KNOWSLEY SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW INTO THE DEATH OF CHILD O

PERIOD UNDER REVIEW

JANUARY 2012 – FEBRUARY 2015

OVERVIEW REPORT

CONTENTS

CHAPTER 1

1. INTRODUCTION AND CONDUCT OF THE SERIOUS CASE REVIEW

1.1 Incident Leading to the Serious Case Review

In January 2015 Child O was found deceased in a public place. Their body was discovered by a member of the public who called police to the scene. Paramedics attended the scene and established that Child O was deceased and had died some hours previously. A post mortem confirmed the cause of death and a subsequent inquest ruled that Child O had committed suicide.

There were no suspicious circumstances surrounding Child O's death. Child O had left no note or indication that they intended to take their own life.

It is not the purpose of this review to try to establish why Child O made a decision to take their own life and no inference is made in this report about any connection between Child O's daily lived experience and their suicide.

1.2 Key People

Person	**Referred to as:**
Child O	Child O
Mother of Child O	Mother
Father of Child O	Father
Step Sibling	Step Sibling
Large Sibling Group	Siblings are not referred to individually in this report

1.3 Confidentiality

Child O's gender and age are not referred to in this report. Pseudonyms are attributed to members of Child O's family and to professionals who worked with them.

1.4 Rationale for conducting the SCR

Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires a Local Safeguarding Children Board (LSCB) to undertake a review of a serious case in accordance with the procedures that are set out in chapter four of *Working Together to Safeguard Children (2015*).

An LSCB should always undertake a serious case review when a child dies or has been seriously harmed and abuse or neglect is either known or is suspected and there is cause for concern as to the way the authority, the Board or other relevant persons have worked together.

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

This serious case review has been conducted under the guidance set out in Working Together to Safeguard Children (2015)[1].

The principles underpinning the review are that it:

- 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.

The review was conducted on the basis that the overview report would be published in full.

1.5 Timeline for the Review

The panel agreed that the period under review would be from January 2012 to February 2015 on the basis that this encompasses significant contacts and practice and is a sufficiently focused and recent timeframe within which to learn from practice and make meaningful recommendations.

The family had a long history of contact with agencies. The panel therefore decided that it was important to reflect the historical context of agency involvement with the children and to that end the author has included an overview of the family life and contact with agencies dating back to before Child O's birth.

1.6 Agencies Participating in the SCR

The following agencies have provided information and contributed to the SCR in accordance with *Working Together to Safeguard Children (2015)*, Chapter 4 and the associated LSCB guidance and relevant learning and improvement frameworks.

- Children's Social Care (CSC)
- Health Visiting Services (HV)
- GP
- Police
- Children's Centre
- Primary School

[1] Working Together to Safeguard Children, Department for Education (Revised 2015)

- Secondary School
- Midwifery and Maternity Services
- GP1
- Safeguarding Unit
- Registered Housing Provider
- Community Safety Services
- Family Centre
- Mentoring Project

One to one and group conversations were held with practitioners, not all of whom knew Child O or worked with the family; this was due to staff turnover and some practitioners having left the authority. Where it was not possible to speak to professionals who worked with Child O or their family service managers and staff provided an overview of the agency's involvement.

1.7 Methodology

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

Work began on compiling a multi-agency chronology in June 2015. In September and October 2015 conversations were held with practitioners involved in the case and following further enquiries conversations were held with additional agencies and professionals in January 2016.

1.8 Research Questions

Systems reviews do not set specific terms of reference. The following research questions were posed by the Review Team to assist in providing focus to the review and constructing and shaping the findings.

1. **Did agencies understand and respond to the daily lived experience of Child O (including neglect, parental drug and alcohol use and domestic abuse)?**
2. **Is the voice of the child evident and does it inform practice and outcomes?**
3. **Were responses by agencies undertaken in a timely fashion when safeguarding concerns were apparent? *(Response to incidents)***
4. **Did safeguarding processes, including assessments, referrals and recording systems support information sharing and decision making in this case? *(Agency to agency systems; tools to support professional judgment)***
5. **How well did agencies communicate with each other to share and seek information? *(Agency to agency systems; tools to support professional judgment)***
6. **How did the family dynamic influence professional practice and how was this managed? (Cognitive human bias)**
7. **Are there examples of good practice in this case that can be replicated?**

1.9 Review Team Members

A serious case review team was convened consisting of senior and specialist agency representatives from the local area to oversee the collation and analysis of information and outcomes of the review.

Position	Organisation
Chair/Author	Independent Lead Reviewer
Detective Chief Inspector	Merseyside Police
Named GP for Safeguarding	CCG
Designated Nurse for Safeguarding	CCG
Head of Service	Local Authority Children's Social Care
Legal Representative	Local Authority
In Attendance	Business Support Officer

The independent lead reviewer chaired the review meetings and attended every meeting of the review team and case group meetings.

The review team met on six occasions to oversee the process, analyse data, report to the LSCB, draw conclusions from the material analysed and oversee the production of draft and final reports.

The review team had access to legal advice from the Local Authority Legal Department.

Written minutes of the review team meeting discussions and decisions were recorded by the LSCB Business Support Officer.

The review has used a systems based approach to analysing information and presenting the findings in the final chapter using recommended best practice in identifying improvement and learning.

1.10 Coronial Matters

At an inquest held in June 2015 the Coroner ruled a verdict of suicide.

1.11 Involvement of Family, Friends and Significant Others

Several attempts were made to involve Child O's mother in the review, however she declined involvement as she said she would find the process to be too upsetting. Child O's mother has said that she would like to see the report before it is published.

Initial attempts to contact Child O's father were unsuccessful, the panel later received information that father was too ill to participate.

CHAPTER 2

2.1 BACKGROUND TO CHILD O

Child O was remembered by professionals as being a lively, inquisitive and 'quirky' child.

