Surrey Safeguarding Children Board

Report of the

Serious Case Review regarding Baby LL

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1. Introduction

1.1 Why this case was chosen to be reviewed

The Local Safeguarding Children Board determined to conduct a Serious Case Review (SCR) because the circumstances of this case met the statutory criteria:

(a) abuse or neglect of a child is known or suspected; and (b) (i) the child has died (Working Together to Safeguard Children, 2015 4:18 p 76)

1.2 Succinct summary of case

1.2.1 This review concerns services provided to Baby LL and his family. Baby LL was four months old at the time of death and lived in the community with his mother, father and Sibling 1 for all of his life. Baby LL's parents had difficulties parenting their earlier children; his father had received a prison sentence for failing to protect his eldest child from physical abuse by her mother and his mother had an older child who was in the care of the Local Authority Children's Services because of emotional abuse and neglect. Social Care (CSC) were working with Baby LL and the family at the time of his death, because there were concerns about the care being provided by the parents to both children and Baby LL and Sibling 1 were the subject of child protection plans because of concerns about neglect[1]. The cause of Baby LL's death was unclear at the time of death, however the post mortem later identified the cause of death as Acute Pneumonia[2] due to Klebsiell Oxytoca[3] superimposed on upper respiratory tract viral infection.

1.3 Family composition

Family member	Age at the time of the child's death
Child LL	Died aged 4 months old
Sibling 1 (LL's brother)	2 years
Half-sibling 1 (LL's maternal half-sister)	10 years
Half-sibling 2 (LL's paternal half-sister)	7 years
Mother	30 years
Father	33 years

1.4 Timeframe

The time frame for the review was agreed as being from July 2015 when the first child protection plan ended and 12th May 2016 when the Baby LL was pronounced dead.

1 If child protection enquiries show that a child may be suffering or is likely to suffer significant harm, an initial child protection conference will be organised and if the conference decides that the child is suffering (or is likely to suffer) significant harm then the decision will be made for him/her to have a child protection plan. The aim of the plan is to try and stop any harm happening to the child and make things better for him/her.

2 Pneumonia is swelling (inflammation) of the tissue in one or both lungs. https://www.nhs.uk/search?collection=nhs-meta&query=pneumonia

3 Klebsiella Oxytoca, is a bacterium that is responsible for many urinary tract infections. Klebsiella Oxytoca is also responsible for Septicemia which is a very serious infection of the blood which could be life-threatening. http://klebsiellaoxytoca.com/

1.5 Organisational learning and improvement

1.5.1 Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including serious case reviews states that:

'Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children'.[4]

1.5.2 The Learning Together Review process requires that prior to starting the review the LSCB identifies broad research questions which go beyond the facts and issues in this case, to look more widely at their child protection systems. Specifically, it was felt that it would be useful to examine the following areas:

- How effectively are agencies working together with families where children are on child protection plans because of neglect?
- How effective are professionals at achieving change with families where there is disguised compliance?
- How effective are professionals at using information and knowledge gained when working with older siblings in assessing risk for babies when all children are the subject of child protection plans?

1.6 Methodology

Statutory guidance requires SCRs to be conducted in such in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings'[5] .

It is also required that the following principles should be applied by LSCBs and their partner organisations to all reviews:

- 'there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;

4 Working Together 2015, 4:7 http://www.workingtogetheronline.co.uk/chapters/chapter_four.html

5 WT 2015, 4:11http://www.workingtogetheronline.co.uk/chapters/chapter_four.html

- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith; families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process'.[6]

To comply with these requirements, the LSCB has used the SCIE Learning Together systems model[7]. Detail of what this has entailed is contained in Appendix 1 of this report.

1.7 Reviewing expertise and independence

1.7.1 The review has been led by Fiona Johnson, an independent social work consultant, and, June Hopkins, an independent health consultant, who are both accredited to carry out SCIE reviews and have extensive experience in writing serious case reviews. Both reviewers have had no previous direct involvement with the case under review.

1.7.2 The lead reviewers have received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

1.8 Acronyms used and terminology explained

Statutory guidance requires that SCR reports: 'be written in plain English and in a manner that can be easily understood by professionals and the public alike'[8]. Writing for multiple audiences is always challenging. In the Appendix 2 we provide a section on terminology aiming to support readers who are not familiar with the processes and language of the safeguarding and child protection work.

1.9 Methodological comment and limitations

1.9.1 There was good attendance at review team meetings, although due to unforeseen circumstances and organisational priorities there was no representation by CSC at any of the review team meetings. However, the draft report was shared with the principal social worker prior to completion. Involvement by practitioners in the case group meetings was positive and there was good attendance by CSC staff at these meetings.

1.9.2 Another difficulty was that it was not possible to involve the parents in the review because they did not respond to requests for contact.

6 ibid

7 Fish, Munro & Bairstow 2010. Fish, S., Munro, E., Bairstow, S., SCIE Guide 24: Learning together to safeguard children: developing a multi-agency systems approach for case reviews, Social Care Institute for Excellence (SCIE), 2009

8 WT 2015, 4:11http://www.workingtogetheronline.co.uk/chapters/chapter_four.html

1.10 Participation of professionals

The lead reviewers and the review team have been impressed throughout by the professionalism, knowledge and experience that the case group (the professionals involved with the family, from all agencies) have contributed to the review; and their capacity to reflect on their own work so openly and thoughtfully in the review process. All this has given the review team a deeper and richer understanding of what happened with this family and within the safeguarding network and why; and has allowed us to capture the learning that is presented in this report.

1.11 Input of the family

1.11.1 Significant effort was made to involve the parents in the review, but this was unsuccessful. The LSCB contacted the parents early in the review and initially Mother indicated that she would like to be involved but asked that this be delayed until after Christmas. Further contact was made in the spring by email, telephone and letter but there was no response. The family have moved out of the area and contact was made with local services to see if there was a professional who could facilitate contact however this was also unsuccessful. It is thought that Father did not want to be involved in the review and this may have influenced Mother's later response.

2. The Findings

2.1 Structure of the report

2.1.1 Statutory guidance requires that SCR reports 'provide a sound analysis of what happened in the case, and why, and what needs to happen to reduce the risk of recurrence'.9

2.1.2 This section contains priority findings that have emerged from the serious case review. The findings explain why professional practice was not more effective in protecting Baby LL. Each finding also lays out the evidence, identified by the review team, that indicates that these are not one-off issues, but are matters that if not addressed could cause risks to other children and families in future work, because they are issues that undermine the effectiveness with which professionals can do their jobs.

2.1.3 Immediately prior to the findings section an overview is provided of what happened in this case. This clarifies the view of the review team about how timely and effective the help that was given to Baby LL and the family was, including where practice was below expected standards. This is then followed by the section that summarises the views of the parents.

2.1.4 A transition section of the report highlights the ways in which features of the involvement with Baby LL and the family are common to work that professionals conduct with other families; and, therefore provides useful organisational learning to underpin improvement.

2.2 Appraisal of professional practice in this case.

2.2.1 This section provides an overview of 'what' happened and 'why'. The purpose of this section is to provide an appraisal of the practice that is specific to the case and it therefore includes the review team's judgements about the timeliness and effectiveness of practice including where practice was below expected standards. Such judgments are made in the light of what was known and was knowable at that point in time. For some aspects, the explanation for 'why' will be further examined in the findings in section 4 and a cross reference will be provided.

2.2.2 This case focusses on the dilemmas faced by professionals working with families where there are significant historical concerns about parents' capacity to care adequately for their children but the immediate evidence of risk of significant harm is not apparent. There were questions about the parenting ability of both parents and there had been attempts made to work with the family to achieve change however despite this most professionals remained concerned about the long-term outcomes for the children even though there were no immediate signs of harm.

TIMELINE

12/08/15	Review Child Protection Conference held.
22/09/15	Team About the Family meeting in respect of Sibling 1. Parents struggled to accept risks remained for Sibling 1 – CSC close the case.
October 2015	Family have Council Tax arrears of £966.93.

