Serious Case Review

Child M

Executive Summary

April 2011

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1. Introduction

1.1 The decision to complete a Serious Case Review

1.1.1 Bristol Safeguarding Children Board (BSCB) made a decision to complete a Serious Case Review following an incident in which Child M, aged 2, died in an incident at his grandmother's home.

1.1.2 The Independent Chair of the Bristol Safeguarding Children Board is Dr Ray Jones. Information about the board can be found on (www.bristol.gov.uk/safeguardingchildren).

1.1.3 Child M lived with his mother Ms A and her partner Mr B. At the time of the incident, Child M had been in the care of his maternal grandmother. After Child M's death, there were concerns about aspects of his care and the suitability of Ms C as a carer. Three adults were charged with the manslaughter of Child M and child cruelty. Before the planned trial, the defendants pleaded guilty to charges of child neglect, and their pleas were accepted by the Crown Prosecution Service. They were sentenced in relation to these charges on 21st July 2011.

1.1.4 Safeguarding Children Boards should always undertake a Serious Case Review when a child dies and abuse or neglect is known or suspected to be a factor. The BSCB decided that it must conduct a Serious Case Review in order 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.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- Improve intra and inter-agency working and better safeguard and promote the welfare of children.

1.1.5 Child M and his parents lived in Bristol so Bristol Safeguarding Children Board led the Serious Case Review. Members of the family, including Child M, had lived in South Gloucestershire. This meant that South Gloucestershire Safeguarding Children Board was also involved in the review.

1.2 The Serious Case Review Process

1.2.1 The government guidance, 'Working Together to Safeguard Children' published in 2010, sets out how serious case reviews must be conducted. A copy of this guidance can be found at www.workingtogetheronline.co.uk/wt_2010.PDF.

1.2.2 The Terms of Reference for the review were drawn up by BSCB. These set out how the review was to be conducted.

1.2.3 In addition to the general requirements set out in Working Together to Safeguard Children, the serious case review and Individual Management Reviews were specifically asked to consider in relation to Child M:

- In relation to this child, was there a failure by agencies in working with this family in not recognising evidence of risk of significant harm? If such evidence exists, was this shared and/or acted upon in an appropriate and timely manner?
- In relation to the parents (and anyone who had care of Child M) are there any relevant medical, mental health, substance misuse (including alcohol) issues, previous

convictions, intelligence, domestic violence reports which were known. Is there any information available about the parents' own childhood experience which is relevant?

- Did any agency working with this family fail to recognise previous evidence of risk of significant harm or need? Where such evidence exists was it shared and/or acted upon in an appropriate and timely manner?
- Do any issues emerge in relation to the provision of services to persons in the immediate or extended family who misuse alcohol?
- Do any issues emerge in relation to the use of and accessing of services within another local authority?
- Were members of the immediate and extended family assessed as supportive and appropriate carers for Child M and/or was the appropriateness of these persons considered in the management of the case?

1.2.4 The Terms of Reference identified which agencies were involved in providing services to Child M and his family. Each agency was asked to write a report called an Individual Management Review (IMR) on their work. The aim of an IMR is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and if so, to identify how those changes will be brought about. Most IMR authors were not directly involved in the management of the case. This provided an element of independence in the process.

1.2.5 The review was primarily about Child M but review authors were asked to consider all relevant information about Child M's parents and extended family members who were significant to Child M. The period covered by the review included the time from Ms A's pregnancy with Child M until his death. Professionals were asked to use their judgement whether to include earlier information.

1.3 Reports were produced by the following agencies:

A Health Overview Report was prepared by NHS Bristol.
Individual Management Reviews were prepared by:

- North Bristol NHS Trust
- University Hospitals Bristol NHS Foundation Trust
- General Practitioners (Bristol and South Gloucestershire)
- Bristol Community Health
- Great Western Ambulance Service (GWAS), Clinical Standards Manager
- Children's Social Care, Bristol City Council Children and Young People's Service
- Children's Social Care, South Gloucestershire Council, Department for Children and Young People
- Avon and Somerset Constabulary
- Private Day Nursery attended by Child M
- Barnardo's
- Connexions
- Cafcass
- Youth Offending Service
- 1625 Independent People (formally Wayahead)

1.4 Serious Case Review Panel

1.4.1 A Serious Case Review Panel was set up to manage the process as set out in the Terms of Reference.

1.4.2 The panel commissioned an overview report that brought together and analysed the findings of the various Individual Management Reports as well as information from the family and made recommendations for future action. The panel put the recommendations into an action plan, which is contained in Appendix 1.