In their earlier years at primary school Child O was disruptive in the classroom and did not have an established network of friends. Attendance at primary school was poor and Child O and their siblings were noted on occasion to be unkempt.

The older members of the sibling group attended the same primary school and it was noted that they were close to each other with Child O being openly fond of their siblings and protective of them. It was noted that Child O was somewhat unusual amongst their peers in that they did not have a mobile phone and did not appear interested in social media.

When Child O transitioned to Secondary School they were said to be a very popular and visible member of the school community. Child O had an enquiring mind and got involved in school projects. Child O's behaviour improved and there was only one occasion on which it was felt necessary to speak to Child O in relation to a derogatory remark made to another pupil. Within a short time of joining Secondary School Child O had become part of a close knit group of peers; this was seen as a positive peer group who supported each other and had a strong friendship.

Child O attended a local mentoring project where they were reported to 'thrive'. Child O's first learning mentor had to leave the project following an allegation by another child and Child O was assigned to another learning mentor with whom they developed a good bond. Child O attended a residential facility whilst undertaking the project and was observed to be supportive and helpful to other children, have a strong sense of social justice and to have aspirations for the future. Child O had expressed a strong desire to enter the 'forces' when they left school.

Child O did not present with any physical or mental illness and was never subject to referral to CAMHS. Child O was not known to have self-harmed and to the knowledge of professionals involved in the review had not spoken about or contemplated taking their own life.

2.2 Professional Narrative – Background to the family

The account given below is drawn from the conversations with professional and additional material taken from case records and multi-agency chronology. It does not include insights from family and friends into Child O's wishes, feelings or daily lived experience as family members did not want to participate in the review.

The family had been known to services since 1998. The summary below includes an overview of agencies contacts to provide context to the events and contacts covered in the period under review (2012-2015).

Child O lived in the family home with both parents an older half sibling and a large sibling group.

Child O's parents had a difficult and volatile relationship with episodes of domestic abuse involving verbal and physical altercations. It was known by all professionals involved in the review that domestic abuse had been present in the parental relationship for many years. The first domestic incident recorded in the chronology took place when Child O was a baby.

All professionals who participated in the review were aware of neglectful parenting[2] and those who entered the family home saw poor home conditions which were described by some professionals as at times being unacceptable and occasionally extremely unacceptable.

Mother told professionals on numerous occasions that she had separated from father; professionals commented that incidents of domestic abuse and subsequent separations were cyclical. Mother minimised and denied domestic abuse following incidents and told professionals on each occasion that father was no longer living in the family home. Each reported separation appeared to be followed by a pregnancy.

Child O's family were visible to professionals in the local area and stood out for a number of reasons, they were an unusually large family and this brought them to the attention of others, especially when they were all seen together. Child O's mother was sometimes observed to be loud and aggressive with the children in public, she was seen by professionals shouting and swearing at the children when she was taking them to and from school.

Father was less visible and he was not seen with any frequency in the family home, the majority of professionals did not have much contact with him. He sometimes took the children to school and picked them up.

Some professionals believed that mother was using drugs based on reports from the children and from their own observations. Domestic violence reports indicated that father was sometimes intoxicated with alcohol during altercations. Father had been an offender in the past and during Child O's life he was arrested and charged with a number of offences. For a period of approximately three years father's younger brother lived at the family home, he was a serial young offender and was arrested and charged with several offences during this time.

There were complaints from neighbours about anti-social behaviour involving some of the children, including Child O. The registered housing provider became involved in these complaints and warnings were issued to mother.

The older children attended the same primary school. At primary school Child O displayed some behavioural difficulties; Child O could be disruptive in the classroom and experienced outbursts of temper. The children's presentation at school was described as often 'scruffy'; attendance at school was inconsistent and parental engagement with school was minimal.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/379747/RR404_-_Indicators_of_neglect_missed_opportunities.pdf

The Primary school made numerous referrals to CSC regarding their concerns in relation to the children's general presentation and home circumstances. During the period under review Child O transitioned to Secondary School and appeared to settle well, Secondary School were surprised that Child O's behaviour was markedly different to that seen at primary school and Child O quickly integrated into Secondary School and formed a small and close network of friends.

Family support was offered to the family and attempts were made by professionals to engage mother (as father was often absent). More than one CAF was put in place and between 2012 and 2013 the family were at Child in Need level. However mother did not engage with professionals in any meaningful way and failed to consistently maintain any temporary improvements in home conditions.

It was the view of all professionals involved in the review that mother did not consider herself a victim of domestic abuse, that she normalised these incidents and behaviours and therefore did not seek help or support for herself or the children. Professionals discussed domestic abuse with mother but she said that she did not want to attend any specialist domestic abuse services. Mother reported to professionals that a more permanent separation from father had taken place in 2013.

There is evidence that Child O and their siblings witnessed many domestic abuse incidents. On more than one occasion Child O told staff at the primary school that their mother and father had argued and fought. On one occasion Child O rang police to say that their father had hit them in the face; although this was judged to have been an accident by professionals based on father's account of the incident.

From 2007 to 2014 there were eleven reported incidents of anti-social behaviour opened and closed by the housing provider, nine of these took place between 2012 and 2014. The earlier incidents related to father's behaviour and him causing a nuisance around the property. There were complaints about mother using foul language and shouting at the children.

In October 2010 a neighbour made a complaint about Child O to the housing provider. This incident was looked into by the housing provider and discussed with social care and was judged to be an isolated incident. A CAF was put in place that same month and a multi-agency meeting took place followed by a strategy meeting. The case then remained at CAF level until it was closed in January 2012.

The majority of the complaints were about the children being unruly. There were a number of incidents in which the children, including Child O were name calling and stone throwing in the neighbourhood. On several occasions the incidents involved the children intimidating other children who lived nearby. One neighbour reported that they felt that the family were being subjected to a 'witch hunt' by other neighbours.