8 WT 2015, 4:11http://www.workingtogetheronline.co.uk/chapters/chapter_four.html

20/10/15	Sibling taken to A&E by police and parents following concerns being raised by gardener.
21/10/15	SW1 visits the family and discusses events of previous day and concludes no evidence that father hit Sibling 2
22/10/15 – 23/10/15	Maternity Safeguarding team attempt to contact SW1 on 3 occasions
24/10/15	Neighbour contacted police expressing concern about a child heard crying at the address the previous day
11/11/15	Conversation between CSC and named nurse. SW1 informs maternity that family have been assessed and unborn remains a closed case.
12/11/15	Parents tell CSC that Half Sibling 1 cannot return to their care.
13/11/15	Half Sibling 1 accommodated under section 20 in the local authority's care as placement with father broke down
30/11/15	Debt Enforcement agency visit
02/12/15	Mother made a further payment to the Enforcement Agents of £363.67
02/12/15	SW1 visits the family to ask for photos for Half Sibling 1. Mother decides no contact with Half Sibling 1 till after the birth of Baby LL. Social worker records a view that the relationship between Mother and father shows a high degree of controlling/coercive behaviours.
16/12/15	Debt Enforcement agency visit and agree payment schedule
22/12/15	Strategy meeting held (following incident on 24th Oct). Did not meet the threshold for section 47
07/01/16	Baby LL born at 38 weeks gestation.
22/01/16	Mother made a further payment to the Enforcement Agents of £45.00
26/1/16	Child and Family Assessment started by SW2
09/02/16	Separate Home visits by HV and Outreach worker. HV worried about rapid eye movement and advised LL be seen by GP urgently.
10/2/2016	Mother advises council she is starting work so housing benefit and council tax benefit cease at this point there is a small rent arrears of £44.47 plus the historic council tax debt.
11/02/16 – 17/02/16	HV attempts to chase up with mother and SW why GP appointment not made and to remind mother to register LL. GP attempts to ring HV but they keep missing each other.
17/02/16	Mother with SW2 present speaks with GP by phone. Reports that whilst HV is concerned she is not. GP agrees to review at 6-week check (2 weeks away).
22/2/16	Enforcement agent visits and warns mother that there will be no more chances and that the car will be taken if the arrangement is not kept to.
23/02/16	LL registered with GP
25/02/16	Home Visit by HV to Baby LL no concerns.
14/03/16	Baby LL seen by GP for 6-week check. All well except for horizontal nystagmus. No follow up planned.
15/03/16	Child and Family Assessment completed and results in a Strategy Discussion being held – recommendation from the assessment is that an Initial Child Protection Conference should be held
24/03/16	Family were given a pre-court rent arrears letter

29/03/16	NSPCC referral to CSC. NSPCC receive a referral from friend of mother saying that Mother was shouting and using derogatory words to address sibling 1, and Baby LL was left in a soiled nappy
11/04/16	ICPC for Sibling 1 and Baby LL. Both made subject to CP plan under neglect. Psychologist to be identified to undertake a whole family assessment.
22/04/16	Core Group Meeting. Parents not present as father had received bad news about an aunt.
29/04/16	Report of Sibling 1 seen in A&E with swelling and 2cm laceration below left eyebrow. Parents reported he had fallen from highchair.
11/05/16	Half Sibling 1 made the subject of a full care order. Mother did not go to court
12/05/16	SW3 visits family and sees both parents and both children. Parents tell SW that Baby LL has a slight temperature – she sees the child who appears a little warm but otherwise presents as fine and does not appear ill.
12/05/16	Whilst in the sole care of father, Baby LL was found pale, floppy and lifeless in his Moses basket at 4pm.

Relevant background history

2.2.3 Prior to the review period Father was convicted in February 2011 of 'causing unnecessary suffering to a child under 14' and was imprisoned for 12 months. His daughter, Half-sibling 2, had suffered several serious injuries inflicted by her mother. Although there was no evidence that Father was involved with the assault, he lived in the family home at the time but denied any knowledge that his daughter was being harmed. The judge in the trial raised concerns about Father's ability to empathise, understand the emotions of another and his failure to protect his baby or seek medical help.

2.2.4 Mother was the single carer of her older daughter, Half-sibling 1, for much of her life. During this time Mother had periods of drinking to excess which impacted on her ability to care for her daughter. Half-sibling 1, was made the subject of a Child Protection plan in 2013 after her mother commenced a relationship with Father and he moved into the family home, at this stage there were concerns about sexualised behaviour and that her emotional needs were not being met. Mother became pregnant with Sibling 1 and in November 2013 the unborn child was made the subject of a child protection plan and mother signed an undertaking saying that Father would not care for either child unsupervised.

2.2.5 In 2014 concerns about the family continued and CSC initiated Public Law Outline (PLO) proceedings[10] with the major focus being on a psychological risk assessment of father and the risk he posed to both children. There were also concerns regarding the nature of the relationship between Mother and Father and questions about whether Father was coercive and controlling of Mother. She was adamant that their relationship was very positive, but professionals felt that Father appeared threatening on occasions and were anxious about the implications of this for her and the children.

10 PLO – Public Law Outline the framework within which court proceedings are initiated by the Local Authority under The Children Act 1989 – see glossary for more details

There was significant delay in this assessment being commissioned because of time taken to get permission from the High Court for documents associated with proceedings concerning Half-sibling 2 to be made available to the psychologist; there was then some delay in accessing the relevant expert for the assessment. During this time the children remained the subject of child protection plans, and the parents were co-operative. There were no real concerns about Sibling 1 who was developing well however there were continuing concerns about Half-sibling 1 who moved to live with her father in May 2015. There was also no evidence of domestic abuse although professionals continued to have concerns about the control exerted by Father over Mother.

2.2.6 At the start of the review period CSC received the expert psychological assessment commissioned through the civil court process which concluded that neither parent presented a risk of physical harm to Sibling1 and made recommendations for further work with the parents that included: attending a parenting programme; mother to have individual therapy; and the family to undertake a whole-family assessment with an independent provider. CSC were surprised by the conclusions of the assessment and considered that they had no choice but to cease the PLO process as the assessment did not support their judgement that the children were suffering significant harm.

Review Child Protection Conference that ends the Child Protection plan for Sibling 1 and starts Team Around the Family process.

2.2.7 At the review child protection conference in August 2015, the social worker (SW1) recommended that the child protection plan for Sibling 1 should end and this was supported unanimously by all professionals present at the meeting. The chair said he felt the plan had worked well for Sibling 1 and there were no concerns about the parents' ability to understand his needs. He noted there may be concerns about father's parenting in the future, especially about discipline as Sibling 1 gets older and that this will be looked at. All professionals at the conference agreed that Sibling 1 should be stepped down to a Team Around the Family and the HV agreed to take on the role of Lead Professional. It is interesting to note that the expert psychiatrist recommended continuing to work with the family via a child protection plan and this was agreed with regard to Half-sibling 1 however it was not felt appropriate for Sibling 1. This raises questions about the status given to 'expert' opinion particularly in the context of court process. **This is explored further in finding 1.**

2.2.8 Despite the psychiatric report saying that neither parent presented a risk of physical harm to the children, this report nonetheless made substantial recommendations for further work with the family and this was particularly important because the parents had previously indicated they were unwilling to work cooperatively with professionals around these issues. These factors suggest that a more appropriate step-down plan would have been to a 'child in need' plan with a social worker as the key worker which would have provided a structure within which there could have been escalation back to Child Protection plan if the family had not co-operated. **The reasons for this and the implications of working in this way is explored further in Finding 2.** From this point there was no allocated social worker however SW1 was a point of contact when referrals were received from other agencies.

Professional response to investigation by police of concerns by member of the public

2.2.9 On the 20th of October 2015, the police received a call from a professional gardener working in the vicinity of the parent's house. This person reported that h/she had heard a baby crying and the sound of whacking followed by silence at the home address. When the police arrived at the home, Father explained that he was alone with Sibling 1 and had put him to sleep at 15:00 and reported that he was himself asleep and had been woken by Sibling 1 crying at 16:00. He could not recall raising his voice and denied hurting Sibling 1. Due to the parent's history the attending officers felt Sibling 1 should be taken to Accident & Emergency (A&E) to be examined by a doctor, this was good practice. On arrival at hospital, a Senior House Officer examined Sibling 1 and discussed the case with the A&E Consultant. They in turn had a telephone discussion with the Paediatric Consultant who felt that because Sibling 1 had no visible injuries or symptoms there was no justification for him to be examined by a paediatrician. The Hospital spoke with an Emergency Duty Team (EDT) social worker who did not feel that the child needed a full paediatric assessment as there were no signs of bruises. Although the A&E consultant was concerned he took the advice of both the Paediatric Consultant and EDT and discharged Sibling 1. It is noteworthy that although all agencies knew some of the family history (particularly that there had been historic concerns about previous children) the full details of father's conviction were not shared. Given the family history best practice would argue that the child should have been seen at this time by a paediatrician to check that there were no hidden injuries such as rib fractures or similar. **The reasons for this action by the hospital consultant are considered in finding 3.**

2.2.10 When SW1 was informed of the incident by the police on the 21st October she concluded that there was no evidence that Father had hit Sibling 1 and therefore the concerns were found to be not substantiated. Following a safeguarding intervention of this sort it is good practice to hold a strategy discussion[11] to conclude the investigation and agree any further action – this is particularly true when, as in this case, the intervention is mainly single agency because it occurred out of hours. There was no attempt by the police or CSC to call a strategy discussion about this incident which was not good practice. This was discussed at length by the case group and review team who considered that the child protection procedures are not clear about how historic information should be addressed when investigations of this nature are undertaken. **This is addressed in finding 3**. It was however felt that the current MASH[12] arrangements would mean that there would now be a multi-agency discussion of this case. **This may be something that the LSCB examine in their regular review of MASH arrangements.**

11 When there are concerns that a child may be at risk of significant harm, CSC will talk to partner agencies about the child and jointly decide if the threshold for a child protection investigation (see Section 47 below) has been met and who should carry out the investigation – CSC and the police (joint agency) or the police alone (single agency) these communications are called strategy discussions and may be by telephone or via a meeting.

