Executive Summary of
Review of Practice for

Infant B

Report from: Chief Social Worker
Office of the Chief Social Worker
Ministry for Vulnerable Children, Oranga Tamariki

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Introduction

Infant B was found dead in his cot. The cause of his death had not been established at the time of the review being undertaken. Infant B lived with his family including his mother and his mother's partner in the family home. In the months prior to his death, Child, Youth and Family were requested by the District Court to write a report on the suitability of mother's partner to live in the family home. In addition, a report of concern was made in relation to Infant B in the month prior to his death by the hospital. Infant B was discharged to his mother's care the following day with a safety plan in place. Tragically, Infant B was found dead 5 days later.

The primary objective of the review has been to consider Child, Youth and Family's involvement with Infant B and his family, in particular with the adults living with Infant B at the time of his death. The focus of this review has primarily been on the period of activity in the last three months of his life, however an extensive history of Child, Youth and Family involvement prior to this time period has also been considered to determine what was already known by agencies and how this informed social work decision making.

It was not the remit of this review to investigate the circumstances of Infant B's death as this responsibility sits with the Coroners and the police. Rather the purpose of this review was to consider what was known by Child, Youth and Family at the time, what could have been known, and to consider whether Child, Youth and Family responded appropriately within this context. In undertaking the review, it became clear that a number of agencies also had significant involvement with either Infant B and/or his family. Therefore this review was also designed to consider the learning around the inter-agency mechanisms within which Child, Youth and Family and other agencies operated and to identify areas of learning around these key processes.

The review identified areas where practice was found to be inadequate, both in relation to Child, Youth and Family and in respect of the inter-agency processes. The main objective of the review has been to develop a deeper understanding of what happened and to identify any necessary lessons so as to better protect and support children in the future.

Terms of Reference

The review's terms of reference were to consider Child, Youth and Family's involvement in the assessment of mother's partner for the District Court, and the subsequent investigation for Infant B in light of the report of concern about his injuries. These events are considered in the context of interagency practices and processes.

As part of the review, the review team explored the context in which practice occurred to identify any gaps and learning including;

- The processes around the District Court's request for Child, Youth and Family to undertake an assessment of the suitability of mother's partner to reside in the family home.
- The interface with existing practice policy and procedures, and arrangements outlined in the current protocol between Corrections and Child, Youth and Family

in relation to requests for information from Child, Youth and Family by Community Probation Services.

- The assessment, decision making and report completed by Child, Youth and Family in response to the request from the District Court.
- The concerns reported to Child, Youth and Family in the months before his death and Child, Youth and Family and the inter-agency responses to this.

Review methodology

The review team undertook interviews with key members of staff from the Child, Youth and Family sites as well as staff from Community Probation and Correction Services and hospital staff. Information from Child, Youth and Family's computerised case management system (CYRAS) were interrogated in conducting this review. Invitations were extended to the family members who had raised concerns about the family's recent circumstances and interviews were subsequently held involving a number of family members.

Learning is a key reason for undertaking a practice review. Learning can take place at various levels; the individual practitioner's personal learning about their own practice, the site's or region's learning about their current service provision, and the organisation's learning about systemic barriers to practice. In conducting this review, the review team found individual staff and the site keen to reflect on their practice and had already taken action to improve their practice at a local level. New systems had been implemented at a local level to address some of the issues identified as part of the review – including management of staffing levels, allocation of work, and processes with local partner agencies. Individual staff also identified changes in their own practice since the tragic events. Subsequently, this review therefore focuses on the wider learning for the organisation.

Practice Review – key findings

Consideration of Family Histories in Current Assessments

This review has focused primarily on Child, Youth and Family's involvement with Infant B and his family in the last three months of his life. Prior to this period there had been considerable Child, Youth and Family involvement with the adults in Infant B's life. There was a significant history including previous relationships, patterns of parenting and childcare that ultimately influenced Child, Youth and Family's understanding of the family dynamics and potential risk factors. Whilst the site primarily involved with Infant B and the family were aware of some of this history, there was evidence that some of these patterns of parenting were not robustly explored in the subsequent assessment undertaken by Child, Youth and Family and some significant information was not fully captured. There has been much work done in other child care jurisdictions, particularly in the UK on the merits and design of chronologies and the reviewers believe that this practice would have assisted staff in identifying emerging patterns of behaviours, concerns and responses. This is not standard practice in Child, Youth and Family currently.

Recommendation 1

The development of practice guidance on the compilation and use of chronologies for Child, Youth and Family staff.

Provision of Reports to District Court

It is not usual practice for a request to be received from the District Court for Child, Youth and Family to provide a report on the suitability of a mother's partner to reside in the family home. Child, Youth and Family does not usually have a role in District Court proceedings. The Department of Corrections are responsible for assessing the risk of offenders applying for electronic bail monitoring and whilst they can request information from Child, Youth and Family to inform their recommendation, there is no agreed protocol for Child, Youth and Family providing a report directly to the District Court in such instances. Consequently, the purpose and format of the report, and the process for approving the draft report requested of Child, Youth and Family, was ambiguous and unclear. This, in the reviewer's opinion, influenced the final version of the report which did not contain sufficient critical analysis of the potential risk factors. In hindsight, the report request should have been queried with the Courts.