By the time Child O transitioned to Secondary School their parents were facing prosecution for non-school attendance (Level 4 action). Primary school was concerned that Child O

would continue to experience difficulties in their daily school life and provided Secondary School with information to support their concerns.

In 2013 Child O was referred by a Social Worker who had previously worked with the family to a local mentoring scheme to give them an opportunity for personal development. Child O was assessed as meeting the criteria for inclusion in the scheme, although it was unusual for the scheme to take children of Child O's age. Child O was said to thrive at the project. There was an issue with Child O's original learning mentor who had to leave the scheme because of a breach of policy in relation to a child, however Child O built up a good relationship with a new learning mentor and graduated successfully in 2014.

CHAPTER 3 – AGENCY INVOLVEMENT

3.1 Contacts in the period under review

3.1.1 Contacts in 2012

During the period January to December 2012 the chronology contains around 80 recorded contacts with or about the family.

The year began with the closure of the CAF in January due to recorded improvements in home conditions and school attendance. Two weeks later primary school made a referral to CSC as all the children were absent from school and no response was received to phone calls or a home visit.

In early February police were called to an altercation between father and Child O's older half sibling in which father was reported to be drunk. Police attended and found the children to present at this incident. Police spoke to both parties and removed father to prevent further breach of the peace. No further action was taken by the police as no allegations were made. Police referred the incident to CSC.

The following day a social worker visited the family home and recorded the home conditions as 'disgusting and there being a stench', and that all the children were sharing beds.

A strategy meeting took place on 7th February and agency checks were completed, the children were seen and spoken with by a social worker and a referral was made to the specialist domestic abuse service.

The case records shows that a single assessment was finalised on 20th February which concluded that mother was acting appropriately to safeguard the children and that there was no further role for CSC. The case was closed to CSC on 1st March 2012.

In mid-April mother attended a booking appointment with the Community Midwife, she was nineteen and a half weeks pregnant and a late booker. A 'Social and Mental Health' assessment was completed at which mother disclosed that she had previously experienced violence in her relationship with Child O's father but that she was no longer in a relationship with him. She also reported that CSC had been involved with the family due to domestic

abuse. Mother was referred to the local domestic abuse service. Concerns were noted regarding overcrowding in the property.

Four days later the registered housing provider received complaints about anti-social behaviour by the children. This was investigated by the housing provider however there was no action taken to look into any potential safeguarding issues with the children. A warning letter was issued and an appointment was made for the following month to discuss putting in place an anti-social behaviour contract however this was not attended by mother.

In May there were two further contacts with the housing provider regarding anti-social behaviour and an anti-social behaviour agreement was put in place and a further appointment missed.

During June and July mother attended appointments with the community midwife to monitor the pregnancy. In mid-August mother was admitted to hospital and gave birth without complications.

On 17th August police attended a domestic abuse incident and noted poor home conditions, a referral was made to CSC who conducted a home visit and recorded that home conditions were acceptable. Four days later police were called to another domestic abuse incident, the house was reported as being in 'squalor' and it was noted that the children were present at the incident; a referral was made to CSC. Three days later a Health Visitor conducted a birth visit and recorded no concerns.

Four days later the health visitor completed a birth visit at the family home. Home conditions were described as chaotic due to the number of children present. The house was described as being warm and 'not dirty'. It was noted that there was no floor covering in the property. The children were described as being clean and appropriately dressed.

A further anti-social behaviour complaint about the children was received four days after the birth visit mother was visited at home but denied that any of her children had been involved in the incident described.

In early September Child O disclosed at school that their grandfather had been round to the house and said that he was going to take the children away because 'father takes drugs'. Child O said they didn't know if father was back at home because 'sometimes he is and sometimes he isn't'.

A week later the Health Visitor reported the home conditions as poor and recorded that there was a plan to rehouse the family.

That same week Child O disclosed at school that they are the only one who can stop their parents fighting because 'dad won't hit them'.

Two weeks later police attended a domestic abuse incident where father had taken money from mother. The children were reported as being present and the house conditions were noted as poor; a referral was made to CSC. On the same day father was arrested for possession of a controlled drug. The CSC records show that on 26th September a discussion was held in supervision with the Social Worker showing that a written agreement would be

sought that father should not have contact with the children until safeguarding concerns were addressed. A written agreement was drawn up to say that father should not have contact with the children and if the agreement was broken that Section 47 enquiries would commence.

A referral was made to Family First by CSC on 2nd October. A single assessment was completed on 4th October in which CSC recorded that 'there is no role for the service'. The record shows that there was a plan for family support to stay involved for six weeks.

The following day the Family First service conducted an initial home visit. The domestic abuse incident of the previous day was discussed and mother told professionals that she would tell them if father attempted to contact her or the children.

Later that month, following a report by father that mother used drugs, the social worker referred mother to the local Drug Service saying that failure to attend would result in child protection proceedings being initiated. It appears that mother failed to attend on the first occasion. Mother was given a further appointment to attend the service but did not do so as it was on one of the children's birthday, she requested a change of appointment and was given an alternative, it appears that she did not attend the appointment, however no action was taken to step the case up to child protection conference.

On 8th November a Health Visitor went to the family home to discuss access to 2 year funding. At this meeting mother told the Health Visitor that father had made an allegation about her using cocaine and that this was not true. She said she had attended the drug service and they had laughed at her; there is no record of mother attending the drug service.

A CIN meeting held in early December noted that mother had been referred to a drug service and that it was desirable that mother should undertake drug testing as there were concerns she was spending money on cocaine. Mother agreed to this but there is no further reference to whether she attended or not or any record of follow up by CSC.