12 Multi Agency Safeguarding Hub. The Multi-Agency Safeguarding Hub (MASH) is a partnership between The County Council, he Constabulary, and health agencies working together to safeguard children, young people and vulnerable adults.

2.2.11 Midwifery staff were informed of the attendance at Accident & Emergency by Sibling 1 and in October they unsuccessfully attempted to discuss this with SW1. On the 28th of October Sibling 1 was discussed at the weekly Safeguarding meeting which was attended by the Safeguarding Midwife and the social worker sent from the local team to attend the routine meeting and the Liaison Health Visitor. After this SW1 returned the midwife's call and informed her that Sibling1 was no longer on a CP plan and confirmed that the case remained closed for unborn Baby LL. Midwifery staff decided to keep the case open to maternity safeguarding and provided enhanced midwifery care. Given the history of the family, and the significance of the allegation, it was important that the midwife was fully updated about any actions taken in response, to inform her work with mother. The midwife was tenacious in trying to contact SW1.

2.2.12 Despite there being no direct social work involvement with the family the social work team continued to have concerns. The Service Manager for the social work team had a management oversight meeting with the Area Head on the 17th of December where she discussed the family and her ongoing concern that 'things were not right' within the family but that she was anxious that she might be penalising them unjustly. A decision was made to call a Strategy Discussion meeting to discuss the two incidents when the police were called out to the family home – October 20th and October 24th regarding reports of hearing a baby crying and concerns for their welfare. The meeting was held on the 22nd of December. The outcome was that the case did not meet the threshold for a Section 47 investigation[13] however it was agreed that a further Child and Family Assessment should be undertaken. It was very good professional practice that the manager discussed her ongoing concerns with her supervisors and that the advice given was to hold a further strategy discussion – it was also effective professional practice to recommend a further assessment.

Communications between GP and Health Visitor about 'flickering eyes'

2.2.13 Baby LL was born in January 2016 and was discharged home within 24hours. There were no concerns about the baby from midwifery staff and the handover to the health visitor (HV1) was unremarkable. On 9th February 2016 however HV1 saw the family at home and was worried about Baby LL having a 'rapid eye movement'. She advised mother to take Baby LL to be seen by the GP urgently.

13 A Section 47 enquiry is an investigation undertaken when social workers have 'reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm'. The enquiry will involve an assessment of the child's needs and the ability of those caring for the child to meet them. The aim is to decide whether any action should be taken to safeguard the child

Over the next two days, HV1 checked if this appointment had been made and left a message on the 11th February asking to talk with the GP. The GP rang the health visitor on three occasions that day but was unable to make contact. When the health visitor discovered that mother had not made the appointment she told SW2 that mother needed to take Baby LL to a GP appointment and to remind mother to register Baby LL with the GP. On 17th February the social worker visited and when Mother told her she had not yet seen the doctor she made her ring the GP while she was still present which was assertive social work intervention. Mum talked with the GP and explained the health visitor's concerns. The GP was unaware of the family history and explained that a baby's eye movements do not become fixed until they are 6 weeks old. In the absence of any other concerns these eye movements can be part of normal development at that stage. The GP felt that a baby of 4 weeks old would not 'fix and follow' and therefore that it was too soon to make a proper assessment. As there were no other concerns the GP arranged for Baby LL to be seen at 6 weeks when eye movements were assessed routinely as part of the 6-week check. On 14th March 2016 Baby LL was seen by the GP for a 6-week check. The GP considered that all was well with Baby LL except that he had a horizontal nystagmus[14].

2.2.14 It was good practice for the health visitor to both notice the unusual eye movement by the child and then to be proactive in contacting the GP and asking for an early assessment of the baby, and then involving the CSC when it became apparent that mother had not made the appointment as requested. Whilst it was clear that both GP and HV1 spent significant time trying to talk to each other the absence of email/written communication undermined the GP understanding of HV1's concerns which was compounded by the GP being unaware of the family history. **These issues are discussed further in findings 4 and 5.**

2.2.15 The Child and Family Assessment was completed with a recommendation that an Initial Child Protection Conference (ICPC) should be held. This resulted in a Strategy Discussion being held on 15th March 2016. On the 29th of March 2016, mother contacted CSC to inform them that she had a disagreement with the MGM who had threatened to contact CSC. Subsequently on the same day NSPCC received a referral stating that mother had been abusive towards Sibling1 and was neglectful in respect to Baby LL. Mother explained that she had been upset when the social worker had told her that there was to be an ICPC and so had gone to see her mother in West Sussex (late at night 10.30pm). When she arrived mother and her friend were both drunk and an argument ensued. The referrer to the NSPCC was drunk and the social workers accepted mother's explanation as to what had happened. Just over a week later on the 9th of April (2 days before the ICPC) another referral was made to the NSPCC reporting that mother was drinking daily and was being emotionally abusive towards Sibling 1. Once again, the referral was passed onto CSC.

14 Nystagmus is persistent, rapid, involuntary eye movement (most commonly from side to side), which usually impairs vision. Nystagmus may be present at birth, caused by defects in the eye or the visual pathway from the eye to the brain. https://www.nice.org.uk/guidance/ipg299/.../treating-nystagmus-by-horizontal-eye-m...

Further Initial Child Protection Conference

2.2.16 On 11th April there was an ICPC which received an assessment report from the social worker about the risks to the children. The concerns that the social worker identified were: the incident where it was reported by a neighbour that Sibling1 was being smacked in October; a recent report that Mother took both children unexpectedly to her parents at 10.30pm when most children were asleep; that mother did not take BabyLL to the GP when advised to do so by the HV because of his flickering eyes; and that Sibling1 had severely delayed speech and the parents are not being proactive in responding to this.

2.2.17 This assessment was needed to assess the risk posed to Sibling1 and LL by both parents and it was therefore especially important to explore 'family and environmental factors' including parental dynamics and where the children fitted into the parents' priorities. The report of this assessment had minimal information about the family's finances and no information about any debts or money pressures. It also did not address why mother was planning to return to work, with two children under three, (one a new born baby) and it did not fully examine what risks this may pose to the children as it meant that the Father would be caring for the children, alone and full time.

Issues about why this assessment was limited are discussed in finding 6.

2.2.18 At the ICPC both children were made the subject of CP plans because of neglect, and plans were put in place to protect them. The decision to make the children subject to a plan was not clear-cut given there was comparatively little evidence of significant harm to the children. The chair of the conference was able to pull out effectively the risk factors including the parents' lack of co-operation.

2.3 In what ways does this case provide a useful window on our systems?

2.3.1 The LSCB agreed broad research questions at the start of the process, which go beyond the facts and issues in this case, to look more widely at their child protection systems. The questions are set out at in paragraph 1.5.2 and directly link to the areas covered in the appraisal of practice and the findings.

2.3.2 A key area of research was how effectively agencies work together with families where there are concerns regarding neglectful parenting. This review has shown that these parents exhibited behaviour indicating low levels of neglectful parenting such as poor supervision, a child with delayed speech, and parents' failure to act on professional advice. Professionals responded to these issues effectively and they were the main reason that at the time of Child LL's death he and his sibling were the subject of child protection plans.

2.3.3 One of the research questions was concerned with how effective professionals were at achieving change with families where there is disguised compliance. This was an area where the review indicated that professional practice was less successful. In particular, the decision to replace the child protection plan with a family action plan led by the health visitor was unhelpful. The health visitor lacked authority for this role and it was evident from the start that the family were unlikely to co-operate. This decision also led to a lack of continuity in the case planning as the health visitor did not have full access to all the information contained in the independent expert assessment which was necessary to continue effective work with the family.

2.3.4 The LSCB was also concerned to understand better how effectively professionals were using information and knowledge gained when working with older siblings in assessing risk for babies. This review has shown that whilst information was known and shared, the key challenge was in being able to interpret the effect on the children of the parents' actions, and in particular, in judging whether this was causing significant harm.

2.3.5 A further issue considered by the Review Team was the extent to which the issue of father's controlling and coercive behaviour was addressed by the professionals working with the family. It was clear that all the professionals interviewed considered that Father could on occasion present to professionals in a threatening way. SW1 did record that she considered Father to act in a controlling way with Mother. Social workers involved later were aware of this view and did consider it in their assessments however they could find no further evidence of this behaviour. Mother continued to affirm that her relationship was very positive and that she felt supported by Father. Other professionals, such as midwife and health visitor, routinely inquired about domestic abuse and Mother was also positive about Father with them. The Review Team felt however that this was an issue that would have warranted further investigation, and that possibly professionals were inhibited from this by anxieties that they might be unduly penalising the family because of their past history.