1.4.3 The panel evaluated all the Individual Management Reports and supervised the production of the Overview Report and Executive Summary.

1.5 Serious Case Review Panel Members

- David Dungworth, Independent Panel Chair
- Designated Doctor for Child Protection, NHS Bristol/South Gloucestershire PCT
- Designated Nurse for Safeguarding, NHS Bristol
- Service Manager, Safeguarding and Quality Assurance, Bristol Children and Young Peoples Service (CYPS)
- Service Manager – Safeguarding, South Gloucestershire Department for Children and Young People
- Principal Solicitor, Community Services, Bristol City Council
- Chief Executive, PEYTU (Play and Early Years Training Unit)
- Consultant Psychiatrist, Colston Fort Assessment Unit (Avon and Wiltshire Partnership)
- Detective Inspector, Bristol Public Protection Unit, Avon & Somerset Constabulary
- Service Manager, NSPCC
- Head of Service, Cafcass
- BSCB Policy and Project Officer – Safeguarding

1.6 Overview Report Author

1.6.1 Julia Oulton was the independent overview report author.

1.7 Family involvement in the review

1.7.1 Child M's parents and grandparents were invited to take part in the review. One family member contributed to the review through an interview with the Panel Chair and BSCB Policy and Project Officer – Safeguarding. This contribution was used in the overview report. The family will be given the opportunity to read the executive summary before it is published.

1.8 Parallel Processes

1.8.1 The panel has been kept informed of the criminal justice process. The overview report and executive summary will be reviewed following the conclusion of this process to take account of any new information. Neither report will be published until after the criminal justice process has been concluded. Information from the Child Death Overview Panel, which conducts an overview of all child deaths, has been shared with the panel. This

Child Death Overview process will be concluded after the Serious Case Review has been completed.

2 The facts/summary of events

2.1 Child M lived with his mother Ms A and father Mr B. He was regularly looked after by his maternal grandmother Ms C. He also spent time with his paternal grandfather and his partner. All the adults were White British. None of the family had any special needs.

2.2 The year before Child M was born, South Gloucestershire Children's Social Care (SGCSC) had information from Ms A's school with concerns about her welfare. Her attendance had dropped and the school thought there were problems at home. At around the same time, the police told SGCSC that Ms A kept running away from home. Ms A's parents were reported to be drunk when the police called at the house. The house was in a poor condition. There was evidence of an abusive relationship between Ms A's parents and a report that Ms C, Ms A's mother, had assaulted Ms A.

2.3 SGCSC completed an Initial Assessment which focussed on Ms A's behaviour.

2.4 Ms A was offered sessions with an Adolescent Support Worker. She met with a Connexions Personal Advisor who gave information about home tuition and options for nursing and teaching as possible career options. SGCSC closed the case within a few months.

2.5 When Ms A became pregnant with Child M a few months later, she lived with Mr B, Child M's father in bed and breakfast accommodation. A Housing Support Worker (HSW) started to help them to find a more suitable place to live.

2.6 Around this time, Ms A was a passenger in her mother's car when they were stopped by the police. Ms C (Ms A's mother), had been driving erratically. She was found to be drunk and was fined for this offence. Ms A tried to stop the police arresting her mother and she was also arrested.

2.7 Ms A was late booking for ante natal care at a hospital in Bristol. The midwife assessed that she needed support with parenting skills, housing and benefits. The midwife made a referral to Bristol Children and Young Peoples Services (CYPS). Ms A gave permission for the midwife to share information with Connexions.

2.8 Bristol CYPS completed an Initial Assessment which included an assessment of Ms A and Mr B's capacity as parents. The focus of the assessment was on practical help but it did not consider any risk issues. The case was closed before Child M was born. There was no plan to monitor progress.