No further action appears to have been taken in relation to mother's drug taking despite mother being told that child protection proceedings would commence if she did not do something about her drug use. There appears to have been no further liaison between CSC and the drug service from this point onwards.

Family first visited the family at home on 20th December to drop off food packs. The door was answered by one of the children who was naked. Mother followed the child to the door and appeared to have just awoken; the downstairs living room appeared to be very untidy with quilts lying around and children in pyjamas. Mother said they had all stayed up late watching films which was why they were sleeping downstairs.

3.1.2. Contacts in 2013

Between January and December 2013 the chronology records around 35 contacts with the family. There are several recorded attendances at A&E and Walk-In Centres with minor

injuries to the children, these injuries appear to be associated with play and did not raise any concerns.

In late February the family moved to a new GP practice. Social Care involvement was continuing and a CIN meeting took place in February however mother continued not to engage.

In June the Social Worker referred Child O to a local mentoring project to provide support and to assist with personal development. The Social Worker had referred another child to the project and felt that the programme would be beneficial to Child O. Although it was unusual for the service to accept referrals via this route and Child O was older than the usual age range accepted by the project, they assessed Child O and accepted them onto the mentoring programme.

Staff from the mentoring project went to see Child O at home and found mother to be welcoming and engaging, although they did note that the home conditions were chaotic. As part of the assessment for inclusion in the scheme Child O's mother was visited at home; she was observed to be very welcoming, although there were observations about the condition of the home and mother's possible use of substances. Child O thrived in the mentoring project; they were observed to be quirky and 'secure in their own skin'; enjoying outdoor games and playing outside. The practitioner from the project described Child O as not being aggressive or bullying, as having a real sense of justice; being protective towards their younger siblings and to other children in the project.

In August the housing provider received a complaint regarding nuisance being caused by the children. In the same month two complaints were also made to the Community Safety Team regarding anti-social behaviour. All complaints were followed up by the service however the safeguarding needs of the children were not explored.

Two further reports were made by neighbours in September, one was a complaint about the children's behaviour; the other report was anonymous and said that the family were being subjected to a 'witch-hunt' by some of their neighbours.

In October the CIN was closed to Social Care, the case was transferred to the Duty Team at this time and remained open to Family First.

3.1.3. Contacts in 2014

During the period January to December 2014 there were 12 recorded contacts with the family; the first of these took place in January when a complaint was received by the Community Safety Team that one of the children had thrown stones at another child in the street. This was logged on the Community Safety System.

In April Child O graduated from the mentoring project. This was seen to have been a very positive experience and Child O indicated that they would like to return to the project at some point in the future and wanted their mentor to be present when they were accepted into the Army at the age of 18. On reflection the project saw this as an indication that Child O was thinking positively about their future.

That same month a Family First worker visited the family home to deliver Easter Eggs. One of the children had come to the door and said that mother wasn't at home and that a brother was looking after them. The Family First worker spoke to a social worker who said that police should be notified that children were at home without adult supervision. Police did not attend the home address and the report was not taken any further as further enquiry established that there was an older step sibling living at the address.

A second report from a neighbour of anti-social behaviour took place in August; the complaint involved the children throwing stones, swearing and putting a note through the neighbour's door containing bad language. The complainant also said that their child had been intimidated and hit by the children.

Throughout the latter part of 2014 the housing provider and the Community Safety Team were involved in investigating complaints. They made several attempts to engage mother by making appointments and issuing warning letters about potential action if the anti-social behaviour did not stop. Several letters were sent and meetings attempted with mother, however she failed to engage.

3.1.4. Contacts in 2015

In January 2015 the event leading to this serious case review took place, as described in the introduction to this report.

CHAPTER 4 – ANALYSIS OF PRACTICE

4.1 During the period under review there were a number of missed opportunities to bring professionals together.

The period January to December 2012 stood out as being particularly chaotic for the family and numerous incidents took place.

4.2.1 Did agencies understand and respond to Child O's the daily lived experience?

Multiple agencies worked with Child O and their family over many years. Child O's parents were consistently resistant to change; engagement with agencies was minimal and any temporary improvements in the home conditions and presentation of the children were short lived.

The review found that throughout the period under review (and historically) professionals who visited the family home did not sufficiently or consistently respond to the neglectful conditions in which Child O and their siblings lived. At the time the graded care profile[3] (a checklist for rating home aspects of family life including safety, home conditions and relationships) was not in use (it has since been adopted for use in the Borough).

[3] https://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/graded-care-profile/

The Review has seen evidence that Child O's frequent lived experience was one of neglectful parenting and poor home conditions. The home conditions were described by some professionals as disgusting, this may be a matter of interpretation, however the review team believe that there was sufficient evidence to support the view of some professionals that conditions in the family home were frequently very poor and occasionally extremely poor, for example children not having beds to sleep in, no furnishings in the home and sitting on the floor, no wall-coverings or curtains, a lack of food in the home, food left to deteriorate, lack of cleanliness, children left unsupervised, children seen out 'alone' after the hours of darkness, children seen in the home without clothing.

It was observed by professionals that home conditions did improve from time to time, but that there was no consistent and sustained improvement in home conditions which were at times seen to be significantly below an acceptable level. The neglectful home conditions appear to have been viewed differently by different groups of professionals, there being no consistent approach to addressing the neglect that the children were experiencing.

There is little evidence that agencies collectively identified and responded to the daily lived experience of Child O and their siblings.

There is little evidence that any agency, other than Child O's primary school[4] made realistic attempts to assess the impact of domestic abuse on Child O and their siblings. Responses to chronic domestic abuse lacked robust multi agency assessment and intervention.

Police responded appropriately to domestic abuse 'call outs' and made referrals to CSC whenever children were present at incidents; the follow up to these referrals lacked consistency and a sense of purpose. Little consideration appears to have been given by CSC to the frequency and severity of the incidents and the impact that witnessing domestic abuse would have upon the children.