2.4 Summary of findings

The review team have prioritised 6 findings for the LSCB to consider. These are:

	Finding	Category
1	Does expert opinion have an undue impact on case planning as opposed to social work professional experience when balancing the evidence of risk posed by a parent?	Professional norms & culture around multi-agency working in assessment and longer-term work.
2	In the county social workers are not always allocated to work with families with 'step-down' plans from child protection to ensure effective co-ordination of the care plan; and there is inconsistency in the implementation of Child Protection conference recommendations regarding the allocation of lead professional for Child in Need and Family Action plans.	Patterns in human–management system operation
3	The current child protection procedures in the county are insufficiently clear about the context and circumstances in which children should be subject to an assessment by a paediatrician and when strategy discussions should be held where there are historic safeguarding concerns	Patterns in human–tool operation.
4	Professionals in the county do not routinely communicate and record underlying concerns and relevant historical information to inform analysis and decision making when they share information.	Professional norms & culture around multi-agency working in assessment and longer-term work.
5	In the county, current primary care registration processes are inconsistent about how they ask for information regarding a family's previous contact with social care and cross-reference with existing child protection records meaning that key information may not available when a GP sees a new baby.	Patterns in human–tool operation.
6	The complexities of the current benefits systems, general levels of personal debt and families not readily disclosing, make it hard for professionals in the county to assess the relevance of families' finances to child protection when undertaking assessment work.	Professional norms & culture around multi-agency working in assessment and longer-term work.

2.5 Findings in Detail Finding 1

Does expert opinion have an undue impact on case planning as opposed to social work professional experience when balancing the evidence of risk posed by a parent?

Professional norms & culture around multi-agency working in assessment and longer- term work.

Introduction

As part of an assessment of a family, particularly when initiating or progressing care proceedings, social workers may commission 'expert' assessments of parents. These assessments are often undertaken by psychologists or psychiatrists and are usually based on clinical judgements using information gathered from the professionals and the parents. They often have no direct contact with the children and are usually based on a small number of contacts. They are important assessment evidence for social workers but are one element of information that is considered alongside the social worker's professional knowledge of the family over a longer period and with direct observation of the parents caring for their children. Parenting and multi-disciplinary assessments may be required before or during care proceedings. The main reason for commissioning an assessment will be in instances where there is a need for additional expertise or specialist opinion which cannot be provided by the local authority social worker. It is assumed that any qualified social worker will be able to assess immediate risk, basic care, and other aspects of child development and parenting capacity specified in the Core Assessment Framework and Professional Capabilities Framework[15] . The courts expect a social work parenting assessment in each case. The social work parenting assessment should evidence that the social worker is the expert in the child's life (i.e. that they know the child and the quality of their care).

How did the issue feature in this particular case?

The Review Child Protection Conference followed on from the completion of the assessment of the parents by the psychiatrist which determined that neither parent posed a risk of physical harm to Sibling 1. The social workers were very surprised at the outcome of the assessment and their managers felt that the effect was to undermine any case that they had to take legal action to protect Sibling 1 and so they ended the Public Law Outline process. The psychiatrist's assessment also made recommendations for further work with the parents that included: attending a parenting programme; mother to have individual therapy; and the family to undertake a whole- family assessment with an independent provider. It also recommended that both children should remain the subject of child protection plans whilst the work with the parents was undertaken. At the review child protection conference, the social worker recommended that the child protection plan for Sibling 1 should end and this was supported unanimously by all professionals present at the meeting. The social worker's

15 The Professional Capabilities Framework (PCF) is an overarching professional standards framework, developed by the Social Work Reform Board. The PCF gives social workers a framework around which to plan their careers and professional development. https://www.basw.co.uk/resource/?id=1137

concerns were mainly focussed on half-sibling 1 who had been rejected by mother but did acknowledge that it was hard to know what the future held as Sibling 1 was quite young and had not presented much challenge to father who had only cared for him alone for very short periods. There was no discussion at the conference of the recommendation by the psychiatrist that both children should remain the subject of a child protection plan nor how the recommended work programme would be achieved. In part this was because whilst the social worker and the parents knew the content of the psychiatrist's report this was not shared with other professionals at the conference. Another influence may well have been that it is not considered good practice for children to remain the subject of child protection plans for over two years and because of delays in achieving the psychiatric report promptly the children had already been the subject of child protection plans for almost two years. What was evident was that the judgement by the psychiatrist that the parents presented no risk of physical harm to the children became the dominant theme and that other aspects of the report that identified other risks of emotional abuse and neglect were lost. This was in part because only some professionals had access to the report, but also indicated how powerfully the psychiatric opinion undermined previously agreed professional judgements about the family and particularly the judgements of those workers who had been involved with the family over a significant period of time and who had seen them in a range of contexts and circumstances.

How do we know it is an underlying issue and not something unique to this case?

Discussions with the case group showed that whilst it is not common there are occasions when independent 'expert' opinions do challenge the dominant professional views on a family. It was also agreed that the Public Law Outline process means that when this happens it is often only the family and the social workers who have direct access to the information in the reports meaning that other professionals are very dependent on direction from the social worker as to the relevance and status of the expert opinion. It was noted that social workers can and do challenge expert opinion, but it was also agreed that currently the courts are likely to give greater weight to expert opinion than to the views of the social worker meaning that it is difficult for social workers to argue against 'expert' opinions. It was agreed by the Case group and review team that if expert opinion was to be challenged this would need a concerted effort across all agencies and that current case planning arrangements do not always facilitate such an action. In particular, there was discussion about whether there should be processes built into the PLO system that would allow the social worker to share with other agencies the findings from expert opinions which could therefore ensure that such findings were fully considered by all professionals involved in child protection conferences.

How common and widespread is the pattern?

This review only involved staff from one area within the county however the reasons given by professionals for the differences in working relations could apply across all of the county. During the period 01/04/17 to 31/03/18 there were 74 specialist assessments commissioned for 63 children subject to a Child Protection plan across the whole of the county. It is not known how many 'expert' opinions overturn the previously agreed child protection conference plan as such data could only be collected on an individual basis and this does not happen at present.

What are the implications for the reliability of the multi-agency child protection system?

Assessment is an ongoing process, and whilst there is clearly a role for specialist 'expert' opinion, if this becomes too dominant there is a risk that other information and opinion will be lost meaning that risk assessment becomes too narrow. For children to be fully protected those professionals who have been involved over a period of time need to be as fully involved as those with 'expert' opinion and the risk assessment on the children needs to take into account both judgements to enable safe decision-making.

Finding 1: Does expert opinion have an undue impact on case planning as opposed to social work professional experience when balancing the evidence of risk posed by a parent?
This review has identified that on occasions expert opinion may be given too great a weight which potentially undermines the risk assessment of children. There is a need for any expert opinion to be shared across agencies and to be balanced by the judgements of those professionals who involved with a family over time and can provide a historic assessment as well as observe current behaviours. **Considerations for the Board and partner agencies** • Do the reasons given for this fully explain the issue? • What lies behind this? • Is it likely to apply to all the teams in the county? • Should attempts be made to amend the PLO initiation process to enable the sharing of findings of 'expert' opinion at child protection conferences? • Does the Board think it would be helpful to review/examine the outcomes of expenditure and impact of expert assessments? • Does the Board think that expert assessments are sometimes commissioned in the county because social work teams are insufficiently resourced to undertake parenting assessments?

Finding 2

In the county social workers are not always allocated to work with families with 'step-down' plans from child protection to ensure effective co-ordination of the care plan; and there is inconsistency in the implementation of Child Protection conference recommendations regarding the allocation of lead professional for Child in Need and Family Action plans.

Patterns in human–management system operation.

Description

When a child is the subject of a child protection plan the services provided to the family are reviewed every six months at a Child Protection Review Conference. This conference must decide explicitly if the child has suffered, or is likely to suffer 'significant harm', and hence whether the Child Protection Plan needs to be continued. If the risk of significant harm has reduced consideration should be given to discontinuing the plan and at that stage a decision should be made about what ongoing services should be provided often described as a 'step-down' plan. Discontinuing the Child Protection Plan must never lead to the automatic withdrawal of services and in the county the Child Protection Review Conference can recommend that services should continue to remain available to the child/family as a 'Family Action Plan[16] '. The Lead Social Worker must discuss with parents and child(ren) what services continue to be needed, based on the re-assessment of the child and family and a Family Action Plan made if support continues. After the discontinuation of a Child Protection Plan, the Family Action Plan will be reviewed.

How did the issue manifest in this case?

At the point of step-down from the child protection plan the case moved to a Team around the Family (TAF) plan as there were no Child in Need teams and the RAIS[17] teams were mainly focussed on assessment work. The health visitor had a very large caseload and insufficient time and experience to manage effectively a 'step-down' plan with the risks presented by this family. Despite the psychiatric report denying that the parents presented a risk of physical harm to the child, this report nonetheless made substantial recommendations for further work with the family and therefore a detailed 'step-down' plan that included responding to the psychiatrist's recommendations, with continued oversight by a social worker was required. This was particularly important because the parents had previously indicated they were unwilling to work cooperatively with professionals around these issues and therefore there was likely to be a need for the case to be re-escalated in the future. These factors suggest that a more appropriate 'step- down' plan would have been to a child in need plan with a social worker as the key worker. Given the psychiatrist had made specific recommendations about future work with this family to safeguard the child, the 'Family Action Plan' plan needed to explicitly link the services being offered to the family to the psychiatrist's recommendations.

16 Current procedures in the LSCB indicate that when a child protection plan ends there is a step down to either a child in need plan or a family action plan – previously family action plans were known as Team about the family (TAF) plans.

