Lancashire Safeguarding Children Board

Serious Case Review

Overview Report

Child G

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1 Introduction and context for the serious case review

1. The serious case review concerns a 13 month old infant (Child G) who died in March 2014 whilst in the care of a 25 year old man who believed he was the child's father and who was having overnight contact with Child G and two siblings at the home of the 'paternal' grandparent who was not at home at the time of the child's death[1].

2. The identity of Child G's birth father is not known. Both mother, aged 26 years, and 'father' had believed he was Child G's birth father until a DNA test in December 2014 showed that he was not. He is the father of three year old Child 2 but is not the father of five year old Child 1 (which he had understood was likely to be the case from the time he began a relationship with mother when she was pregnant). The couple were supposed to have separated following a long history of domestic and substance abuse and incidents of child neglect. As becomes clear in reading the report, the couple misled professionals about their relationship and in regard to other significant matters.

3. For the purpose of clarity, the use of acronyms for the various people involved is kept as simple as possible in a complex family structure. The 25 year old 'father' is referred to as simply the father for the remainder of this report given he was for a large part living with the mother and was regarded by the children as their father. Other members of the family are referred to in terms of their relationship with Child G (mother, grandparent, etc.); the siblings are referred to as Child 1 or Child 2. Professionals are referred to in respect of their professional role such police officer, doctor, social worker, etc.).

4. The regional ambulance service was called by the father in the early hours. Child G had been sleeping a bed with two older siblings and the father. Child G had been discovered to be blue and showing no signs of life. Child G was taken to the local hospital where upon arrival was certified as having died.

5. A complex criminal investigation and Family Court proceedings were ongoing when the serious case review was commissioned and largely completed. A draft overview report was provided to the Lancashire Safeguarding Children Board (LSCB) in May 2015. This allowed action to be taken to address areas of learning and improvement although the report could not be finalised or published until all of the parallel legal proceedings had been concluded.

6. There were care proceedings that had to determine arrangements for Child G's two surviving siblings that also required a finding of fact by the judge regarding Child G's death pending decisions in regard to criminal proceedings. The initial proceedings in the Family Court issued by the local authority after Child G's

[1] All ages relate to the date of Child G's death in 2014.

death upheld the allegations that father had deliberately smothered Child G. This finding of fact was appealed successfully by father. Father had faced potential criminal proceedings. Following the appeal the Crown Prosecution Service did not proceed to trial and formal not guilty verdicts were entered in April 2016.

7. A second hearing before the Family Court resulted in a finding of fact that the local authority had not established *on the balance of probabilities* that father had deliberately smothered Child G but the judge considered that it was at least as likely that Child G had died a result of being overlain by father or wedged in a position where the child could not breathe. The judge could not exclude the possibility that Child G had been smothered but it had not been proved.

8. Toxicology reports on the sample of blood taken from father confirmed high concentrations of Diazepam and Nitrazepam consistent with regular high use and of Olanzapine. Typical effects of the medication include drowsiness, dizziness, confusion, impaired co-ordination and loss of concentration that can last for 24 hours or more. The toxicology report did not confirm that father had ingested any other drugs or alcohol. Some of the medication had been acquired from 'a friend' rather than being prescribed to help father 'chill'. In his statement to police father said that he had not been aware he would have care of the children when he took the Diazepam for example.

9. The legal proceedings were long and complex involving for example 17 lever arch files of evidence and seven expert witnesses who were dealing with 46 pathological findings relating to different sites of bruising to Child G's body. The evidence of the domestic violence, child neglect and substance misuse which are discussed in this report was also considered by the Family Court proceedings. The extent of mother and father being dishonest in their dealings with the local authority and with other professionals including substance misuse services regarding the domestic and substance abuse was established during the proceedings.

10. Prior to Child G's death there had been previous concerns about neglect of the children and the parents' longstanding alcohol and domestic abuse. Father had been previously convicted of child neglect and had only recently been released from prison. The parents were believed to be separated based on their separate assertions to different professionals. All of the children were the subject of a multi-agency child protection plan because of a primary concern about parental neglect and the additional risk from emotional abuse.

11. As part of that child protection plan father was expected to comply with an agreement that he would not have unsupervised contact with the children overnight. Given the children were staying with father at the paternal grandparent's home the expectation was that supervision would be provided.

The paternal grandparent died from an overdose in June 2014 and therefore further clarification on this matter with the grandparent has not been possible.

12. The judge dealing with the first set of public law proceedings in regard to the two siblings ordered that the review panel would receive the expert medical evidence presented during those proceedings in order to establish what bearing it might have on the findings of the review. The expert evidence described bruising and marks on Child G's body that was the subject of disagreement between the different experts as regards their cause or precise history. However, there was consensus that some of the bruising and marking was unusual in a young child and could be indicative of poor supervision and that they did not all occur at the same time. As such, the expert evidence provided further evidence that Child G had suffered neglect.