Mother was advised on more than occasion to seek help from specialist domestic abuse services but did not do so.

The impact on the children of substance misuse by both parents was not taken into consideration as a risk factor or adequately assessed as impacting the children's emotional wellbeing. Mother was referred to the local substance misuse service and reported that she had been 'laughed at' although there is no evidence that mother attended the service. This was not followed up despite the SW having said that failure to engage would lead to Child Protection proceedings.

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https://www.researchgate.net/publication/283563033_Preventing_domestic_abuse_for_children_and_young_people_A_review_of_school-based_interventions

4.2.3. Is the voice of the child[5] evident and does it inform practice and outcomes?

Primary school undertook wishes and feelings work with Child O and their siblings and the mentoring scheme recognised the importance of seeking and hearing the voice of the child; however the wishes and feelings of Child O and their siblings did not appear to influence the way that the majority of agencies worked with the children.

On more than one occasion Child O spoke about their home circumstances, specifically the violence perpetrated by their father and the arguments between mother and father. This was recorded by police and primary school and raised as a concern by primary school but was not acted upon.

4.2.4. Were responses by agencies undertaken in a timely fashion when safeguarding concerns were apparent? *(Response to incidents)*

The timeliness and quality of responses by agencies to safeguarding concerns was variable and inconsistent.

The review considers that there were a number of missed opportunities to review the case in light parental non-engagement, resistance and new incidents.

The probability of child protection planning was used to try to engage parents in services however this was not followed through when parents failed to engage.

Agencies did not challenge CSC views on step-down and case closure despite continuing concerns; there is no evidence of a chronology, other than in the primary school; and agencies appeared to see each event or incident in isolation.

There was no evidence of an integrated and clear plan to address the vulnerabilities and risks of the children or of parenting capacity and capability, including willingness to change negative behaviours.

4.2.5. Did safeguarding processes, including assessments, referrals and recording systems support information sharing and decision making in this case? *(Agency to agency systems; tools to support professional judgment)*

The quality of information sharing in the case is variable and inconsistent. It is clear that professionals communicated with each other in relation to the family and that they contributed to meetings and assessments when these took place however this tended to be in response to incidents. It would have been desirable to hold a professionals meeting to enable each agency to review their involvement with the family and to discuss resistance and lack of engagement.

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5 http://webarchive.nationalarchives.gov.uk/20141124154759/http:/www.ofsted.gov.uk/sites/default/files/documents/surveys-and-good-practice/t/The%20voice%20of%20the%20child.pdf

Neither mother nor father engaged in the CAF or CIN processes, which should have been reviewed by a multi-agency group. Continued lack of engagement was not addressed by the CAF or CIN and therefore did not escalate the family to child protection planning. A clear multi agency plan for managing resistance and increasing engagement was missing.

The CAF process should have been more streamlined to the needs of the family with clarity about the outcomes expected. There should have been clearly agreed thresholds for escalation from the outset. Persistent non-engagement with the process and no consistent improvement in home circumstances should have been escalated to consideration of statutory interventions.

The review team has highlighted the need for a robust approach to monitoring and escalating cases where families do not engage with CAF and CIN, non-compliance should trigger consideration of step up to child protection planning.

4.2.6. How did the family dynamic influence professional practice and how was this managed?

Family size was viewed by all professionals as a key factor in family functioning and interactions with professionals. The nature of family life appeared to often be chaotic and disorganised, some professionals saw this as understandable given the demands on the parents, however this was taken at face value rather than considered as a potential risk or vulnerability factor.

Mother's inability to manage a large family was exacerbated by father often being absent from the family home, however it was acknowledged that when he was absent the children were not exposed to domestic abuse. What is not clear is that any professional had a full understanding of the presence or absence of father, and that mother's self-reporting of periods of separation was accepted at face value.

Some professionals, particularly those who visited the home such as Health Visitors and Family First were allowed entry although there were occasions on which mother was not present at the home and the children were unsupervised, which raised professional concerns.

Mother was viewed by some professionals as a parent who 'loved her children', however this did not appear to translate into actions to meet the children's needs or safeguard them. Professionals could have more strongly challenged the reasons given by mother for the poor conditions in the home; for chronic non-school attendance and for neglect of the children's physical and emotional well-being.

Father did not feature strongly in the professional mind-set as he appeared to spend considerable periods away from the family home, however, professionals were aware of numerous on-going domestic abuse incidents and they knew that these incidents involved father, even when he was reported by mother not to be living at the family home.

4.2.7. Are there examples of good practice in this case that can be replicated?

Primary school were rigorous in keeping a chronology of their concerns and tenacious in raising these with CSC.

The mentoring project focused on the needs of Child O in relation to personal development and provided opportunities for personal growth; Child O appeared to thrive in this environment.

CHAPTER 5 – LEARNING FROM THE REVIEW

5.1 Summary of Learning

As stated in the introduction, it is not within the remit of this review to establish why Child O ended their life; the reasoning behind that tragic event may remain unknown. However, this serious case review is charged with critically examining the practice of agencies involved with Child O and their family and to identify learning and opportunities to modify practice and support practitioners in strengthening safeguarding and preventing tragedies such as this occurring in the future.

Overall it is the view of the panel that the daily lives of Child O and their siblings during the period under review were unsupervised, unpleasant and at times unsafe and that the daily lived experience of Child O and their siblings was generally poor with the children living in unacceptable conditions.[6]

The review team has concluded that based on the information received by the review neither professionals, agencies or indeed Child O's family could have predicted or prevented Child O's tragic death.