17 RAIS – Referral, Assessment and Intervention Service, the team within CSC that responded to referrals and undertook immediate assessment work.

This would have provided a structure within which there could have been escalation back to a child protection (CP) plan if the family had not co-operated. It could also have been supported by a written agreement. Instead, the first 'Family Action Plan' meeting suggest the arrangements were all offered on a voluntary basis and there was evidence that the parents were un-co-operative from the beginning.

How do we know it is an underlying issue and not something unique to this case? (what other evidence is there?)

Current arrangements for 'stepping-down' child protection work in the county are that a 'step-down' from a CP plan can either be to a Child in Need (CIN) plan, if there are specific outstanding tasks that need to be completed and require a social worker's input, or less typically to a Family Action Plan (i.e. what used to be TAF). It is primarily for the social worker and their manager to review each case to determine the 'step-down' process. The case group reported that the decision to end a child protection plan is a multi-agency decision based on the recommendation made to the conference by the key worker, but that if it is recommended that there should be a child in need plan, it is the decision of the CIN team manager whether they will accept the case. Thus, there can be circumstances where the Child Protection Chair recommends the case transfer to the Family Support Service, but local managers interpret thresholds differently and it is then 'stepped down' to a Family Action Plan not a CIN plan. The Review Team noted that Child in Need teams are the only CSC teams who are able to decide whether or not to accept 'step down' cases and members of the Case Group and Review team were able to identify cases where the Child Protection chair had identified a 'step-down' process to the Child in Need teams and the cases were 'rejected' by those teams. The review team thought that whilst there were probably not many cases currently where this happened but that when it did they were likely to be key cases. It was also noted that within CSC there had been a review of all 'step-down' cases because of concerns that children with child protection plans were being 'stepped down' too soon leading to them becoming the subject of a further child protection plan; this audit had identified some cases where plans had ended too early. A further issue that was identified by both Review Team and Case Group members was that where a Family Action Plan was agreed there was a lack of consistency about the role of the key worker and in particular how often that person would have contact with the family and how they would share information with other agencies.

How common and widespread is this pattern?

This review only involved staff from one area within the county however the reasons given by professionals for the differences in working relations could apply across all of the county. Sample data regarding child protection conferences in the first quarter of 2018 (from 15th Jan 2018 to 31st March 2018) showed that there were 49 conferences where the child protection plan was stepped children down to a Child in Need plan and that 34 of these were referred to the Family Assessment Service there were 5 conferences where the child protection plan was stepped down to a Family Action Plan. Where there is a Child in Need plan the key worker is usually a social worker but that is not usually the case where there is a Family Action Plan.

What are the implications for the reliability of the multi-agency child protection system?

The period after a child protection plan ends is often as significant for protecting children as when all agencies are working together via child protection conferences and core groups. It is important that families continue to be supported in a multi-agency fashion even when the immediate risk of significant harm is reduced. An effective safeguarding system therefore has a multi-agency process of support for families that enable early identification of problems and has clarity about how agencies will support the family.

Finding 2

Social workers are not always allocated to work with families with 'step-down' plans from child protection to ensure effective co-ordination of the care plan; and there is inconsistency in the implementation of Child Protection conference recommendations regarding the allocation of lead professional for Child In Need and Family Action plans.

In the county the decision to end a child protection plan is multi-agency however, although recommendations can be made about whether the family is supported through a child in need plan, it is a CSC judgement as to whether the threshold for allocation to a social worker is met and some families are supported by other professionals through a family action plan. This review has highlighted that these arrangements may leave some families in a vulnerable position if they are not allocated a social worker and there is a lack of clarity about the support needed by the family and the role of the key worker in delivering that package of care.

Considerations for the Board and partner agencies

- Is this a known problem to the Board?
- Does the LSCB think that the decision about whether a family should be supported via a child in need plan or a family action plan should be multi- agency in the same way that a child protection plan is agreed?
- Does the Board think that the recommendations of a multi-agency meeting and an independent chair should be over-ruled by the manager of a Child in Need Team?
- Does the Board think that there are differences between professionals and agencies in their understanding of thresholds around child in need work?
- Does the Board think that all children 'stepping down' from child protection plans should be supported via a child in need plan for at least six months after the child protection plan ceases?

Finding 3

The current child protection procedures in the county are insufficiently clear about the context and circumstances in which children should be subject to an assessment by a paediatrician, and when strategy discussions should be held, where there are historic safeguarding concerns. **Patterns in human–tool operation.**

Each hospital has its own individual protocols and guidance regarding safeguarding which are supported by the LSCB safeguarding procedures. These protocols provide staff with further detail regarding when and how children should be examined by paediatricians when there are safeguarding concerns. The protocols in place at one hospital in the county whilst providing clear guidance about examinations of children where injuries are evident has less clarity where they may be historic concerns but less evidence of immediate harm.

Strategy discussions are multi-agency conversations or meetings that are convened to plan investigations whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm; they should routinely involve Children's Services and the Police, Health (Named Nurse and/or Named Doctor) and other bodies as appropriate (for example, children's centre/school and, in particular, any referring agency.) The LSCB procedures are clear that when emergency action is or has been taken by the Police or Children's Services, the Strategy Discussion must be held within 1 working day and that if the child is in a hospital setting and there are child protection concerns a Strategy Discussion/Meeting must take place within that setting before the child leaves it[18].

How did the issue manifest in this case?

When the Sibling 1 was taken in to the hospital by the police officer because of an allegation by a member of the public that he'd been hit, he was seen by a junior doctor in Accident & Emergency. Although that junior doctor contacted the paediatrician, he declined to examine him because there was no bruise and the current protocols do not require that children in these circumstances are medically examined by a paediatrician. There was also consultation with the Emergency Duty Service[19] who agreed there was no need for the child to be seen by a paediatrician in the absence of a visible injury.

Whilst the hospital staff knew that the child had previously been the subject of a child protection plan and that the family had other children about whom there had been concerns they were not aware that the father had served a prison sentence for failing to protect a child. The police officer was aware that father had served a prison sentence but only have had minimal information about the previous multi-agency child protection plan.

18 The Safeguarding Children Board Procedures Manual - 4.7.2 Timescales of Strategy Discussion/Meeting -

http://surreyscb.procedures.org.uk/zkpqq/managing-individual-cases/strategy-discussions-and-section-47- enquiries/#s1142

19 The Emergency Duty Team provides an emergency social work service for urgent situations which arise out of normal office hours and which cannot be left with an appropriate degree of safety until the next normal working day.

The Emergency Duty Service had electronic access to the social work case file which may not have included all the detail regarding the history. The rationale for the paediatrician not seeing the child, and for there not being a strategy discussion, was the same - in the absence of physical evidence of harm to the child (as witnessed by a bruise or similar) there were insufficient child protection concerns to warrant further action. The family history and previous concerns about the parents did not feature, partly because some professionals did not have the full story, but also because, in the absence of a bruise, it was considered that the allegation could have been malicious.

How do we know it is an underlying issue and not something unique to this case?

Within the Review Team and Case Group there was consensus that current procedures mean that it is unlikely that a strategy discussion would be held after a single agency investigation unless there was clear evidence that the child had been harmed. It was acknowledged that on occasions this would mean that the full history of a family would not be known or considered and that the decision to end an investigation would therefore be made based solely on the presenting information available at the time.

The Review Team and Case Group was less sure about practice within hospitals and it was felt that in some hospitals the child would have been seen by a paediatrician regardless of the absence of physical evidence of injury because of the serious nature of the concerns that were reported to the police. It is evident that procedures across hospitals vary and there is the potential for inconsistencies in response as a result.

How common and widespread is this pattern?

This review only involved staff from one area within the county however the child protection procedures being used by social work and police staff are county-wide and therefore this would apply to all professionals across the county. The hospital procedures are locally agreed, and some members of the Review Team did suggest that in other hospitals the child would have been seen by the paediatrician automatically. The reasons given by professionals for the differences in working relations which were that in the absence of physical evidence of significant harm there are insufficient grounds to define the issue as child protection would appear to be applicable to staff across all of county.

What are the implications for the reliability of the multi-agency child protection system?

Professionals in paediatric and accident and emergency (A&E) teams have a vital role to play in spotting and responding to all forms of child abuse and neglect. If safeguarding practice especially in relation to when a Paediatrician should undertake an examination is not consistent across all hospitals in the county, then potentially opportunities to identify hidden injuries are missed.

Finding 3 The current child protection procedures in the county are insufficiently clear about the context and circumstances in which children should be subject to an assessment by a paediatrician, and when strategy discussions should be held, where there are historic safeguarding concerns.

Within the county the child protection procedures are not currently clear about when children should be assessed by a paediatrician and when strategy discussions should occur where there is no immediate evidence of physical harm but there are historical concerns and there have been allegations made of abuse.

Considerations for the Board and partner agencies

- Does the Board recognise this issue?
- Are there reasons for each hospital having their own procedures and protocols?
- Are there reasons for different practice across hospitals in the county?
- Should the criteria for calling strategy discussion be made more explicit?
- Is the Board assured that all partners are involved in strategy discussions appropriately?

