Knowsley Safeguarding Children Board

KNOWSLEY SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW IN THE CASE OF CHILD R

Executive summary

The Knowsley Safeguarding Children Board (KSCB) has published the independent serious case review following the death of Child R.

The circumstances that gave rise to this review are that in 2015 emergency services responded to a 999 call from Child R's Mother asking for assistance.

It was reported that a baby below the age of twelve months had suffered a suspected cardiac arrest. When paramedics arrived at the address they were told that the father had attempted cardio pulmonary resuscitation (CPR) and this was continued by paramedics. However, resuscitation was unsuccessful and Child R was pronounced deceased by an advanced paramedic at the home address.

It was reported by the parents that Child R had been in bed with mother; an older sibling had gone into the bedroom to wake mother who did not wake immediately. The older sibling found Child R not moving and told mother. Mother then took Child R downstairs and made several phone-calls. Father then arrived and attempted CPR.

Police conducted an investigation into the death of Child R. A report was submitted to Her Majesty's Coroner, who recorded the cause of death as 'Unascertained'.

KSCB commissioned a serious case review to be undertaken in accordance with Regulation 5 of the Local Safeguarding Children Board Regulations 2006.

The Local Safeguarding Children Board appointed a Lead Reviewer, Maureen Noble, to undertake the review using systems methodology.

The review used a systems based approach to analyse information and present the findings using recommended best practice in identifying improvement and learning.

The purpose of the review was to establish what lessons can be learned from the case to improve safeguarding in the future, to improve inter-agency working and to better safeguard and promote the welfare of children in the local area.

The report identified five key lessons from the serious case review and has made four recommendations, which the board have accepted.

BACKGROUND TO CHILD R AND THEIR FAMILY

The family had a history of involvement with services dating back to 2008. Father has had contact with adult mental health services since 2004.

Child R was the youngest child in a large sibling group. Health records show that when Child R was seen at home by Health Visitors (HV), the home conditions were acceptable and Child R was clean, appropriately dressed and fed, and appeared to have a good bond with Mother.

The family had come to the attention of Children's Social Care (CSC) on a number of occasions. In 2011 a referral was made to CSC because of concerns for the wellbeing of the children.

Father's mental health condition is chronic and enduring and he continued to experience mental ill health throughout the period under review.

His lifestyle appears to have been chaotic throughout the period under review, with frequent intentional overdoses and suicidal ideation (thoughts of taking his life), ongoing drug and alcohol misuse and episodes of violence.

There were reports made that Mother used drugs. The extent of Mother's substance misuse is not known, however concerns about her use of cannabis and cocaine is documented in the referral to CSC in 2011.

Other anonymous referrals to CSC alleged that Mother was using drugs and leaving the children unsupervised. There were also concerns raised in anonymous referrals that unknown men were visiting the family home.

Mother discussed low mood and anxiety with a support worker, although she did not pursue further help with this, despite referral and assessment.

During the period under review, there were several police call-outs in relation to domestic abuse incidents. There is no evidence of assessment being undertaken in relation to wider aspects of domestic abuse including sexual violence.

AGENCY INVOLVEMENT

The review identified numerous contacts with the family during the period under review. The primary agencies involved with the family were Mental Health Services (Father); Maternity and Midwifery Services; Health Visiting Services; Probation Service (Father); Children's Social Care and Family First/Early Help Services. Police were also involved in relation to domestic abuse call-outs and Father's offending.

FINDINGS

The review identified number of findings, where lessons can be learned across agencies on how we safeguard and promote the welfare of children in Knowsley.

The key findings of the review are summarised as follows;

1. *The daily lived experience of the children did not influence professional practice in the case.*

Opportunities to seek and respond to the children's views were missed on several occasions. There were some attempts to engage the children, however there is only one

occasion on which CSC undertook 'wishes and feelings' work with the children following a domestic abuse incident.

There is no record that other agencies assessed the daily lived experience of the children, either by the use of tools to elicit wishes and feelings or by observing the children in the home or school setting.

2. *The impact of Father's mental health on the family was not fully assessed or acted upon. Mother's mental health was not fully explored. Systems need to be strengthened to support joint-working with adult mental health services.*

Adult mental health issues impacted on the functioning of the family. Father's enduring mental health problem was largely treated in isolation of the rest of the family. He cited the children as protective factors and this was taken at face value rather than explored.

Mother's mental health may have been impacted by her drug use; there may have been co-morbidity with depression and suicidal thoughts. She attended a mental health assessment but refused to complete it; this was never followed up.

3. *Domestic abuse was an ongoing factor in the relationship between the parents. One incident resulted in a MARAC referral, however this did not appear to influence decisions in relation to safeguarding the children e.g. there was no Section 47 resulting from MARAC***.**

The children appear to have been present at the majority of domestic abuse incidents. Incidents were appropriately reported by Police, however follow-up assessments and interventions were not focused on the impact of domestic abuse on the children.

There were two missed opportunities in the school setting to respond to disclosures of domestic abuse by one of the children.

4. *Parental drug use and its impact on the children was not fully explored or addressed.*

There is strong evidence that both parents used drugs and that both were chaotic in their use. Despite MGM providing information about Mother's drug use, professionals believed Mother's accounts when she denied using drugs, rather than exploring information received from MGM.

Father's drug and alcohol use was well known to mental health services, but this was addressed in isolation, and without consideration of the impact this had on the family.

5. *Multi-agency working was inconsistent and uncoordinated.*

There appear to have been no multi-agency meetings to discuss the family's multiple risks and vulnerabilities. There was no lead professional for the case and no clear ownership by any agency.

RECOMMENDATIONS

1. The LSCB should be assured that:

(a) When a parent has a chronic and enduring mental health problem and has access to children - even if that access is supervised - that strong links are established and maintained with adult mental health services to ensure frequent monitoring and review of compliance with treatment and the ongoing impact on the children.

(b) All practitioners take appropriate action to include assessment of parental mental health issues in parenting assessments.

(c) There is a robust multi-agency response to failure to engage in mental health assessments and services where this may impact on the wellbeing of the children.

2. The LSCB should be assured that the impact on children of domestic abuse, drug misuse and mental health (the Toxic Trio) is understood by practitioners in all agencies and is taken into account in all assessments and referrals.

3. The LSCB should be assured that the daily lived experience of the child is sought, understood and taken into account in contacts with all agencies. The daily lived experience (or voice) of the child should influence safeguarding practice in all agencies.

4. The LSCB should be assured that local Safe Sleeping[1] guidance is not delivered in isolation of other interventions with chaotic and resistant families (i.e. assessment of other risk factors such as drugs, alcohol and mental health).

The board accepts the findings of the review and is committed to learn from the lessons, which are identified in the report.