The timeline for this review goes back to 2012 when practice in the local area was judged by the panel to be less robust, particularly in relation to responses by CSC to concerns raised by other agencies and the integration of multi-agency reporting and response systems. In that regard the review has seen evidence of improvement in systems and practice, however the review recommends that the findings below are given full consideration by the LSCB and that a robust action plan that clearly sets out the response and actions associated with each finding be put in place as a matter of priority.

5.2 Agency Learning

A summary of agency learning is attached at Appendix One.

5.3 Review Findings

5.3.1. Finding 1 – Responses to neglect and emotional abuse lacked shared understanding, consistency and multi-agency action.

Professionals in all agencies did not take sufficient action to address clear indicators of on-going neglect and emotional abuse of Child O and their siblings.[7]

[6] https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/neglect/

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/379747/RR404_-_Indicators_of_neglect_missed_opportunities.pdf

The Review found that some professionals were over optimistic about parenting capacity and parental ability to maintain temporary improvements in home conditions or to change behaviours that put Child O and their siblings at risk (e.g. patterns of incidents of domestic abuse; lack of supervision; non-school attendance).

The neglectful home conditions were viewed differently by different groups of professionals this resulted in an inconsistent approach to addressing the neglect that the children were experiencing.[8]

5.3.2. Recommendation 1

The LSCB should be assured that the local strategy to tackle neglect is up to date and informed by this review. This should include assurance that all professionals have a clear understanding of neglect and emotional abuse and adopt a child centred approach to their assessments in this regard.

The LSCB should be assured that the professionals are skilled in assertive practice and models of change[9] when working with resistant parents.[10]

The LSCB should be assured that the graded care profile is understood and adopted by all relevant agencies and that there is multi-agency agreement on the application and interpretation.

The LSCB should ensure that there is regular graded care profile training and training for professionals in terms of drug misuse and working with resistant families.

The LSCB should put in place a mechanism to audit use of the graded care profile by professionals and analyse the results to ensure compliance with the requirement to use this tool.

5.3.3. Finding 2 – Reponses to domestic abuse need to be strengthened to ensure that the needs of children who live with domestic abuse and the impact that this has on their emotional wellbeing is understood and responded to by all professionals.

All agencies and professionals were aware of the frequent domestic abuse incidents between mother and father and attempts were made to encourage mother to seek specialist support. However, the impact of on-going domestic abuse on Child O and their siblings was not fully addressed by services. Professionals identified a lack of integrated responses to domestic abuse and a reduction in services to meet the needs of victims and families.

[8] This was before the roll out of the current Graded Care Profile training
[9] http://www.socialworktech.com/2012/01/09/stages-of-change-prochaska-diclemente/
[10] http://www.safeguardingchildrenea.co.uk/safeguarding-events/working-with-resistant-hostile-or-uncooperative-families-chester/

5.3.4. Recommendation 2

That the LSCB strengthen the domestic abuse/family pathway against evidenced based effective interventions[11] and map the provision and availability of services to domestic abuse victims and their families.

That professionals working with children and families understand the on-going impact of domestic abuse on child development and are equipped to assess and refer children to appropriate services.[12]

5.3.5. Finding 3 – Parental substance misuse impacted the lives of Child O and their siblings however some agencies were unaware of the concerns in relation to drug use, there was a lack of follow up to referrals and plans to escalate the case to child protection were not followed through.

Parental substance misuse both suspected by some professionals and known CSC professionals. Despite this knowledge mother's use of cocaine was not fully addressed as a risk factor to the children. In addition father's alcohol misuse appears to have gone unchallenged by professionals. Mother was asked to self-refer to the drug service which she did, although she subsequently failed to attend appointments. Neither CSC nor any other agency took action to escalate the case to child protection despite warning mother that this would happen if she failed to address her drug use.

5.3.6. Recommendation 3:

That the LSCB are assured that a mechanism is in place to track referrals to substance misuse services and that these are followed up by the practitioner making the referral.

That the LSCB are assured that substance misuse services have robust policies and practice in relation to safeguarding children.[13]

5.3.7. Finding 4 – Housing and anti-social behaviour services did not give sufficient consideration to safeguarding in their involvement with the family.

Responses to anti-social behaviour and neighbour nuisance lacked a focus on the safety and wellbeing of the children. Responses were not integrated and there were no referrals made to CSC regarding reported incidents of the children being unsupervised and vulnerable.

5.3.8 Recommendation 4

That the LSCB are assured that housing and anti-social behaviour services continue to develop and implement revised policy and practice in integrating responses to anti-social behaviour, neighbour nuisance and safeguarding and that these are monitored.

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[11] https://www.researchgate.net/publication/283563033_Preventing_domestic_abuse_for_children_and_young_people_A_review_of_school-based_interventions

[12] http://www.youngminds.org.uk/for_parents/worried_about_your_child/domestic_violence?gclid=Cj0KEQiAjMC2BRC34oGKqY27jtkBEiQAwSXzfoPYAzcqdRJhzohCrR1buUGDIll-72XRzTpf1DZiVtcaAie08P8HAQ

[13] http://www.nta.nhs.uk/news-safeguarding-guide.aspx

5.3.9. Finding 5

Many agencies were involved with the family over the timeline of the review however there was a lack of case leadership and no clear 'lead professional' co-ordinating activity and responses.

5.3.10. Recommendation 5

That the LSCB ensure that the role of the lead professional is enshrined in early help and targeted services policy and practice and that there are mechanisms in place to ensure that all cases have a nominated lead professional.

That all agencies understand and act on their responsibilities in relation to enabling staff to adopt the role of lead professional and that any reticence amongst agencies or individual practitioners to adopt the role of lead professional is addressed through training and support.

5.3.11. Finding 6

None of the agencies involved in the review used the local escalation policy to address concerns when the case did not meet thresholds for statutory intervention.

5.3.12. Recommendation 6

That the LSCB continues to monitor use of the escalation policy and procedures and that these are understood and acted upon by all agencies and individual practitioners.