Finding 4

Professionals in the county do not routinely communicate and record underlying concerns and relevant historical information to inform analysis and decision making when they share information.

Professional norms & culture around multi-agency working in assessment and longer-term work. Description:

“Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services.” (Working Together to Safeguard Children 2015)

Good practice when communicating with other agencies / services requires the following:

• Is your reason for contacting the other service / agency clear?

• Is there consent to share information?

• Are both parties clear about the content of the information sharing?

• Are there any actions arising from the information sharing?

• If so, what are they and who will be responsible for undertaking them?

• By the end of the contact both parties should be clear about:

• What information has been shared;

• The purpose of the sharing;

• What each party has agreed to do as a result of the communication; and

• What is being recorded about the contact?[20]

How did the issue manifest in this case?

On 9th February 2016 HV1 saw the family at home and was worried about Baby LL having rapid eye movement. She advised mother to take Baby LL to be seen by the GP urgently. Over the next days, HV1 checked if this appointment had been made and left a message on the 11th February asking to talk with the GP. The GP rang the health visitor on three occasions that day but was unable to make contact. When the health visitor discovered that mother had not made the appointment she told SW2 that mother needed to take Baby LL to a GP appointment and to remind mother to register LL with the GP. On 17th February the social worker visited and when Mother told her she had not yet seen the doctor she got her to ring the GP while she was still present. Mum talked with the GP and explained the health visitor’s concerns with SW2 present. The GP was unaware of the history of the family and did not know that there had been previous child protection concerns. The GP responded to the medical issues raised by the mother and explained that a baby’s eye movements do not become fixed until they are 6 weeks old. In the absence of any other concerns these eye movements can be part of normal development at that stage. The GP felt that you would not expect a baby of 4 weeks old to fix and follow and therefore that it was too soon to make a

20 http://hullscb.proceduresonline.com/chapters/p_effective.html#effective

proper assessment. As there were no other concerns the GP arranged for Baby LL to be seen at 6 weeks when eye movements were assessed routinely as part of the 6-week check. On 14th March 2016 Baby LL was seen by the GP for a 6-week check. The GP considered that all was well with Baby LL except that he had a horizontal nystagmus. Whilst it is clear that both GP and HV1 spent significant time trying to talk to each other the absence of email/written communication undermined the GP understanding of the HV1's concerns which were probably informed by the past history of the family and about which the GP was largely unaware.

How do we know it is an underlying issue and not something unique to this case?

Discussion with the Review Team and Case Group indicated that practice in this case was usual and that when leaving messages for another professional it would be commonplace to focus on the action that was being requested rather than explaining explicitly the reasons and concerns that underpinned the request. It would also be the norm to leave messages rather than following up telephone requests with formal written records of the concerns. Reasons for this included that sometimes the underlying concerns would not have been discussed with the parents. So, it was probable that in this case the health visitor would not have been explicit with the parents about her reasons for being concerned about the flickering eyes. It was acknowledged that this obliqueness could on occasion be confusing for other professionals.

How common and widespread is this pattern?

This review only involved staff from one area within the county however there is no reason to consider that practice in this area was different from any other part of the county. The NSPCC and SCIE analysis of 38 Serious Case Reviews (SCRs), published between May 2014 and April 2015 identified problems with inter-professional communication and its impact upon decision making as a common theme in serious case reviews (SCRs).[21]

What are the implications for the reliability of the multi-agency child protection system?

If professionals are not explicit in their communication with other professionals regarding reasons for referrals, then opportunities to safeguard children in a timely manner may be missed.

21 NSPCC/SCIE (2016) Learning into Practice: inter-professional communication and decision making – practice issues identified in 38 serious case reviews. London: NSPCC/SCIE.

Finding 4

Professionals in the county do not routinely communicate and record underlying concerns and relevant historical information to inform analysis and decision making when they share information.

Professionals within the county are proactive in sharing information with fellow professionals, however, the information communicated focuses on the presenting evidence and does not clearly outline the referrers underlying concerns meaning that there is limited understanding of the risks.

Considerations for the Board and partner agencies

• Does the Board recognise this issue?

• Is there need for an information-sharing form and if so what information would need to be included?

• Does the Board think that professionals are over-reliant on telephone contact rather than e-mail and if so why?

• Are there ways in which electronic systems could be used to enable improved written communication?

Finding 5

In the county, current primary care registration processes are inconsistent about how they ask for information regarding a family's previous contact with social care and cross-reference with existing child protection records meaning that key information may not available when a GP sees a new baby.

Patterns in human–tool operation.

Description

When a new child is registered with a GP, the usual current process for placing the child on the GP data-base does not require a cross-reference with existing records held on other family members such as siblings, mother or father. This means that information already held on the data-base may not be accessed by doctors seeing a baby for the first time. In England, there is no legal requirement for a parent to register their child with a GP. It is however normal practice for most parents to register their children with a doctor and certain health assessments and services, such as immunisations, are co-ordinated and provided through the GP. In particular, GP records are seen by other health professionals as the central point to which reports of all other health interventions are located for example when a child is seen in hospital a summary report is always sent to the GP.

How did the issue manifest in this case?

When the GP was contacted by the health visitor regarding Baby LL's flickering eyes he was unaware of any of the wider family background and did not know that there had been previous concerns about the parenting provided by both parents to other children. This meant that the GP responded to the concerns raised by the health visitor purely as medical issues. If the GP had been aware of the past family history, it is possible that the GP would have asked mother to bring the child into the surgery to be seen.

How do we know it is an underlying issue and not something unique to this case?

The GP working with the Review Team was clear that this GP was operating to procedures and protocols that are common to most GP practices and that current normal practice means that GPs when registering new babies do not access wider information held on their data-bases unless this is triggered by an event such as the child becoming the subject of a child protection plan pre-birth. This means that at initial contact they may be unaware of wider family history.

How common and widespread is this pattern?

This review only involved staff from one area within the county however it would appear that this practice is common to many GPs in the county. The GP working with the Review team had undertaken an audit in Hampshire aimed at identifying 'hidden adults' involved in children's lives. The term "Hidden Adult" is a Hampshire Safeguarding Children Board term to describe significant adults in a child's life about whom professionals are unaware. The overall aim of the audit was to establish whether primary care practices were collecting information regarding adults living with or involved in a child's life.

This audit identified that each GP practice followed their own registration procedures and there was not a standard registration form for children. The overall finding from the sample audit was that details of the parent or carer with Parental responsibility and relationship to the child was recorded in 54% of cases and a previous history of social worker or children's services input was recorded in 0% of cases. This research included some county based practices and it is possible that research about practice throughout the county would have similar results.

An example of good practice has been identified in a practice in the Woking area where a specific registration form for children under 5 is used. The form includes requests for information regarding persons of parental responsibility. Current and previous history of involvement with Children's Services including the name of the social worker and information regarding looked after children status. This demonstrates what good registration procedures look like but also highlights inconsistency in primary care registration practices for children across the county.

What are the implications for the reliability of the multi-agency child protection system?

In order to provide an effective GP service, access to wider medical records is important to understand a family history. This is particularly true with regards to safeguarding where important social information could be withheld meaning that the GP was unaware of risk factors or past child protection concerns which could place children at risk.

Finding 5:

In the county, current primary care registration processes are inconsistent about how they ask for information regarding a family's previous contact with social care and cross-reference with existing child protection records meaning that key information may not available when a GP sees a new baby.

Full understanding of the history of a child is key to a GP being able to assess risk, as the previous history of a family is a good indicator of future risk. The GP is viewed by most health professionals as the 'hub' for all health information and therefore the link for all professionals. Full access to all the historic record is a key factor in enabling professionals to access important medical and social information that could be crucial in safeguarding children. This review has identified that there are some systemic issues that prevent this happening in a timely manner.

Considerations for the Board and partner agencies

• Is the Board aware of this problem?

• Does the Board think that a GP should routinely check the whole family record when a baby is registered?

• Does the Board think that GPs should routinely request parents to provide the same core data when registering a baby and that this should include questions about previous social work involvement?

Finding 6

The complexities of the current benefits systems, general levels of personal debt and families not readily disclosing, make it hard for professionals in the county to assess the relevance of families' finances to child protection when undertaking assessment work.

Professional norms & culture around multi-agency working in assessment and longer- term work.

Description

Parenting capacity is one of three core elements which practitioners assess when concerns about a child's welfare are raised. The other two elements are the child's developmental needs, and wider family and environmental factors. These three elements are inter-related and cannot be considered in isolation (HM Government, 2013). Poverty is neither a necessary nor sufficient factor in the occurrence of child abuse and neglect. Many children who are not from families in poverty will experience abuse in some form and most children in families who are living in poverty will not experience abuse. There are various explanations for the relationship between family socio-economic circumstances and the prevalence of abuse, which include either a direct effect through material hardship or lack of money to buy in support, or an indirect effect through parental stress and neighbourhood conditions. Disadvantaging socio- economic circumstances may operate as acute or chronic factors, including their impact on parents' own childhoods. These interactions between poverty and other contributory factors are complex and frequently circular and may include factors such as life-style pressures and the failure of businesses. Evidence suggests that individual practitioners and child protection systems currently pay insufficient direct attention to financial matters and do not take sufficient account of the role of poverty in child abuse and neglect.[22]

How did the issue manifest in this case?