2.9 The Youth Offending Team (YOT) has a duty to complete an assessment when a young person has received a Final Warning. Just after the Initial Assessment was completed, the YOT tried to visit Ms A to do the assessment. Ms C phoned the YOT to say that Ms A did not want any support because lots of agencies were already involved with Ms A. The YOT were not aware that Ms C was implicated in the offences committed by Ms A. The case was closed without the assessment being completed.

2.10 Child M was born a few weeks later. Ms A was observed by hospital staff to be looking after him independently and two days later they were discharged to live with her mother Ms C. Mr B also joined the household. There was no special discharge plan for Child M.

2.11 The following day, the police were called to a domestic abuse incident between Ms C and Mr F (Ms A's father). Child M was present when the police visited but they did not share this information with SGCSC.

2.12 When Child M was a couple of months old, he moved with his parents into a flat. The Housing Support Worker (HSW) helped Ms A and Mr B set up their home, including help

with paperwork. The HSW took Ms A and Child M to a baby group. The family registered with a new GP. Ms A asked for help from Connexions as she wanted to go to college to do 'A' levels and was looking for childcare.

2.13 Shortly after they moved into the flat, Mr B left Ms A. After an occasion when Mr B had care of Child M, the police were called when Ms A reported that Mr B had failed to return Child M as expected. Ms A said that Mr B had threatened to harm himself. The police checked that Child M was being cared for by Mr B. No other action was taken.

2.14 Ms A applied to the County Court for Child M to be returned to her care. Mr B applied for a residence order. She and Mr B were seen by a Cafcass Family Court Advisor (FCA). The FCA read information from Mr B which alleged that Ms A neglected Child M and that Ms C was an alcoholic. An order was made under Section 8, Children Act 1989 for Child M to reside with Ms A. Ms A was to make Child M available for contact with Mr B on week ends. Cafcass did not follow up the required checks with other agencies or the allegations made by Mr B.

2.15 Ms A and Mr B got back together shortly afterwards. The Health Visitor saw the family at home with Child M twice over the next few months. He was meeting his developmental milestones and had had his immunisations. Good attachment was observed between Child M and both his parents. The Health Visitor knew that Child M was being looked after at weekends by Ms C. Some information about alcohol fuelled arguments between Ms C and Mr F was known.

2.16 When he was a year old, Child M attended a private day nursery so that Ms A could attend an Employment to Education course. A few months after he started at nursery, Child M was taken to hospital by ambulance suffering from a high temperature and fever. The ambulance staff were concerned about the state of the flat. There were cat faeces on the floor and Child M was seen to be in unhygienic conditions. The ambulance staff made a referral to Bristol CYPS.

2.17 The case was allocated quickly for an Initial Assessment to be completed by a Social Worker. This assessment noted concerns from the private nursery attended by Child M. He was unkempt and dirty. His attendance was sporadic. The Social Worker noted that the condition of the home was unsuitable for Child M. The assessment was not as thorough as might be expected. No contact was made with other agencies such as the Health Visitor. Mr B was not living with Child M at the time and he was not contacted. The case was opened for a service to be provided under S17 (Child in Need), Children Act 1989.

2.18 Meanwhile, Ms A lost her college placement because she was not attending. As a consequence, Child M lost his place at nursery. Ms A had a lot of debts and she believed she was suffering from depression. She was drinking a lot at week ends.

2.19 The Social Worker discussed the case in supervision with the team manager. However the agreed plan to complete a Child in Need review or a CAF (Common Assessment Framework) did not take place. CYPS records note that the Health Visitor would make a referral to a Young Mother's project and to Barnardo's. However this is not in the Health Visitor records.

2.20 The case was closed shortly afterwards on the understanding that Ms A was using these services although there is no evidence that this was the case.

2.21 At this time, Mr B was not living with Ms A and Child M. Child M was spending weekends with Ms C. Mr B's father and his partner regularly had Child M to stay.

2.22 Over the next few months leading up to Child M's death, Mr B returned to live with Ms A. A different Health Visitor visited three months before Child M's death. A new assessment was completed. This was followed up by a clinic appointment to check Child M's weight and an appointment with the GP to check the reason for a change in his weight and height. Ms A

and Mr B kept these appointments and noted that Child M was eating and drinking well. No concerns were raised.