Recommendation 2

Child, Youth and Family and the Department of Corrections and other services ensure there is clarity in policy around the provision of assessments for the District Court.

Risk Assessment and Joint Decision making

The response to the report of concern in respect of injuries to Infant B was initially robust and there is evidence of good communication and planning in the immediate follow up to the concerns. However this practice was not sustained and the review team found little evidence of collaborative discussion or robust safety planning in the decision for Infant B to be discharged from hospital. Infant B had sustained a number of injuries including one of some severity and there remained a lack of clear explanation for these. In addition there was a known history of concerns about the adults responsible for his care. Given the particular vulnerabilities of Infant B – his young age, number of injuries and the history of both adults, there should have been a more robust consideration and acknowledgment of these uncertainties. Whether these concerns would have been sufficient to allow Child, Youth and Family or the Police to take legal steps to prevent the discharge of Infant B is unclear however the review team would have expected to see some critical exploration of this option as part of a multi-agency discussion as a minimum. Instead, it appeared too much reliance was placed on the medical opinion without full consideration of the other factors outlined above. In addition, the review team found poor communication played a significant role. Roles and responsibilities were not clear and follow up tasks and monitoring was insufficient.

Recommendation 3

Practice guidance on investigation/assessment of initial responses to care and protection concerns is reviewed to strengthen:

a. *Initial risk assessments should more explicitly highlight areas of uncertainty and what steps should be taken to explore and manage these uncertainties*
b. *Child, Youth and Family supervision and management of child protection investigations which promote coordination of investigations and critical reflection of decision making.*
c. *The importance of joint face-to-face inter agency planning, and collective consideration and management of risks.*

Safety Planning

The safety plan developed for Infant B was not sufficiently robust. There was a failure to involve and communicate the plan to key people detailed within it, thus rendering it ineffective and in addition to this it did not sufficiently address the ambiguities and unknowns of the situation. The review team considered the current practice guidance around multi-agency safety planning and felt this to be generally sound and unambiguous in the various steps that should be taken following an admission into hospital as a result of a possible non accidental injury. However in this instance there was no multi-agency discharge meeting. The current guidance on the practice centre outlines core themes and principles of building safety with families and is aligned with the wider departmental assessment framework. Whilst there are obviously clear strengths in this model the reviewers felt the current description on the Practice Centre does not provide sufficient guidance at the initial stages of an investigation or assessment where a core priority must be on the immediate identification of risks to a child and how these risks can be reduced.

Recommendation 4

Practice guidance on safety planning is reviewed to better reflect the guidance on multi-agency discharge planning including the need for:

a. *A clear account of risks, both known and unknown present in the situation, as well as identifying any known strengths that can address/off-set these risks*
b. *Specific reference should be made to areas where there remains uncertainty and a safety plan constructed to take account of these uncertainties*
c. *The actual or potential impact on the child should be central to the decision making and evidenced throughout the safety plan*
d. *A clear rationale for a child returning to or remaining in the family home*
e. *Mechanism in place to ensure the safety plan is constructed and shared with the relevant persons, including family members, agencies etc. who will be contributing to the safety of the child.*
f. *Contingency arrangements should be explicit if elements of the safety plan are not adhered to.*
g. *Quality assurance mechanisms to ensure safety plans meet the expected standards.*

Information Sharing

The review team found evidence that the way information was shared and understood was a frequent barrier to good practice. This applied not only within Child, Youth and Family but also with partner agencies and services. It was noted that whilst agencies and individuals considered in this review 'shared' concerns, there was less evidence of them sharing responsibility for considering what these concerns could mean and how best to manage a response. Instead, agencies and individuals appeared to work in isolation, – passing on information (mostly) and considered their part in the response effectively complete, when in reality information sharing was incomplete and uncoordinated.

Recommendation 5

To work with the Investing in Children Programme, who are leading on the design of the core services that will be delivered by Oranga Tamariki, on the development of principles and operational guidance to enhance the level and quality of information sharing between agencies.

a. *Cross agency guidance should emphasise the principles and purpose of information sharing that allows staff to make informed, child centred and justifiable decisions about sharing relevant information.*

b. *The guidance should also highlight the need for professional conversations to understand the information available and inform planning and joint decision making.*

c. *Particular attention should be paid to highlighting the need for informed conversations between agencies where there is differing opinions and potentially conflicting information where there are concerns about a child's safety and well-being. The purpose of these conversations is not primarily to secure agreement, but rather to acknowledge the uncertainties and ensure an open mind and flexible response is maintained by all involved and identifies mechanisms for progressing assessments and planning.*

Capacity

The review team found local capacity issues to be significant, and it was clear that the team were exceedingly pressed to respond effectively to the requests coming in the door. This resulted in a lack of role clarity, and poor co-ordination of responses. Despite steps being taken at a local level to alleviate some of these pressures, these were largely unsuccessful at the time.

Recommendation 6

Regions will have a plan to identify and manage local site capacity and staffing issues and take action to address these.