At the initial Child Protection Conference in April 2016 all professionals involved with the family provided reports about the family. None of these professionals provided information about the family's financial position or considered why mother was planning to return to work, with two children under three and one a new born baby. None of the professionals at the conference was aware that the family had been visited by bailiffs who were threatening to remove the family car and that there was court action regarding rent arrears. Furthermore, there was no evidence that they had specifically asked the parents about current debts. At the conference, Mother clearly stated that she was looking for paid work and said she had to do unpaid work because she was in receipt of job-seeker's allowance. At the meeting it was agreed that a whole family assessment was to be 'explored' that assessed child/adult attachments but did not fully examine what risks mother returning to work may pose as it left father, about whom there had been most concern, caring alone for the children.

22The relationship between poverty, child abuse and neglect: an evidence review Paul Bywaters, Lisa Bunting, Gavin Davidson, Jennifer Hanratty, Will Mason, Claire McCartan and Nicole Steils. Joseph Rowntree Foundation, March 2016 www.jrf.org.uk

How do we know it is an underlying issue and not something unique to this case?

The case group was clear that while it was routine to discuss finances with families when undertaking assessments there was an assumption that parents would volunteer this information and that if there were problems they would be told. It was acknowledged that at present there were no systems in place for routinely including the Housing Department in these assessment processes even though Housing may be consulted as part of the MASH processes. It was also accepted that current benefit systems are complex and that usually where there are benefit problems families are advised to access specialist services such as the Citizens Advice Bureau. The Review Team were aware that a lack of awareness by professionals of family financial difficulties had been a feature of recent domestic homicide reviews.

How common and widespread is this pattern?

This review only involved staff from one area within the county however there is no reason to consider that practice in this area was different from any other part of the county.

According to a recent report by the Joseph Rowntree Foundation, 39% of people in households with children now live below the Minimum Income Standard. The figure has risen by over a third since 2008/09. Household debt is now the highest it has ever been. In January 2018, the average household debt was £57,943 (including mortgages) with consumer credit debt of £7629. 276, people a day in the UK are declared insolvent or bankrupt and 1756 county court judgements (CCJ's) were issued every day between October and December 2017, with 18 properties a day repossessed[23].

Families with children are now at greater risk than any other group of having an inadequate income and the number of homeless families living in bed and breakfast accommodation has risen by 300% over the last five years as a direct result of austerity and welfare changes. The roll out of full Universal Credit[24] in the county, scheduled in the autumn 2018, will further affect both working and non-working households on low incomes and together with high housing costs will continue to be a source of pressure on families.

The links between poverty and a child's chances of becoming subject to child protection processes or being looked after are undeniable according to the international and national research. A child in the most deprived decile of neighbourhoods nationally has an 11 times greater chance of being on a child protection plan and 12 times greater chance of being a looked after child than a child living in the most affluent decile[25] .

23 http://themoneycharity.org.uk/money-statistics/

24 https://www.gov.uk/universal-credit

25 http://www.communitycare.co.uk/2015/06/30/child-protection-must-dealing-symptoms-increased-poverty/

What are the implications for the reliability of the multi-agency child protection system?

Previous research by The Children's Society has suggested that financial difficulties experienced by families have a detrimental effect on the wellbeing and mental health of parents as well as children and young people. Therefore, when working with families it is important to understand the financial challenges faced by a family and identify any additional risks it may pose to the children within the family.[26]

Finding 6: The complexities of the current benefits systems, general levels of personal debt and families not readily disclosing, make it hard for professionals in the county to assess the relevance of families' finances to child protection when undertaking assessment work.
In the county the obtaining of information in relation to family finances is not explored to the same extent as other areas of parental capacity. At a time when more families are experiencing financial challenges it is importance that professionals working with these families understand fully the extent of the pressures on the family. **Considerations for the Board and partner agencies** • Is the Board aware of this problem? • Does the Board think professionals have sufficient understanding and awareness of the relationship between poverty and safeguarding? • Does the Board think professionals are sufficiently curious about people's financial problems when undertaking safeguarding assessments of families and always include it when assessing environmental factors? • Is the Board assured that all safeguarding assessments of families undertaken include all aspects of the assessment framework and that all agencies are involved appropriately? • Given that families may be reluctant to disclose financial difficulties to professionals how can the Board be assured that assessment of finance is included in all safeguarding assessments of families? • Should the Housing Department routinely be consulted by agencies when professionals are undertaking assessments?

26 Pople, L., Royston, S. & Surtees, J. (2014) 'The Debt Trap - Exposing the impact of problem debt on children'. The Children's Society & StepChange. Accessed 12th August 2016:

http://www.childrenssociety.org.uk/sites/default/files/debt_trap_report_may_2014.pdf

Appendix 1 – Methodology

1. This SCR has used the SCIE Learning Together model for case reviews. This is a 'systems' approach which provides a theory and method for understanding why good and poor practice occur, to identify effective supports and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high-risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and CP work (Munro, 2005; Fish et al, 2009). National guidance in the 2015 revision of *Working Together to Safeguard Children* (2015) now requires all SCRs to adopt a systems methodology.

2 The model is distinctive in its approach to understanding professional practice in context; it does this by identifying the factors in the system that influence the nature and quality of work with families. Solutions then focus on redesigning the system to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.

3 Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.

4 The basic principles – the 'methodological heart' – of the Learning Together model are described in summary form below:

a. Avoid hindsight bias – understand what it was like for workers and managers who were working with the family at the time (the 'view from the tunnel'). What was influencing and guiding their work?

b. Provide adequate explanations – appraise and explain decisions, actions, in-actions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it

c. Move from individual instance to the general significance – provide a 'window on the system' that illuminates what bolsters and what hinders the reliability of the multi-agency CP system.

d. Produce findings and questions for the Board to consider. Pre-set recommendations may be suitable for problems for which the solutions are known, but are less helpful for puzzles that present more difficult conundrums.

e. Analytical rigour: use of qualitative research techniques to underpin rigour and reliability.

5 Typology of underlying patterns

To identify the findings, the Review Team has used the SCIE typology of underlying patterns of interaction in the way that local child protection systems are functioning. Do they support good quality work or make it less likely that individual professionals and their agencies can work together effectively?

They are presented in six broad categories of underlying issues:

1. Multi-agency working in response to incidents and crises
2. Multi-agency working in longer term work
3. Human reasoning: cognitive and emotional biases
4. Family – Professional interaction
5. Tools
6. Management systems

Each finding is listed under the appropriate category, although some could potentially fit under more than one category.

Anatomy of a finding

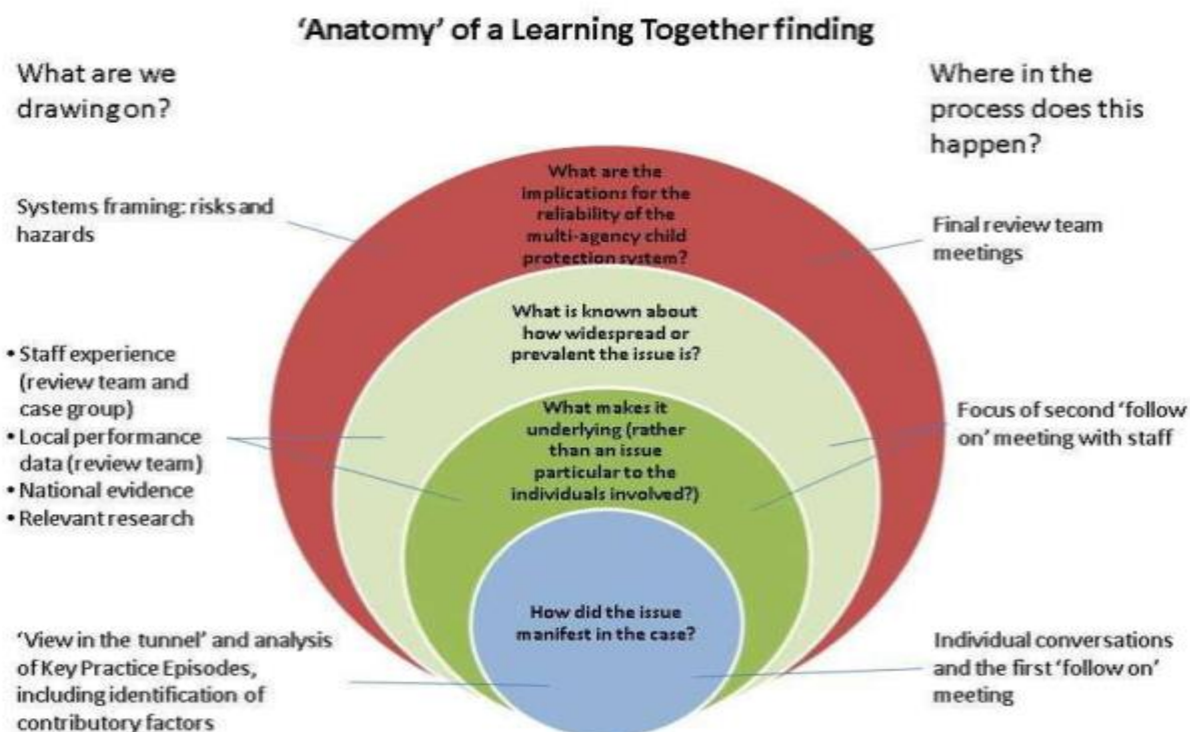
For each finding, the report is structured to present a clear account of:

• How the issue manifests itself in the particular case?

