Executive Summary

Significant Case Review Child R

Undertaken on behalf of

Highland Child Protection Committee

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1. FOREWORD

The Lead Reviewer wishes to thank all those who contributed to this Significant Case Review (SCR). It is recognised that tragedies such as the death of Child R are hugely upsetting for professionals who were involved with the family and it is to their credit that they were honest and frank in their interactions with the Lead Reviewer.

Particular thanks are due to the members of the Phase 2 Review Team who played a pivotal role in considering decisions and actions taken by practitioners involved with the family. Their professionalism and understanding of their agency's policies, practice and guidance was vital in supporting the Lead Reviewer.

This SCR was conducted over a two year period due to parallel criminal proceedings resulting in an unavoidable lengthy review period.

The importance of the SCR must be the lessons learned and the transition of these into learning outcomes. It must also protect family members who have been affected by the events and the impact it had and may continue to have on their lives, in particular that of siblings. While anonymity is important, it is vital that practice issues are explored thoroughly in order to improve outcomes in the future. It is hoped that the family will be comfortable with the approach taken and the findings of the Review. In particular that Child R's sibling and his carers know their voices have been heard and find a small degree of comfort in this.

December 2016

2.0 INTRODUCTION & REVIEW PROCESS

2.1 This Significant Case Review was commissioned by Highland Child Protection Committee (CPC) in accordance with Scottish Government Guidance for CPCs. The Review was led by an external reviewer.

2.2 A Significant Case Review is intended to discover whether lessons can be learned about the way care and protection systems work together, where a child has died or experienced significant harm.

2.3 Agreed remit:-

"To consider the actions of agencies and their staff in the management of (Child R's) case, including any relevant matters relating to the involvement of agencies with his immediate family, and to identify any learning points in relation to improvements in practice, also taking account of the inter-agency review that has already taken place".

2.4 Process:-

The SCR took place in 2 phases. Phase 1 involved a review of all case files relevant to the family from Social Work, Education, Public Health Nursing and Police Scotland. During this phase meetings were held with managers and supervisors within Social Work, Health, Education and Police regarding their agencies' contact with Child R and his family. Practitioners directly involved with the family were spoken to and these included Midwives, Health Visitors, Social Work personnel and school staff.

In December 2014, in liaison with the then Chair of Highland CPC, it was agreed that the SCR would be put on hold until after the completion of criminal proceedings.

Phase 2 of the Review commenced in July 2016. . At this stage access was permitted to all Police and Crown Office documents relevant to the investigation carried out following the death of Child R.

3.0 FACTS

3.1 Child R aged 2 years old, was found dead on the afternoon of 23 February 2014 in his bed. The only other person within the home at this time was his elder brother aged 10 years.

3.2 The cause of death was cot death and post mortem found no evidence of his death being directly linked to the neglect he had experienced. The child's mother had gone out to work the previous evening and had not returned home. From the subsequent Police investigation it was found that it was not uncommon for the children to be left at home alone overnight.

3.3 Prior to the birth of Child R in 2012, the family had come to the notice of all agencies on a regular basis, most often when domestic violence has been identified. Between 2005 and 2009 on several occasions it was documented by Police and Social Care that the home was dirty, in a mess and that the child's mother was not coping. All such instances were discussed by police and social work and further actions agreed in terms of support.

3.4 The family had received support from services at various points throughout the life of the elder sibling, His name had been on the Child Protection Register twice. The first instance centred on parenting concerns and the second as his mother was the victim of domestic violence.

3.3 In 2011 when pregnant with Child R, his mother had ongoing contact with adult mental health services and continued to be a patient of adult mental health services throughout her pregnancy and following Child R's birth. She was assessed not to be suffering with from any mood disorder or, after his birth, post-natal depression. The handover from midwife to health visitor was a verbal one, with no concerns raised by Child R's midwife.

3.4 From 2003 to the time of Child R's death in 2014 the family had come to the notice of all agencies, most often when domestic violence had been identified within the family. Child R's mother was identified as both a perpetrator and frequent victim at the hands of several partners over a number of years, including the fathers of both her children

3.5 From December 2012 until February 2014 the children's mother worked in a nightclub in Inverness. This included working part-time on a Friday and Saturday night from 2100 to 0300 hours. This meant she did not leave the premises until after 0400 hours.