13. The judge dealing with the second Family Court rehearing finding of fact proceedings also released to the serious case review panel the judgement together with the agreed narrative and schedule of agreement and disagreement regarding the expert evidence in November 2016 at which point the overview report was finalised for publication.

1.1 Rationale for conducting a serious case review

14. Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires a local safeguarding children board to undertake a review of a serious case in accordance with procedures set out in chapter 4 of *Working Together to Safeguard Children (2013)*[2].

15. The local safeguarding children board is required to undertake a serious case review when a child has died and there is cause for concern as to the way in which the local services have worked together.

16. The purpose of a serious case review is to establish what lessons can be learned to improve inter-agency working and better safeguard and promote the welfare of children and young people in Lancashire.

17. The circumstances of the death were referred by the police to the serious case review group on the 24th March 2014 and was discussed by the serious case review group on the 8th April 2014. The group agreed that the circumstances met the criteria for a serious case review due to the child dying and abuse or neglect of the child being known or suspected. The serious case review group discussed the likely key lines of enquiry for the serious case review to be domestic abuse, decision making in regard to the decision making that

[2] *Working Together to Safeguard Children. A guide to interagency working to safeguard and promote the welfare of children March 2013 and 2015*; also incorporates the revised arrangements for assessment of children that will be based on locally determined single assessment framework.

returned the children to the care of the mother and the circumstances under which the father had unsupervised contact of the children. The group also identified safe sleeping and disguised compliance as themes to be considered.

18. The independent chair of the Lancashire Safeguarding Children Board endorsed the recommendation on the 9th April 2014.

1.2 The methodology and scope of the serious case review

19. A serious case review panel was convened of senior and specialist agency representatives responsible for the methodology and to oversee the scope, collation and analysis of information and to identify the findings and learning from the review. The review was co-ordinated by two independent lead reviewers with appropriate experience and training. One of the reviewers took principle responsibility for coordinating and chairing the work of the serious case review and liaising with different services; the other reviewer took principle responsibility for drafting this report. Further information is provided in section 1.5.

20. The timeline for detailed analysis is events and service responses from 1st January 2013 to 25th March 2014. Any relevant information prior to 2013 was included in the chronology as a summary if it had a bearing on the assessments, decision making and service responses during the specified time frame. This included information about any history of abuse or neglect in the families of the parents, domestic violence, drug and alcohol use, offending behaviour, mental health concerns, previous risk assessments and decision making.

21. The review panel first met on the 20th June 2014 to agree the scope of the review and a timeline for completion. It was acknowledged at that first meeting that the review was likely to take longer than six months due to the parallel investigations that had implications for being able to interview and take evidence from key professionals and family members who might be required to give evidence in criminal proceedings.

22. The case review panel met on six occasions between June 2014 and March 2015. The initial chronology of services involvement was completed by May 2014. The draft overview report was presented to an extraordinary meeting of the Lancashire Safeguarding Children Board in May 2015 pending completion of other parallel processes including decision making regarding any potential criminal proceedings.

23. It was agreed that the review would be informed by a hybrid systems based methodology that would involve practitioners in conversations. In addition, all the agencies were required to complete a rapid appraisal of learning and identify any action for learning and improvement for their service. This was to ensure that any improvement action was implemented as quickly as possible.

24. The review panel identified a list of practitioners to participate in conversations that took place in the last quarter of 2014. In addition to the conversations the review panel received over 50 documents that included assessments, plans, agreements and minutes of key meetings. The group also reviewed relevant policy and procedures.

25. The scope and methodology of the review was routinely monitored and updated at subsequent review panel meetings to take account of any new or emerging information and reflection.

26. The analysis in the final chapter of this report uses an adaptation of the framework developed by SCIE (Social Care Institute of Excellence) to present the key learning within the context of the local systems. This takes account of work that suggests that an approach of developing very prescriptive and SMART recommendations have limited impact and value in complex work such as safeguarding children[3].

27. The final chapter of the review for example explores the influence of family and professional interactions, the responses to incidents and the tools that are used by professionals to help inform their judgments and decisions.

28. The following services provided information via a chronology and also participated in collating further information and analysis by providing documentation and facilitating the involvement of their practitioners in conversations with members of the review panel.

    a) Health services in Lancashire that included:

        - NHS England as commissioners of GP services;
        - Lancashire Care NHS Foundation Trust (LCFT) (provide health visiting services in Lancashire and the nurse led rapid response service to sudden unexpected deaths in childhood (SUDC);
        - Lancashire Teaching Hospitals NHS Trust (provide midwifery and acute services).

    b) Lancashire County Council (LCC) children's social care statutory involvement for child in need (CIN) and child protection plans;
    c) LCC early years services;
    d) Greater Manchester West NHS Trust Discover (Lancashire adult substance misuse service in relation to the parents);

[3] *A study of recommendations arising from serious case reviews 2009-2010*, Brandon, M et al, Department of Education, September 2011 The study calls for a curbing of 'self-perpetuating and proliferation' of recommendations. There is ongoing debate about how the learning from serious case reviews can be most effectively achieved with some encouraging a lighter touch on making recommendations for implementation through over complex action plans

e) Lancashire Constabulary (in relation to crime and investigation of the death of Child G);
f) Lancashire Probation Trust (provided community supervision to father);
g) An independent early year's provider (who provided nursery services to one of the older children from February 2014).