5.3.13. Finding 7 – Listening to and acting on the voice of the child

Efforts to seek and listen to Child O's voice did not take place across all agencies. This resulted in a lack of understanding of Child O's needs and views and a lack of professional insight into the quality of Child O's daily lived experience. Single and multi-agency interventions (other than those in the primary school and the mentoring programme) were therefore often adult focused and driven and not child centred.

5.3.14. Recommendation 7

The LSCB should be assured that work to strengthen local policy and practice on ensuring that the voice of the child drives practice is taking place.

Performance management information via the use of multi-agency audits should be provided to the LSCB as part of its quality assurance programme.

5.3.15. Finding 8

There was a lack of engagement by Child O's family with CIN

Child O's family did not engage with CIN or early help services and processes, this lack of engagement persisted over many years without review or escalation or triggering consideration of statutory intervention.

5.3.16. Recommendation 8

The LSCB should refresh guidance to all agencies regarding persistent non engagement with CAF and CIN and other forms of early help service. The thresholds for escalation of concerns should be considered and agreed upon in the initial or planning phase in CAF reviews

5.4 Wider Learning

The local public health suicide prevention strategy includes a focus on preventing suicide amongst children and young people. There has been a national upward trend in child suicide in recent years. It is not possible to compare trends in the local area with national figures during the time period under review.

The national suicide prevention strategy provides useful information on indicators and risk factors and on assessing and referring those who have contemplated or are contemplating suicide. [14]

[14] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405407/Annual_Report_acc.pdf

APPENDIX ONE – AGENCY LEARNING

Agencies participating in the review were asked to identify key points of learning and to develop and action plan based on these points.

The learning for each agency is shown below, action plans will be presented to the LSCB and followed up through the Learning and Improvement Sub Group of the Board.

1. **Children's Social Care/Family First**

The overall learning by Children's Social Care is in relation to responding to chronic neglect and resistant parents that resulted in inadequate care of the children over a number of years.

There were opportunities in this case whereby professionals could have challenged parents and each other by asking the question 'is the care the children receive good enough?'

The completion and sharing of chronologies in this case would have shown a clear picture of when home conditions were not good enough, at the same time recorded observations of the mother could have been analysed, as she was often seen in a heightened state.

Staff should be trained in the effects of drug misuse, as in this case the mother was thought to have used cocaine which would account for her heightened state but also excessive lethargy.

Professionals involved with the family may have been not only too optimistic about the capacity of the parents, particularly mother, but also too hopeful that with support mother may have met the needs of the children.

The family is large and mother in the last few years has cared for the children on her own, to be too optimistic places pressure on parents by professionals and they can become overwhelmed

Given that the children's needs were not met for substantial periods a legal planning meeting could have been convened at a much earlier stage, during this period drug testing and parenting assessments should have been completed, although this could have been completed at any stage during the time the case was open to CSC

Recommendations from CSC are made below:

All social workers should undertake the graded care profile training

All social workers should be trained in the effects of drugs upon parenting, in addition it would be beneficial for social workers to spend time co- located with drug services

Social workers should complete case chronologies and share them with families and professionals at multi agency meetings

Children subject to Child in Need plans should be seen and spoken to alone, to ensure they have the opportunity to talk about their lived experience

All neglect cases should be regularly assessed to evidence change/impact upon children, at intervals not longer than 6 months.

The CSC Review Panel member will feed back all recommendations to the Local Authority Workforce Planning Team.

A joint meeting will be arranged between Drug Services and Social Care to begin a process of closer collaboration and joint working.

There will be a multi-agency Child in Need planning meeting held on a regular basis.

2. Health Services (5 Boroughs Partnership)

The learning identified by the Health Services is as follows:

Poor use of escalation procedures

Lack of professional leadership for children with complex health needs

Inconsistent reporting of home conditions

Lack of evidence of the voice of the child

Differing understanding of thresholds in relation to neglect

Lack of use of chronology within health records

Lack of understanding of domestic abuse and the impact on the child

To address these points Health Services will put in place the following actions:

Promotion of the escalation procedures

Consider appropriate use of multi-disciplinary meetings for children with complex needs.

Promotion of the use of the graded care profile to determine the extent of neglect and to monitor changes.

Guidance/ protocol for additional assessment/ case supervision/ wider information gathering or similar for cases where there have been a significant number of referrals to CSC, even when the threshold has not been considered to have been met on each individual occasion.

3. Housing Provider

This agency has learned that the Housing/ASB service did not give sufficient consideration to safeguarding in the involvement with the family and that professionals did not sufficiently or consistently respond to neglectful home conditions.

The agency has engaged an external consultant to support an organisational review of its safeguarding practices and is currently draft new safeguarding Children and Adults policies which have been completed in consultation with the Borough Council.

The agency now has a 'corporate seat' in the local MASH (Multi Agency Safeguarding Hub) which has created better working relationships with key agencies and improved referrals for safeguarding.

A commitment has been made to training the workforce in relation to safeguarding and will be working with the Safeguarding Children Board to arrange multi-agency training for staff.

The agency has implemented a new case management system that will improve record keeping and facilitate transparent records of all interactions with customers (which was identified as being an issue when completing the chronology for this case). This will improve overall functionality and will specifically improve responses to safeguarding.

The agencies Safer Communities Team has embedded a quality assurance framework that ensure that cases are now consistently managed in line with agreed service standards.

4. Mentoring Scheme

This agency has identified the on-going need for professionals to have the opportunity and platform to share and reflect on issues and concerns, particularly when families are not at statutory/CP level. This would assist in raising awareness of on-going chronic neglect and the impact this can have on the children.