3.6 During the summer of 2013 it is now known, that the children on at least one occasion were left at home alone while their mother went out drinking in the city centre with friends and work colleagues. On one occasion a work colleague had to tend to Child R. The flat was described as untidy and dirty with food and rubbish strewn on the floor.

3.7 In 2013 a Housing Officer arrived at the family home with a gas engineer as the mother had failed to respond to letters regarding essential servicing of gas appliances. At the same time the Children's Support Worker and a social worker arrived at the house but were refused entry. The Housing Officer raised concerns with Child R's health visitor because of the dirty state of the home.

3.7 Between September 2013 and February 2014 Child R's mother failed to keep appointments with Social Work, Health and Education – in particular she missed essential appointments with the Health Visitor regarding Child R.

3.8 In September 2013, due to increasing concerns from Child R's older brother's school, a report was compiled and shared between Health, Education and Social Work teams. The report was based on assessments of Child R's sibling and commented that his home was "one where he is often subjected to fear, and that was reported to be filthy by housing officials and where there are concerns he has a caring role for his younger brother". It recommended that family circumstances were placing the child at direct risk of harm, and that Social Work should be the key agency in addressing this need.

3.9 These concerns escalated in seriousness in particular concerns regarding neglect of the elder sibling and his violent outbursts at school. Around this time the mother began a course of withdrawing permission for Child R's sibling to speak to a Children's Services Worker at school, cancelling appointments with CAHMS, Health Visitors and Social Workers.

3.10 In late 2013 the NSPCC contacted Social Work having received an anonymous call reporting the flat where the children were living with their mother was smelling badly, with a lot of animal excrement and rubbish lying about. The house was described as poorly decorated and furnished. The caller also alleged that the children were often left alone while the mother worked from 2100 hours to 0300 hours. Social workers arranged a police welfare check and the children were seen with their mother at a friend's flat and were assessed as being well and properly looked after at this time. It was stated that this friend often looked after the boys when the mother went to work. The matter was not discussed as a child protection concern during feedback to Social Work from Police.

3.11 On the night of 22 February 2014 the children were left in the flat alone while their mother went to work. Child R's sibling tried to waken him and when he could not he tried to contact other family members unsuccessfully before going to a neighbour for help. On the arrival of emergency services it was found that Child R was dead. The flat was described as filthy and chaotic. When contacted by telephone the mother refused to say where she was and returned home at 1600 hours the next day. At this time she admitted to police that she had been out since the night before and that the children had been alone.

4.0 ANALYSIS & APPRAISAL OF PRACTICE

4.1 This was a family who spiralled into crisis on several occasions, each time indicated by or preceded by a lack of engagement with agencies involved, including Child R's older sibling's school and social work.

4.2 It is evident from social work files and interviews that there were periods when the mother worked well with agencies and this was true around the time of Child R's birth and for a period immediately following that. However, throughout 2013 a downward spiral of engagement is apparent.

4.3 Child R's mother behaved in a way that was deliberately manipulative at times. This included on at least one occasion persuading a neighbour to lie to Police and say that she often babysat the children following an anonymous concern to social care. Police did not raise a child concern form for one such occasion when completing a welfare check for out of hour's social care and whilst this is not assessed as pivotal, there was a missed opportunity to actively assess the child's living environment to inform child protection considerations.

4.5 The consistent view at all times when the family was an open case to social work was that the elder sibling was at risk due to domestic violence and while that was an accurate and serious concern, other concerns relating to their mother's mental health were not documented as risks at that time within the Child's Plan.

4.6 With regard to Child R's older sibling, there were significant concerns about his presentation to school and his behaviour despite agency discussion and sharing of concerns, these serious concerns for Child R's sibling were not appropriately escalated to senior social care managers.

4.7 The transition between the responsibilities of the Named Person to the need for active social work involvement due to serious child protection concerns did not begin to occur until a senior social work officer was alerted to the case and immediately asked for further assessment. This should have happened at an earlier stage.

4.8 What is clear is that there were several occasions when Child Protection processes could have been instigated and were not and times when important information was not sought or shared that could have better informed assessments of how the family was functioning to enable interventions around neglect.