29. Information was also sought from members of the families and is described in section 1.7.

1.3 Particular themes identified by the review panel for detailed analysis and examination

30. These were:

a) Patterns of incidents relating to domestic abuse and the response from organisations;

b) Parental use of alcohol and drugs, assessments and referrals;

c) Assessment of risk to children and decision making;

d) Initial child protection conference and the child protection plan from November 2013;

e) Involvement of other family members;

f) The management of the sudden unexpected deaths in childhood (SUDC)

g) Influence of cognitive biases in processing information and assessments.

1.4 Membership of the case review panel and access to expert advice

31. The case review panel that oversaw this review comprised the following people and organisations;

Position	Organisation
Chair of the panel	Independent lead reviewer
Service Manager	Discover Drug and Alcohol Recovery Services (Greater Manchester West NHS Trust Discover)
Early Years Lead Officer	Lancashire County Council
Principal Social Worker	Children's Social Care Services (LCC)
Named GP for Safeguarding	West Lancashire Clinical Commissioning Group on behalf of NHS England

Designated Doctor for Safeguarding Children	Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR)
Review Officer	Lancashire Constabulary
Senior Probation Officer	Lancashire Probation Trust
Assistant Director of Nursing Safeguarding Children	Lancashire Care Foundation NHS Trust
Named Nurse for Safeguarding Children	Lancashire Care Foundation Trust (LCFT) (representing Health Visiting)
Designated Nurse for Safeguarding Children	West Lancashire Clinical Commissioning Group
Safeguarding Practitioner	West Lancashire Clinical Commissioning Group
Lead Nurse Sudden & Unexpected Death in Childhood (SUDC)	Lancashire Care Foundation Trust (LCFT)
Safeguarding nurse for Safeguarding Children	Lancashire Care Foundation Trust (LCFT)
Lead Nurse for Safeguarding Children	Lancashire Teaching Hospitals Trust (LTHT)
Independent Author	
Panel Observers/Support	
Business manager	Lancashire Safeguarding Children Board
Support officer	Lancashire Safeguarding Children Board

32. The independent author of the overview report attended every meeting of the panel.

33. The panel had access to legal advice from a solicitor in the council's legal service.

34. Written minutes of the review panel discussions and decisions were recorded by a member of the local safeguarding children board staff team in Lancashire.

1.5 Independent author of the overview report and independent chair of the serious case review panel

35. Annie Dodd was previously employed as an assistant director with a local authority children's social care service and has over 30 years of experience as a qualified social worker and is registered with the Health and Care Professions Council (HCPC). Ms Dodd is now self employed as a consultant. She has previously chaired serious case reviews for Lancashire SCB but has no other connection with Lancashire Safeguarding Children Board and has not been involved in any aspect of the management of the case.

36. Peter Maddocks is the author of this report and has over forty years' experience of social care services the majority of which has been concerned

with services for children and families. He has experience of working as a practitioner and senior manager in local authorities and working in national government services and the third sector. He has a professional social work qualification and MA and is registered with the HCPC. He undertakes work throughout the United Kingdom as an independent consultant and trainer and has led or contributed to several service reviews and inspections in relation to safeguarding children. He has undertaken agency reviews and provided overview reports to several local safeguarding children boards in England and Wales as well as work on domestic homicide reviews. He has undertaken work as an independent reviewer on previous serious case reviews in Lancashire. Apart from this, he has not worked for any of the services contributing to this serious case review. He has participated in training and professional development as a reviewer; this has included specific training in the use of systems learning applied to serious case reviews.

1.6 Status and ownership of the overview report

37. The overview report is the property of the Lancashire Safeguarding Children Board as the commissioning board for the serious case review.

38. Since June 2010, all overview reports provided to local safeguarding children boards in England have to be published in full.

39. The Lancashire Safeguarding Children Board will determine how and what further information is provided to the family at the conclusion of the review and following the submission of the overview report to the Department for Education and to the National Panel.

1.7 Parental and family contribution to the serious case review

40. The parents of Child G were made aware of this serious case review when it was commissioned. The criminal investigation and Family Court proceedings meant that contact with the parents and family was not possible before the serious case review was completed. On completion of these parallel processes several offers were made by the Reviewer to meet with parents but no response was received.