• In what way it is an underlying issue – not a quirk of the particular individuals involved this time and in the particular constellation of the case?

• What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?

• How the issue is usefully framed for the LSCB to consider relative to their aims and responsibilities, the risk and reliability of multi-agency systems. Illustrated below.



7 Structure of the Review

There were three main groups who worked together to complete the review:

7.1 The review team comprises senior managers from the agencies involved in the case, who have had no direct part in the conduct of the case. Led by two independent lead reviewers, they act as a panel working together throughout the review, gathering and analysing data, and reaching conclusions about general patterns and findings.

They are also a source of data about the services they represent: their strategic policies, procedures, standards, and the organisational context relating to particular issues or circumstances such as resource constraints and changes in structure. The review team members also have responsibility for supporting and enabling members of their agency to take part in the case review.

Review Team Members
Fiona Johnson, SCIE Independent Lead reviewer
June Hopkins SCIE Independent Lead reviewer
LSCB Partnership & Support Manager
County wide Deputy Designated Nurse Safeguarding Children
County wide designated GP for safeguarding children
Named Nurse for Safeguarding Children Children, Community Health Service Provider
Service Co Ordinator, Child Protection Conferences Children and Families
Detective Chief Inspector Public Protection
Head of Housing Advice at a borough council
Safeguarding Advisor Safeguarding & Health Team Early Help & Family Services

7.2 The Case Group are the professionals who were directly involved with the family. The Learning Together model offers a high level of inclusion and collaboration with these workers/managers, who are asked to describe their 'view from the tunnel' – about their work with the family at the time and what was affecting this. In this case review, the Review Team carried out individual conversations with 17 case group professionals, and up to 19 professionals were invited to attend the case group meetings which discussed the practice in this case and agreed the findings.

7.3 Review process

A Learning Together case review reflects the fact that this is an iterative process of information-gathering, analysis, checking and re-checking, to ensure that the accumulating evidence and interpretation of data are correct and reasonable. The review team form the 'engine' of the process, working in collaboration with case group members who are involved singly in conversations, and then in multi-agency 'Follow- on' meetings. The report will be received by the Serious Case Review Sub-group and the GSCB Executive who will have oversight of the final report and response plan.

The sequence of events in this review is shown below:

Date	Event
3/11/17	Introductory meeting for the Case Group – to explain the Learning Together model/method, and the case review process which they will be part of.
7/11/17 & 23/11/17	Two days' conversations with members of the Case Group (individual sessions of about 1.5 hours with conducted by the lead
24/11/17	First Review Team analysis meeting
12/12/17	First Follow-on meeting (Review Team and Case Group) In this meeting, the group works together on identifying Key Practice Episodes (KPEs) in the case which affected how the case was handled and/or the outcome of the case appraising the practice in these KPEs considering what was affecting the work/workers at the time (the 'view from the tunnel')
7/2/18	Second Review Team analysis meeting
21/2/18	Second Follow-on meeting (Review Team and Case Group) At this meeting, the group were provided with the emerging underlying patterns and findings, and were asked to consider whether these are specific to this individual case or pertain more widely and form a pattern.
5/4/18	Final review team meeting - to consider final draft report
17/4/18	SCR Sub-Group meeting – to consider the draft final report
21/5/18	LSCB meeting – to consider the draft final report
	Final report, fit for publication, to be submitted to Department for Education (DfE)

7.5 Scope and terms of reference

Taking a systems approach encourages reviewers to begin with an open enquiry rather than a pre-determined set of questions from terms of reference, such as in a traditional SCR. This enables the data to lead to the key issues to be explored.

7.6 Sources of Data

7.6.1 Data from Practitioners

Conversations, as described above, with members of the Case Group; these were recorded and discussed by the whole Review Team.

Members of the Case Group have also helpfully responded to follow-up queries and requests from the Lead Reviewers and the Review Team for clarification or further information, where this has been needed.

7.6.2 View from the Tunnel and Contributory Factors

The data from the conversations with the Case Group translates into their 'view from the tunnel' which enabled us as reviewers to capture the optimum learning from the case. Case Group members are also an invaluable source of information about the why questions – an exploration of the Contributory Factors which were affecting their practice and decisions at the time.

7.6.3 Participation

The Lead Reviewers and the Review Team are grateful for the willingness of the professionals to reflect on their own work, and to engage so openly and thoughtfully in this SCR. Everyone has contributed very fully in the process. Individual practitioners all have participated responsively in conversations, which have recalled their role in this story, and in group discussions which have at times been very difficult and challenging. All this has given the Review Team a deeper and richer understanding of what happened with this family and within the safeguarding network, and has allowed us to capture the learning which is presented in this report.

7.6.4 Data from documentation

The Lead Reviewers and members of the Review Team reviewed the following documentation:

Children's Services records

Midwifery records

Hospital records

Police records

GCH records

Community Health Records/ GP records

7.6.5 Data from family, friends and community

As in traditional SCRs, the Learning Together model aims to include the views and perspectives of family members as a valuable element in understanding the case and the work of agencies.

Appendix 2 Glossary

A & E – Accident & Emergency Department of Hospital

CIN – Child In Need

CP – Child Protection

CSC – Children's Social Care

GP – General Practitioner

HMIC – Her Majesty's Inspectorate of Constabulary. Independently assesses the effectiveness and efficiency of police forces – in the public interest.

LSCB – Local Safeguarding Children Board

MARF – Multi Agency Referral Form

MASH – Multi Agency Safeguarding Hub. A partnership between the county council, the constabulary and health agencies working together to safeguard children, young people and vulnerable adults.

NHS – National Health Service

NSPCC – National Society for the Prevention of Cruelty to Children

Ofsted - Office for Standards in Education, Children's Services and Skills. They inspect and regulate services that care for children and young people, and services providing education and skills for learners of all ages.

PLO - Public Law Outline. This is the framework within which Local Authorities are required to work in cases where it is considered by the Local Authority the threshold criteria is or may be met. Within the framework of the Public Law Outline there is a requirement to attempt to work with the family and their legal representatives before issuing proceedings. Within the framework provision is made for an LBA (letter before action) to be sent to the parents setting out the Local Authority's concerns, setting out what the parents are required to do to address those concerns and inviting them to a meeting with their legal representatives to discuss and plan how to address the concerns raised. If the actions agreed are not adhered to the Local Authority then goes on to consider/issue care proceedings. This means the Court receives and accepts an application on behalf of the Local Authority and sets a date for a first hearing. In order to issue an application the Local Authority must produce to the Court:

1. A completed application form prepared by the lawyer;

2. A statement of evidence prepared by the social worker;

3. A chronology of significant events prepared by the social worker;

4. A care plan for each child, again prepared by the social worker;

5. A threshold criteria document prepared by the lawyer. This document describes how the evidence prepared by the social worker and provided to the Court proves that the requirements of the legal test called the threshold criteria are met to the extent that the Court has sufficient evidence to "Find" (i.e. determine) on the balance of probabilities that the evidence in support of the threshold criteria is factually correct.

Where the Court is satisfied that the Local Authority has proved that the facts in the case are such that the threshold criteria are met it can make a Care Order. A Care Order lasts until the child is 18 unless there is any further order of the Court. The effect of the Care Order is to bestow parental responsibility upon the Local Authority. This means the Local Authority then shares parental responsibility with the parent(s).

SCR – Serious Case Review

Single Assessment - Single Assessment process is the assessment process used in children's social care which replaced initial and core assessments

SCIE - Social Care Institute for Excellence. The Social Care Institute for Excellence (SCIE) improves the lives of people who use care services by sharing knowledge about what works. They are a leading improvement support agency and an independent charity working with adults', families' and children's care and support services across the UK.

Strategy Meeting/Discussion – A strategy discussion is held when there is reasonable cause to suspect that a child has suffered or is likely to suffer significant harm. This may be following a referral and initial assessment or at any time during an assessment where a child is receiving support services if concerns about significant harm to the child emerge. The purpose of the strategy discussion is to enable the Children's Services' department, Police and other relevant agencies (e.g. health services, schools) to share information, make decisions about initiating or continuing enquiries under s. 47 of the Children Act 1989, what inquiries will be made and by whom, whether there is a need for action to immediately safeguard the child, and what information about the strategy discussion will be provided to the family. Decisions will be made regarding the provision of any medical treatment, how to handle inquiries in the light of any criminal investigation and whether other children affected are in need or at risk.

TM – Team Manager

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