5.0 CONCLUSIONS

5.1 INFORMATION SHARING

5.1.1 There were several occasions over the years before and after the birth of Child R that more direct and timely intervention could have been taken both to protect the children and understand their experiences, and this is true of all agencies.

5.1.2 Significant information was held by Adult Mental Health services where Child R's mother was a long term patient. There was no evidence of sharing of concerns to any agency about how her behaviour may have impacted on her children.

5.1.3 Child R's midwife was not aware of the child protection concerns related to his older brother, nor of the domestic violence experienced by Child R's mother and so she could not share this when she handed over to the Health Visitor.

5.1.4 The Named Person for Child R's sibling school did not communicate with Child R's Named Person, in order to share concerns and consider how these could be raised jointly. This was a missed opportunity to widen the frame for professionals involved in the care of this family and to highlight how the issues that affected his sibling, could also translate to increased risk of harm for Child R.

5.1.5 The police investigation into Child R's death showed that at least six neighbours suspected the children were being left alone but did not act and the reasons for this are unclear but it may be supposed that Child R's mother did not come across to her neighbours as being a person who would be able to listen to their concerns.

5.2 ASSESSMENT AND ANALYSIS OF RISK BY SOCIAL CARE

5.2.1 Active social work involvement due to serious child protection concerns did not begin to occur until a senior social work officer was alerted to the case and immediately asked for further assessment. This should have happened at an earlier stage.

5.3 ESCALATION PROCESSES AND UNDERSTANDING OF ROLES

5.3.1 Professionals holding the Named Person role for both Child R and his sibling had significant concerns about their welfare that were felt to be beyond typical wellbeing issues. It was recognised by the Named Person that they needed to raise their concerns to social care but the mechanism, whilst evident within Child Protection Guidance and the Highland Practice Model, was not clear to the practitioners involved.

6.0 RECOMMENDATIONS

1. All staff who are Named Persons and Lead Professionals for children must be fully aware of the remit and limitations of their role and they must understand how to raise and share concerns appropriately and what actions to take when they have significant child protection concerns.

2. To support recommendation 1, the Highland Practice Model guidance and Child Protection guidelines must be updated to reflect clear pathways and mechanisms for staff to escalate concerns.

3. NHS Highland and The Highland Council must ensure that all health staff who have significant contact with children and parents have completed appropriate multi-agency child protection training and understand their professional duty in respect of child protection concerns .

4. NHS Highland must ensure that policies relating to missed appointments or refusal of access are up to date and available to all staff.

7.0 CHANGES IMPLEMENTED SINCE REVIEW

1. NHS Highland has delivered specific child protection training for adult mental health staff and this will continue on a rolling programme.
2. NHS Highland has undertaken work to review and update their policy on missed appointments and this will be completed by the end of 2017.
3. Police Scotland has implemented the Vulnerable Persons Database (VPD) for the digital management and sharing of all vulnerabilities (including child concern & child protection concerns) identified by Police and through the National Risk & Concern Hub model of triage, research & assessment has improved quality of information shared; this includes escalation protocols to support early intervention and information sharing to partners where children, young people and adults come to the attention of Police on multiple occasions.
4. Highland Council have amended Highland Practice Model Guidance to make explicit reference to a concern about one child causing consideration about the wellbeing of any other children in the family and the potential implications for other children in the family or network.
5. Highland Practice Model Training delivery has been amended to incorporate the learning from this Review.
6. Highland Council developed and implemented the Family Team model in the autumn of 2014; this being an integrated service incorporating health and social care services, and introducing a Practice Lead for schools whose role includes liaison between schools and the Family Team.
7. The Child Protection Committee have updated the Highland Child Protection Committee Guidance following the initial review of this case on specific areas highlighted – identifying and responding to concerns, escalation process, notification of child's plan and assessments to Named Person, GP etc by Social Work and advice to practitioners on non-engaging families; the Highland Guidance is to be further reviewed and updated during 2017.
8. The Highland Child Protection Committee held an annual conference in 2017 on Neglect to inform practice and learning which was attended by 160+ multi-disciplinary practitioners from across Highland.
9. The Highland Child Protection Committee have supported the implementation of the Graded Care Profile in Highland to complement the Highland Practice Model and offer practitioners access to a neglect-specific assessment tool to support practice with children and young people.

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