand and respond to the family's needs.

16.2 The parents had been together for eighteen months when their first child was born. Their relationship was described as on/off which was an indication of it being unstable and would have been stressful in addition to caring for a premature baby. LM later told her social worker that her relationship with LF was not always happy, mainly due to his alcohol misuse; which she had not alerted professionals to during the review timeframe.

16.3 Considering her difficult childhood and relatively young age, LM was able to convince professionals that she was a capable parent in a stable relationship, with a good network of support. She participated in the child protection assessments during which she presented as pleasant and plausible.

16.4 LM's troubled childhood history, the lack of information about LF, and the lack of maternal grandmother's involvement in assessments should have raised greater concern for professionals working with the family. On reflection LM was a vulnerable mother who concealed the reality of her circumstances and consequently the risks of harm to her children. During the review process the author has queried whether professionals paid sufficient attention to the potential risks that LS may have experienced whilst living with her mother at the home of maternal grandmother who was a known drug user. There was a lack of comprehensive assessment and robust challenge of the family.

16.5 Professionals should have pushed for the full involvement of all family and household members including LF so that they could fully understand their individual personal vulnerabilities, the family dynamics and potential safeguarding risks. Multi-agency checks and information sharing on occasion was limited and therefore incomplete. Consequently decision making was based on partial information.

16.6 The hospital and NSPCC referrals were an opportunity to highlight potential safeguarding issues for LS and the need for professionals to monitor the situation closely and provide relevant on-going, targeted support and services to the family.

17. References

[1] Working Together to Safeguard Children 2013 p71

[2] National Institute for Health and Care Excellence Practice Standards

[3] Learning from Serious Case Reviews Bandon et al., 2008

[4] Beyond Blame (1993), Reder, Duncan and Gray

[5] Stanley, N.et al Children and families experiencing domestic violence: Police and children's social services' responses NSPCC 2009