1.8 Cultural, ethnic, linguistic and religious identity

41. Child G's family is white British and English is their first and only language. Both parents are long term unemployed. The eldest sibling (Child 1) was born from a previous relationship that mother had. That relationship as well as with Child G's father was characterised by repeat incidents of alcohol and domestic abuse. Child 2 was almost three years old when Child G died. There is no information about cultural or religious identity and no information to suggest a learning difficulty or physical disability. Both of Child G's parents have convictions for assaults.

42. Lancashire has a population of 1.16 million, which is projected to grow by almost eight per cent to 1.23 million by 2028. The county comprises a mixture of urban, rural and coastal communities and covers twelve district councils four of which (Burnley, Hyndburn, Pendle and Preston) rank in the top 30 most deprived districts in the country (Index of Multiple Deprivation 2007). The majority ethnic group is white (97.4 per cent), which covers White British, White Irish and Other White.

2 Summary of contact and significant events

2.1 Historical context

43. Father first came to the attention of the police in 2000; he has 24 convictions having been arrested for 32 offences most of which relate to dishonesty and violence and the majority involve his use of alcohol or other substances.

44. Mother first came to the attention of the police in 2003 and has three convictions having been arrested for nine offences for dishonesty.

45. There have been eighteen incidents involving domestic abuse between the parents or concerns about the children recorded by the police. Sixteen of the incidents occurred between 2009 and the beginning of 2013.

46. During mother's relationship with Child 1's father there were two incidents of domestic abuse reported to the police between 2007 and 2009. Children's social care services were not told about those incidents until September 2011.

47. In April 2010 mother was convicted of theft and a six month community order was imposed. Mother complied with the conditions and requirements of the order and three OASys offender assessments were completed[4]. The assessments concluded that mother posed little risk of serious harm to others from her offending but that her use of alcohol was problematic. It was during one of the community supervision sessions that mother first disclosed her pregnancy with Child 2.

48. In July 2010 and while mother was pregnant and subject to the community order, the police were called to deal with an incident of domestic abuse involving a verbal argument exacerbated by consumption of alcohol during the afternoon. The information was reported to children's social care services. No further action was taken by either of the services.

49. In April 2011 father was convicted of theft from a shop and sentenced to complete a six month community order. He complied with the conditions and requirements of the order and an OASys offender assessment was completed. The assessment concluded that although he was a prolific offender he represented low levels of risk of harm to others through his offending. The assessment recorded problems with alcohol, life style, associates and accommodation.

[4] Offender Assessment System has been used in England and Wales by the prison service and the National Probation Service from 2002 to measure the risks and needs of criminal offenders under their supervision.

50. Two further incidents of domestic abuse (the fifth and sixth episode involving contact with the police) occurred in early July 2011 just six weeks after Child 2 had been born. Neither parent was willing to provide a statement to the police. Information was passed to children's social care services as well as to the health visiting service. No further action was taken.

51. The police dealt with a seventh incident of domestic abuse at the beginning of September 2011 when mother asked for police help. The incident was not reported to any other service.

52. An initial assessment by children's social care services at the end of September 2011 resulted in an agreement with the parents that the children would not 'witness' any domestic abuse.

2.2 Concerns about domestic abuse

53. There was a referral from a primary health services professional (believed to be a health visitor) to children's social care services in late February 2012 about concerns regarding arguments and the impact on the children. There was another referral to the MASH (multi-agency safeguarding hub) from the children's centre in the middle of March 2012 following a 'DV incident'.

54. On the 9th April 2012 the health visitor made a record about a domestic abuse incident when father was arrested for breach of the peace and was found in possession of controlled drugs. Father was bailed to a different address and mother claimed that she had separated from him. She was advised to seek a non-molestation order. A core assessment was undertaken by children's social care services.

55. Father was remanded into custody when he breached the conditions of his bail in mid-April 2012. He was released at the beginning of May 2012.

2.3 Core assessment and child in need plan

56. The core assessment was completed in mid-June 2012 and recommended a child in need (CIN) plan that included advice and support from the Child and Parent Support Service (CAPSS), Sure Start as well as from housing and the GP services. Mother was prescribed anti-depressants. Father's contact with the children was supervised at the local children's centre. The work with CAPSS never started due to the unavailability of a worker.

57. The CIN review in late July 2012 was advised that children's social care services had agreed to allow father unsupervised contact with the children although work with CAPSS and the impact of domestic abuse had not started. Mother had become pregnant with Child G.

58. At the routine pregnancy booking mother reported 'historical domestic abuse' stating that she was no longer in the relationship and denied using alcohol or drugs.

59. Mother and the children were re-housed in early August 2012. A second CIN review meeting heard that the parents had resolved their relationship difficulties and that there was no further role for children's social care services and involvement was closed from children's social care services and the children's centre.

2.4 Further domestic abuse and assessment

60. In January 2013 mother who was then 34 weeks pregnant contacted the police to report that father was at her property and was under the influence of alcohol. Father was arrested and a DASH (domestic abuse, harassment and stalking) assessment was completed and a referral made to children's social care services and information was also sent to the community midwifery service. The specialist midwife made contact with the social worker who had been allocated to make enquiries and complete an assessment.