The agency will seek to put in place an exit plan when a young person is leaving their services that ensures that young people are signposted or referred to services that can meet their on-going support needs. In future all exit plans will be recorded on file, this will include information on who the plan has been shared with.

The agency will monitor actions through case file audits and through the national agency audit that takes place annually.

5. Police

The police learning in the case has been that whilst there does not appear to be a 'critical' event in the lead up to Child O's death, the longer term impact of Domestic Abuse and emotional neglect on children and families was a theme emerging from the panel meetings and from the review.

Increasing the confidence and knowledge to challenge decisions around thresholds is important for safeguarding practitioners

To respond to learning from the Review the police will:

Develop more sophisticated approach to responding to the needs of children exposed to long term domestic abuse situations.

Raise awareness around thresholds so professionals can offer informed challenge with confidence.

The mechanisms for achieving change will be:

Police have tasked actions to the MASH Detective Sergeant through PVP (Protecting Vulnerable People) governance.

Police will put in place Mash Audit and Police Governance supervision.

Ensure feedback from staff and put in place monitoring of escalations through the LSCB.

6. Schools

6.1 Primary School

Primary School has identified learning in a number of areas. Firstly that continuing to focus on concerns and being robust in insistence that other agencies appreciate the seriousness of any given cases is important.

Making reference to the use of the Escalation Policy has subsequently brought about an alignment in agreed actions in family cases post Child O's death.

Leading and taking action in 'Team around the Family' meetings prior to CSC referrals has enabled a broader information pool to provide additional multi agency input to referrals.

The expertise in information sharing due to the importance placed on their existing excellent paperwork and recording procedures and the value of these when such a situation occurs to provide evidence of the actions taken and resulting impact.

The Primary School will continue to make referrals and to use the LSCB Escalation Policy. They will continue to use the Graded Care Profile to assist in assessing levels of potential neglect.

There is a commitment to continuing to value the child's voice and to ensuring regular opportunities for vulnerable pupils to meet and talk. To this end the Learning Mentor will dedicate one a day week solely to pupil voice and pastoral support programmes.

The school will maintain regular safeguarding CPD for designated safeguarding officers and the wider school staff.

The school will maintain a robust approach to all paperwork, recording and building chronologies.

To support their learning the school has implemented dedicated pastoral support and pupil voice programmes.

The Learning Mentor has attended Graded Care Profile training and now utilises this in their work.

School based pro-formas are being utilised by all teaching staff to provide an evidence base and tracking for a range of safeguarding issues.

The Head-teacher regularly challenges other agencies with regard to referrals including challenge to decisions to close cases where the school has concerns.

The Primary School will monitor the effectiveness of their actions by Learning Mentor performance management and supervision meetings. There will be regular monitoring of action planning and targets set.

6.2 Secondary School

After death of Child O it was evident to the Secondary School that they did not have the full picture of what had been the reality of Child O's life outside of school. Although agencies had previously been involved in Child O's life, it was not current involvement and school therefore believed that everything was well.

Transition from primary to secondary school would have presented particular challenges to Child O and Secondary School did not know enough about the family and individual circumstances to ensure enough additional support was given. Because there were no concerns other than attendance which was pursued by Secondary School initially and then by the Local Authority's School Attendance Service and which improved Secondary School were not concerned about other aspects of Child O's life.

Child O was good at being private – they did not share any personal information although they had good relationships with staff and had a group of friends

The school has identified the followings actions for learning from the review:

- Transition procedure – the gathering of information from primary schools needs to be more robust and we need to ensure information shared is up to date and full.
- All pastoral staff need to ensure that students in their care know that we are aware of their personal circumstances and that we are available to support, guide and listen to their voice – it is not enough for us to know – it must be acknowledged to that young person. Opportunities to hear the students voice must be given not once but repeatedly
- Information is key and we need to actively seek it, not expect it to be given to us.
- Training of all staff around key issues needs to be put in place – Domestic Abuse; Anti-Social Behaviour; Working with large families
- School needs to revisit our whole staff training with particular focus and emphasis on whole staff responsibilities
- School needs to develop a protocol around the care of children who are witnesses to domestic abuse and have a clear pathway for support and monitoring these students
- Head teacher, Assistant head and safeguarding lead need to use formal escalation when the situation demands and they need to be familiar with the process.

The way in which the school will implement their learning is as follows:

- One designated staff member with appropriate experience to visit primaries and collect information (SENDCO)

- Head of Year 7 to become a permanent appointment in order to develop the expertise in gathering information and the building of positive links with primary colleagues , in order to share individual and family concerns.
- Assistant Head (student support), Head of Year and designated person for collection of information meet to discuss all students coming in to year 7 – folders are flagged as current involvement with services/historical involvement with services
- Head Of Year to go through all existing files years 8 – 11 and flag files as above
- Head of Year with students with active/historical additional agencies involved acknowledge this with individual students and make them aware that they know their circumstances and are available to support or signpost to additional support.
- Increased use of safer schools officer to ensure we have all appropriate information on all students regarding anti-social behaviour and domestic abuse.
- Appropriately targeted referrals to Learning Mentors and other agencies. HOY
- Staff training to be updated in response to this learning - designated safeguarding lead.
- Domestic abuse protocol developed and shared – designated safe guarding lead and Assistant Head
- Training for pastoral assistants regarding safeguarding/seeking information being tenacious in seeking that information
- Escalation procedure is well understood
- Student voice
- Evaluation from mentor involvement
- Referrals to additional agencies
- Student records/timelines
- Staff feedback
- Referrals to additional agencies
- Use of escalation

Summary of learning for the school has been:

- Sharing of information is key, both at point of transition and throughout the years in order to maintain contact when there are concerns raised by either primary or secondary colleagues, or other agencies, in case these impact on other family members.
- Escalation needs to be used when your professional opinion tells you the situation is not right
- Services need to respond to each other's concerns.