2.23 The Health Visitor made a referral to Barnado's for the Community Family Worker home visiting service. The Health Visitor had meanwhile identified concerns as being Ms A's [redacted], cleanliness in the flat and safety issues. The Health Visitor made follow up visits to monitor progress. The last visit was with a Community Family Worker from Barnardo's. This was shortly before Child M died so the follow up service to be provided by Barnardo's did not take place.

2.24 At this time, Ms C was receiving treatment for health problems and had revealed to the nurse that she was drinking again. She was seen to be looking unkempt and smelling of alcohol early in the morning.

2.25 The following day Child M died in an incident at Ms C's home.

3 Key issues or themes arising from the case

3.1 Applying knowledge of the likely impact of parental alcohol misuse and domestic abuse on children's safety and welfare would have led to more informed assessments and effective intervention.

3.1.1 There was some good information sharing about the domestic abuse incidents involving Child M's maternal grandparents. Agencies working with Child M's family also knew that both Ms A's parents misused alcohol and this led to conflict. Child M was known to be at his maternal grandparents' home on two occasions when the police responded to domestic abuse incidents. Health Visitors and Social Workers knew that Child M stayed with his maternal grandmother regularly.

3.1.2 The Initial Assessment completed on Ms A the year before Child M was born, did not take account of the impact of domestic abuse and alcohol abuse on Ms A. A good assessment would have identified the risk of harm to Ms A and made it clear that that her parents had to address their alcohol use. Ms A may have been supported to remain at school and at home. The assessment would have informed later assessments of risks to Child M when he was cared for by Ms C.

3.1.3 There were two occasions when the police were aware that Child M was at the maternal grandmother's home during domestic abuse incidents. Information was shared with SGCSC on one occasion and this should have prompted an Initial Assessment.

3.1.4 The two Initial Assessments completed by Bristol CYPS, one just before Child M's birth and one when he was just over a year old, did not explore the relevance of Ms A's [redacted] or the information about parental alcohol misuse and domestic abuse. Ms C was known to be the main source of support for Ms A and looked after Child M regularly.

3.1.5 Health Visitors completed Family Health Needs Assessments at the required times. There was insufficient detailed information about Child M's maternal grandparent's alcohol use to assess the potential risks.

3.1.6 GPs and other health staff made efforts to assess Ms C's alcohol use and provide treatment. The GP also knew that Ms A drank to excess. None of these staff thought about the impact on Child M.

3.1.7 Bristol Safeguarding Children Board published guidance,' Working with children of problem drug/alcohol users' in April 2008. This guidance was not referred to in any of the IMRs which suggests that it needs to be revised and re-launched.

3.2 Perceptions of high thresholds for Children's Social Care were a barrier to action.

3.2.1 The Cafcass IMR Author identified that a referral to Children's Social Care should have been made following Mr B's allegations of Ms A's neglect of Child M. He also raised concerns about Ms C's suitability as a carer for Child M because of her alcohol use. One of the reasons for the failure to make a referral was the perception that these concerns would not meet the Children's Social Care threshold for accepting a referral.

3.2.2 Similarly, one of the GPs said that Children's Social Care would not accept a referral about the care of young children by an 'alcoholic' parent.

3.2.3 Staff interviewed did not appear to be aware of, or refer to, guidance issued by both safeguarding children boards on thresholds in relation to making a referral. The Munro report suggests that providing the opportunity to discuss possible referrals helps make sense of the presenting concern and information and agree next steps.

3.3 Managerial decisions about resource allocation impacted on the quality of the assessment and service provided to Child M

3.3.1 The Initial Assessment completed on Child M when he was 15 months old, was not sufficiently thorough. No contact was made with other agencies such as the Health Visitor. The process for the manager to quality assure all assessments was ineffective, partly due to the high volume of assessments handled by the team per month.

3.3.2 At the time, the Social Work team had high caseloads. There was difficulty in transferring long term cases to another team. Child M's case was assessed as being low priority. It was not until a couple of months after the Initial Assessment had been completed that the Social Worker and Health Visitor shared the information they had. They were not able to do a joint home visit because of work pressures. During the whole period the Social Worker saw Child M on one occasion. Referrals for services did not take place. The case was closed despite evidence which suggested that Child M's situation was not improving.