61. An initial assessment by children's social care services was completed in late January 2013 (outside the national timescales that were in place at the time). Father described the incident as a one off due to a family bereavement; the assessment does not provide any further detail about this bereavement. The parents said that they were not in a relationship but were 'taking things slowly'. Mother was not ruling out a reconciliation.

62. In February 2013 father was fined for shoplifting. He was referred to the alcohol and drugs recovery service but declined their involvement. Child G was born.

63. A second core assessment was completed in March 2013. The children's centre were to work with both parents on 'conflict management'. The CIN (child in need) meeting agreed to that work could be taken forward as a team around the child (TAC) plan rather than child in need; children's social care services closed their involvement the day after the CIN meeting.

64. In late May 2013 a head teacher informed the police that father had been seen at lunchtime in a 'horrendously drunk' condition and was in charge of one of the siblings (thought to be Child 2).

65. The police had further contact with father; three days later he was arrested for being drunk and disorderly and a week after was arrested for two burglaries. He was sent to prison for 20 weeks. Probation provided a report but there was no ongoing involvement.

66. In July 2013 mother said that she was three months pregnant. Child G was showing poor weight gain (although this does not feature to any significant degree in subsequent records examined by the review).

67. In mid-August father was released from prison and was placed at a local night shelter. He did not attend for appointments offered with the alcohol and drug recovery service.

68. Both parents were arrested on the 14th August 2013 by the police in a 'paralytically drunk' condition; the whereabouts of the children could not be established initially because neither of the parents could say where the children were; the children were subsequently located at two different locations (a friend and a relative) and they were looked after overnight by maternal grandmother. A referral was processed through the MASH.

69. The children were returned to mother the following day. Within 48 hours mother was again found by the police in a very drunk and incapable condition in the local town centre. The children had been left with a 16 year old 'babysitter'. On the same day father was arrested for burglary and theft. He was sentenced to 12 months community supervision. The children were looked after by maternal grandmother. The children were moved three days later to the maternal great aunt.

70. At the end of September 2013 the maternal great aunt advised children's social care services that she was struggling financially. Children's social care services decided to return the children to mother the following day.

71. At the beginning of October 2013 father went to mother's property to look for food. He became aggressive and assaulted mother. The police were called by a neighbour and he was arrested. CPS declined to prosecute. A referral was made to the MASH that graded the threat of domestic abuse at a medium level.

2.5 Abandonment of the children and prosecution of father for neglect

72. In mid-October 2013 two of the children were taken to the hospital emergency service by ambulance. Father had left them in the backyard of a property where they were found by an eight year old child. The three children were taken to the local hospital where they were medically examined and found to be clean and well nourished. They were initially cared for by maternal grandmother but were placed with a foster carer two days later. Father was subsequently prosecuted for child neglect and was sent to prison for 16 weeks.

2.6 Formal child protection arrangements

73. A third core assessment completed in late October 2013 recommended convening a child protection conference which took place on the 1st November 2013. The child protection conference agreed that the children were at risk of significant harm from neglect and emotional abuse. The children continued to be looked after by a relative under a voluntary agreement with mother. It was agreed that care proceedings should be considered. A family group conference was to be arranged.

74. Mother arrived at the pre-proceedings meeting on the 6th November 2013 under the influence of alcohol. A 'schedule of expectations' was subsequently agreed with her.

75. The initial family group conference took place on the 2nd December 2013. Father was still in prison for a further week and therefore did not attend and no other member of the paternal family participated. The social worker was the only member of the core group to participate[5]. The conference identified four options that included the family providing support including looking after the children in emergencies, the maternal and paternal family had both offered to look after the children and the fourth was for father to be assessed to look after the children.

76. A review family group conference was scheduled for the 18th December 2013. This conference was cancelled when the children returned to mother's care although this decision making was not recorded. There was a family group conference in January 2014.

77. On the 9th December 2013 mother attended a session at the alcohol and drugs recovery service during which she acknowledged having used alcohol since 13 years of age but said that she had been abstinent for four weeks.

78. Father was released from prison on the 10th December 2013 and was placed in homeless accommodation.

79. A pre-proceeding review meeting took place on the 12th December 2013.

80. Seven days after father had been released from prison, children's social care services returned the children to mother on the 17th December 2013. The children remained subject of child protection plans. Mother and the children were living at maternal grandmother's home.

81. A family group conference on the 22nd January 2014 included a disclosure that mother was purchasing illegal drugs for a member of the extended family. It was agreed that the older child would move to live with a maternal cousin.

[5] Family members determine who will participate in the FGC. This is explored in the final chapter.

82. On the 24th January 2014 the maternal grandmother asked mother and the children to move out of her home. The two remaining children went to live with the paternal grandmother. It is thought that father may have been staying at his mother's according to one of the professionals.

83. Father attended for an assessment at the alcohol and drug recovery service. He described a history of drinking since 13 years of age and of using cocaine from 17. At this session he reported being abstinent.

84. A review child protection conference the following day was informed that he was engaging with alcohol services as was mother. The conference agreed that the children could return to mother's care if the parents remained separated.

2.7 Father's unsupervised contact with the children

85. On the 6th March 2014 a core group agreed that father could have unsupervised contact with his children during the daytime but any contact at night was to be supervised. The core group agreed that father had shown 'excellent insight into his problems' although not much detail is recorded and according to his own self-reporting he had been abstinent since beginning work with the specialist alcohol service who were now closing their involvement.

86. On the day before Child G died father had his first recorded unsupervised contact with the children according to children's social care services. It remains unclear why the three children were with father overnight at the paternal grandmother's one bedroomed home on their own.

87. Child G had been sharing a bed with father and the two siblings at the paternal grandmother's home on Friday night. Child G had been found on Saturday morning blue and unresponsive by father who called an ambulance via the emergency 999 number. Child G was taken by ambulance to the local hospital and the police were informed of the death.

88. Initial examination of Child G's body was jointly made by the duty police detective inspector and the consultant paediatrician. This examination was undertaken in a viewing room with subdued lighting where relatives are also taken to be with a relative after death.

89. During that initial examination some marks were noted on Child G's body although at that stage the paediatrician thought that these might be 'pooling'. The evidence of older injuries including bruises to Child G's body were not more visible until the post-mortem examination in a more brightly illuminated room undertaken by a Home Office pathologist.

90. Father was arrested. At this stage the duty inspector who was managing the police investigation was collating information about the background of the

adults and children. Coincidentally the duty inspector had experience of the public protection unit (PPU) where specialist officers deal with child safeguarding and domestic abuse.

91. It had been established that father had sole care of the children when the death had occurred and although it might be a tragic accident of overlay other options could not be closed.

92. The police made a visit to the two remaining siblings to check on their welfare. According to the police, contact had been made with the social care emergency duty team (EDT) but had been advised a social worker would not visit. A different account was provided by EDT that described trying to contact the police in response to earlier calls and messages.

93. The children were left in the care of the maternal aunt and then grandmother. The police had no cause for concern about the two siblings and were mindful of the traumatic experience they had. EDT understood that it was being regarded as a tragic accident. It was after the Home Office pathologist examination that the circumstances of the death became non-accidental.

94. The first strategy meeting did not happen until the Monday and involved just children's social care services and the police.

95. The SUDC nurse was not informed of the death until the Monday; the SUDC nurse is only available during weekday core working hours. The SUDC nurse was briefed by the police senior investigating officer (SIO) and they made a joint a home visit the same day.

96. The Home Office post mortem took place on the Tuesday morning. It was during this examination that more bruising and the injuries were detected.

97. A strategy meeting on the Tuesday evening discussed the post-mortem findings. The SUDC nurse was not invited to that meeting. Following that meeting a joint visit by the police and children's social care services was made to see both parents who agreed to both children being looked after with foster carers.

98. Both of the parents were arrested on the Thursday when the police allocated the case to the force major investigation team (FMIT) as a murder inquiry. The local authority began care proceedings which were ongoing during the review.

3 Appraisal of professional practice

99. The parents have been known to services for several years. Their difficulties in regard to their persistent use of alcohol and the extent to which it was a factor in their relationship and offending behaviour was the focus of many referrals and information reports shared between the police, health and social care services. After father was imprisoned and mother's assertion that their relationship had ended, considerable support was provided to help mother address her problems with alcohol and unemployment.

100. The parents' interaction with professionals in general appears to have been polite and accepting of advice and help and they did not overtly challenge advice or intervention. They appeared to the various health and social care professionals to be motivated to improve their circumstances and to look after their children. It seems that both managed to make some changes to aspects of their lifestyle such as their use of alcohol although this was not sustained and no contact or visits to the home were made outside of core weekday office hours (with the exception of the police when they were called to deal with incidents).

101. This probably contributed to the generally optimistic mind-set and approach and influenced how enquiries and assessment for example were conducted. Domestic abuse, neglect and substance misuse have significant and long term implications for the emotional well-being of children. Focussing on evidence about issues such as physical health and presentation can be misleading. The implementation of the 24 month integrated age and stage questionnaire is an example of where collating information across health, developmental and social domains now provides an improved opportunity to understand potential areas of concern or development.

102. There is little information recorded about what the two older children knew or witnessed in regard to domestic abuse or about their parents substance misuse. The information that is recorded relates primarily to their physical condition which in general appears to have been satisfactory. They were clean and apparently fed regularly and did not have any significant or unusual ailments or difficulties. They received routine health care. The older child's attendance and participation at school was good. In spite of their circumstances the children appeared to be doing well.