3.3.3 Cafcass failed to follow through safeguarding checks and did not complete an adequate risk assessment. Lack of resources and high workloads were a factor in the management of the case at the time of their involvement.

3.3.4 There were resource pressures on the Health Visiting service during the period covered by the Serious Case Review. This meant that four different Health Visitors were involved with Child M. The impact was that there was not a chance to build up a trusting relationship with the family. The lack of continuity meant that referrals for services were slow to be followed through.

3.4 Decisions about needs were made using snap shots of presenting issues

3.4.1 Although most of the services described in IMRs have assessment processes, none used the information available to complete an holistic assessment of Ms A in order to identify her needs and offer services to improve outcomes. Home visits by different Health Visitors provided consistent reports of good attachment between Child M and both parents. There were no concerns about his developmental milestones. The evidence of these mainly visual assessments completely outweighed other information which should have prompted a consideration of risks. These included poor supervision of Child M when he was being looked after by his parents and maternal grandparents or even staying in the maternal grandparents' home with his mother during domestic abuse incidents.

3.4.2 Rose and Barnes (2008) in their study of serious case reviews 2001-2003 noted that children growing up in these circumstances 'showed astonishing resilience – they were bright, intelligent, alert and resourceful even as toddlers. It did not mean, however, that they were less prone to danger or harm, sometimes the reverse. Their very resilience meant that some children placed themselves in potential danger without appropriate parental or other adult oversight' (p15).

3.5 Some agencies need help in order to understand their role in improving outcomes for children

3.5.1 Some agencies found it difficult to identify how the service they provide could improve outcomes for children.

3.5.2 It was not clear that the Youth Offending Service understood how their assessment process could be used constructively to improve outcomes for young people and their children.

3.5.3 Connexions has identified that more proactive monitoring of Ms A's progress could have taken place. Staff did not consider at the time what approach may best engage with a young person in this situation. As a result, Connexions was unaware that Child M had lost his nursery place when Ms A dropped out of college or that this had left her with substantial debts owed to the nursery. Connexions did not know that Ms A was not coping and was being treated for depression.

3.5.4 The private nursery attended by Child M was not able to provide any information about Child M and it was not clear that the author understood how the nursery could have contributed to improving outcomes for Child M.

3.6 'Child in Need' processes did not involve the parents, wider family and professionals in making an assessment and identifying what services should be offered.

3.6.1 Children's Social Care in Bristol and South Gloucestershire provided a service at different times using S17 (Children Act 1989) legislation. This is referred to as Child in Need. However the practice of both local authorities in this case did not bring agencies together with the parents and the wider family to complete an assessment and plan. It has been confirmed that Bristol CYPS policy, procedure and guidance states that Child in Need reviews should include all those involved in the Child in Need plan**.** There is also provision for family group conferences in difficult cases. Although the Bristol CYPS IMR author identifies that expected consultation with professionals did not occur, there is no expectation of a multi agency meeting to include family members as part of the Child in Need plan or review.

3.6.2 Multi agency involvement could have brought together information which would have helped identify the potential risks to Child M which was known by agencies. Involving other professionals such as Connexions could have created a greater understanding of the role each had to play in safeguarding and meeting the needs of Child M.

4 Priorities for learning and change

4.1 Good practice

4.1.1 Although there is good practice identified, its impact was restricted because of the issues as raised in the analysis in section 3.

4.1.2 The Housing Support Worker's engagement with Ms A showed good skills. She established a trusting relationship and provided a good link between agencies. Her approach was positive and sensitive to the needs of Ms A and Mr B and provided practical help. She put in a great deal of effort into finding suitable resources to tackle the issue of parental capacity. She had valuable insights into the issues for Child M and his parents. Her skills and knowledge could have been put to better advantage if they had been co-ordinated with the Initial Assessment and a subsequent support plan.

4.1.3 Health Visitors showed persistence in tracking down Ms A and Child M to ensure family health needs assessments and developmental checks were completed. Health Visitor 7 had begun to engage with Ms A and Mr B. She enabled the involvement of Barnardo's.