103. One of the assessments described mother as being able to meet the children's needs 'in terms of housing, food and emotional warmth'. The assessment does not explore through the children's eyes what the quality of emotional care is or link it clearly enough to their individual developmental needs; there is no indication for example in regard to the style and quality of emotional attachment the children have to either parent or the extent to which they have emotional or linguistic skills to express their emotions and feelings. The

importance of secure attachment is increasingly understood as an essential foundation for children's emotional and psychological development.

104. The only reference to developmental benchmarks appears in reports from the school that the eldest child attended. The school reported a happy and resilient child who socialised well and was working comfortably within age appropriate ranges on phonics, reading, writing and maths; a child who did not present with learning or behaviour needs. This does not mean that this child was not affected by the domestic abuse or neglect; a more reflective approach to the assessment may have looked beyond the physical standards and enquired a little more into why the child was managing to be so resilient in spite of the adverse conditions.

105. Although neglect is a very common feature for children who are the subject of CIN or child protection plans it is more unusual that a parent who has been convicted and imprisoned for neglect is then able to have unsupervised contact with their children.

106. It was unclear from the evidence and information provided to the review whether the arrangement for father to have the three children overnight whilst staying with his mother had been authorised by any professional.

107. As part of the tranche of evidence presented during the care proceedings for the children that the judge made available for the review there are statements made by the parents. In one of those statements it is asserted that the social worker was aware of the sleeping arrangements for the children to stay at the maternal grandmother's flat where Child G died. The pre-proceedings meeting a week before Child G died was clear that daytime contact would be unsupervised and at night would be supervised by a member of the family. The death of the paternal grandparent has removed any further opportunity to clarify the circumstances under which father was left alone with the children.

108. Much of the help and interventions have been focussed on whatever issue was being presented at particular points in time. Some key professionals such as the GP practice were not included in important processes such as assessments and child protection conferences and plans.

109. The parents' chronic and longstanding difficulties with alcohol goes back to early adolescence for both of them. Very little is recorded about whether they grew up in households with problematic drinking; there is evidence that some family members use drugs. Three core assessments were completed although very little appears to be known about either parent's individual history. It is unclear if that is because they have been reluctant to engage more fully in providing information or not.

110. None of the assessments provide a history of the parents or their respective families. There is a general assumption that the respective families are

supportive although no detail in regard to how that judgment is arrived at over and above the willingness of relatives to look after the children. This does not in itself establish the appropriateness or suitability of any particular family member as a carer for the children.

111. Information from the youth offending service (YOS) refers to father having a statement of educational need (SEN) when at school in regard to emotional and behavioural difficulties and that he was at a residential school for some time. He was apparently aggressive at home and at school and he was particularly aggressive to education welfare staff who tried to get him to attend school. He is dyslexic. None of this detail was reflected in any of the assessments but was contained in single agency records. Understanding whether a parent has communication difficulties is an essential part of assessment.

112. Father's propensity for using violence to gain control of a situation is evident in his history of offending as well as in his relationship with mother although it is not explored in any of the assessments.

113. There is a reference to father having experienced family bereavement in regard to a grandparent, the death of two friends and a reference to a history substance misuse in the family.

114. Both mother and father are said to have supportive families and grandparents and other relatives have stepped into provide practical care or the children. Very little is recorded over and above those brief details and the arrangements broke down on more than one occasion. The attitude and knowledge of family to the parents' difficulties are not apparently recorded even following a family group conference[6]. There is evidence of substance misuse by other family members although little in the way of factual information has apparently been collated.

115. The three assessments completed by children's social care services in 2013 did not appear to have involved other professionals despite people such as the specialist midwife making contact in January 2013 after receiving the information about domestic abuse via the police.

116. The assessments do not provide enough information about the vulnerability regarding the children's immediate and longer term welfare or identify clearly enough the strengths and their sources of resilience over and above the generalised reference to a supportive family. The absence of a sufficiently detailed history of the parents and about the level, type and quality of support that was available meant that decisions to use the family group conference

[6] A family group conference is a process led by family members to plan and make decisions for a child who is at risk. Children and young people are normally involved in their own family group conference, although often with support from an advocate.

was made without a more informed history and context. What for example was the experience of either parent as a child?

117. The assessments do not explore the extent to which factors such as Child 1 participating at a school rated as good were helping to counteract or overcome the adversity the children faced at home in regard to their parents relationship, witnessing domestic abuse, living in crowded conditions and low income.

118. The information that is recorded in assessments, minutes of meetings and reports is largely a narrative about immediate concerns or events. Although the term domestic abuse or domestic violence is used the factual information is limited to describing 'arguments'. It is apparent that it was primarily regarded as an issue for conflict management for example in the CIN plan that was agreed in March 2013.