4.1.4 The use of Connexions advice by Ms A suggests that she valued the service.

4.1.5 Avon and Somerset Constabulary collation and analysis of information about domestic abuse incidents involving Mr F and Ms C and concerns about Ms A were shared with South Gloucestershire Children's Social Care. This prompted the first Initial Assessment relating to Ms A.

4.1.6 Similarly, Ms A's school identified and shared concerns with SGCSC about the welfare of Ms A.

4.1.7 The efforts made by the GP and other staff to assess and treat Ms C's alcohol use showed good treatment practice.

4.1.8 GWAS staff understood the significance of Child M's living environment when making a referral to CYPS.

4.2 Lessons learnt

4.2.1 This Serious Case Review has been used constructively by most agencies to identify learning and relevant recommendations in order to improve their safeguarding practice. Each IMR author identified lessons and linked these to the recommendations. These recommendations are included in the action plan in Appendix 1.

4.2.2 The six lessons in the overview report flow from the headings in the analysis in section 3. Each lesson informs a recommendation in Section 5

Lesson 1
Professionals working with adults and children need to use their knowledge of how alcohol misuse and domestic abuse impacts on children's safety and welfare when undertaking assessments.

Lesson 2.
Staff need to be clear about what should prompt a referral to Children's Social Care and their subsequent responsibility for responding to a concern raised.

Lesson 3
Decisions about resource allocation impacted on the quality of assessments and services provided.

Lesson 4
Visual assessments on their own are not sufficient to identify risks and needs. The Framework for the Assessment of Children in Need and their Families should underpin all agency assessments.

Lesson 5
All agencies need to understand their role in improving outcomes for children.

Lesson 6
The involvement of both parents and professionals from agencies in meetings together would have facilitated information sharing and understanding.

4.3 Conclusion

4.3.1 It is clear from this Serious Case Review that some agencies had information which suggested that the capacity of Ms C to care for Child M may have been affected by her alcohol use. However, no assessment by any agency identified whether any adult caring for Child M misused alcohol when he was in their sole charge. This means that, even with hindsight, it is difficult to conclude whether Child M's death was predictable. The need for improvements in assessment practice is the key lesson in this Serious Case Review.

4.3.2 The death of Child M could have been prevented by whichever adult was responsible for his care at the time. At the time of writing this executive summary, Child M's parents and maternal grandmother have been charged with manslaughter and cruelty. The Serious Case Review Panel will need to review the conclusions and recommendations of this summary when the criminal process has been completed to include any new information available at that point.

5 Recommendations and action plan

5.1 The action plan for IMRs and the Overview Report will be monitored by Bristol Safeguarding Children Board. The Overview Report recommendations are as follows:

Recommendation 1
Bristol and South Gloucestershire Safeguarding Children Boards must ensure that knowledge from research about the impact of domestic abuse and alcohol misuse on the welfare and safety of children is embedded in assessment practice in all agencies. Action on this recommendation needs to include revision and re-launch of the BSCB guidance 'working with children of problem drug/alcohol users'.

Recommendation 2
Bristol and South Gloucestershire Safeguarding Children Boards need to identify and promote how referrers can be helped to talk through a concern before a referral is made. This is in line with the solutions proposed in the Munro Review of Child Protection paragraph 2.38.

Recommendation 3
Bristol and South Gloucestershire Safeguarding Children Boards need to evaluate the impact of resource decisions on assessment practice**.**

Recommendation 4
Bristol and South Gloucestershire Safeguarding Children Boards need to ensure that all agencies understand and use the principles underpinning the Framework for the Assessment of

Children in Need in their practice. This could include an evaluation of assessment tools to identify whether and how they use the principles and framework for the assessment of needs.

Recommendation 5
Bristol and South Gloucestershire Safeguarding Children Boards need to ensure that all agencies identify how the service they provide can improve outcomes for children and young people.

Recommendation 6
Bristol and South Gloucestershire Safeguarding Children Boards 'Child in Need' processes should ensure the involvement of parents and carers as well as other agencies in multi agency meetings to achieve improved outcomes for children.

References

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Munro, E. (2011)*The Munro Review of Child Protection, Interim Report: The Child's Journey.*

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