119. Crucial multi-agency meetings were often attended by professionals standing in for a colleague or representing a service rather than by a professional with direct knowledge of the family and with a continuing interest in their circumstances. Some of this arose because of reorganisation of responsibilities in some services as well as covering for an absent colleague.

120. This had the consequence of 'hollowed out' meetings where the principle source of information about the family was vested in the parents whose behaviour, lifestyle and emotional needs were the focus of concerns but they were generally able to minimise in the absence of anybody else having sufficiently detailed information to counterbalance their input. This was behaviour that continued on the contact with other specialist services such as the alcohol and drug recovery service. They acknowledged historical problems with alcohol but both claimed to be abstaining.

121. None of the professionals were in a good enough position of having information and experience of contact with them to provide a sufficient level of sceptical or objective challenge. For example both parents persistently refer to the pattern of binge drinking and violence as being one off events and state that they would participate in assessments and cooperate with support. They say that they understood the concerns for the children but nobody contributes any direct information about how the children were affected.

122. This combined to create the latent conditions in which a 'stop and start' approach to providing help and intervention developed particularly by children's social care services who opened and closed their involvement in September 2012, March and May 2013 and appeared to be reluctant to use anything other than voluntary agreements until after the death of Child G in March 2014.

123. For other professionals who had longer term involvement there appeared to be a high reliance on them keeping to agreements and providing self-reported

evidence about improvements for example in regard to the domestic abuse and alcohol consumption. Referrals to specialist alcohol services in late 2013 resulted in both parents participating in assessments and although core group discussions described engagement to have been good this appeared to be based upon very short involvement. The fact that both parents 'self-referred' after professionals had raised concerns mislead the alcohol workers regarding parental motivation.

124. The logistics of core groups and child protection conferences became complicated with the operation of separate meetings with the parents. Important detail for example in regard to contact arrangements do not appear to have been explicitly agreed and communicated over and above the parents giving a commitment to comply for example with not drinking and not allowing father to have unsupervised contact at night.

125. The GP practice was never aware of any of the statutory enquiries. The effectiveness of interagency meetings were further undermined by key people such as the GP practice not being invited to the meetings or asked for information as part of the enquiries and assessment. The GP practice were not aware of the child protection plan. The implementation of a new electronic children's social care services portal is intended to address this and other issues to improve efficiency and effectiveness.

126. There was a generally high reliance on the parents co-operating with health and social care professionals. The referral to the specialist alcohol and drug recovery service was done as a self-referral by mother rather than a referral from children's social care services or another service. Professionals such as health and social care professionals have to balance the need to achieve a sufficiently trusting relationship with adults who have a deep distrust of services and ensuring that legitimate issues of concern relating to children are dealt with. A parent who self refers will be seen differently to a parent who has been referred. A parent who self refers might be regarded as being more motivated to make changes than a parent who has been referred although this may not necessarily be the case.

3.1 What the case indicates about local safeguarding systems

127. In many respects there is little that is especially significant or extraordinary about this particular case before the tragic death of Child G. Domestic abuse, neglect and substance abuse are common factors for children who are the subject of statutory child in need (CIN) and child protection plans.

128. It is also well known from the work of reviews such as this that practitioners face problems in developing clear enough assessment and plans for providing support.

129. The risk of optimistic mind-sets that are not sufficiently focussed on what children feel, think and say about their circumstances are frequently identified in reviews and inspections.

130. The workload of the lead social worker and of the local children's social care services was a significant factor especially in the summer of 2013 and is explored on the findings of the next chapter. However there are other factors identified about systems in this case.

131. The framework and quality of assessment for helping vulnerable children in troubled families does not deliver a good enough historical narrative about the child and parents stories; it does not achieve a good enough collation of information about the factors of vulnerability and resilience and it does not provide good enough analysis to inform critical judgements and decision making.

132. Domestic abuse was not properly understood and nor is the impact on very young children; at least there is not enough documentary evidence to show otherwise. NICE have published public health guidelines (PH50) designed to improve practice and at single and multi-agency levels[7].

133. Fundamental gaps have been identified in how basic enquiries are completed. For example primary health professionals such as the GP were not asked for information and were not involved in the child protection conferences and plans.

134. Agreements about returning the children to mother's care and arrangements for contact with father were not talked through clearly enough with other professionals.

135. These issues have been identified in previous serious case reviews and in the audit and quality assurance work undertaken by children's social care services.

[7] *Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively*; NICE public health guidance 50; February 2014

4 Analysis of key themes for learning from the case and recommendations

136. Any meaningful analysis of the complex human interactions and decision making processes that are involved in multiagency work with vulnerable young people and troubled families has to understand why things happen and the extent to which the local systems (people, processes and organisations) help or hinder effective work. Appendix I describes the action taken by individual services as a result of the serious case review.

137. This chapter sets out key findings that are designed to offer appropriate challenge and reflection for the Lancashire Safeguarding Children Board and partners. The findings are framed using a systems based typology developed by SCIE and includes specific recommendations as well as challenges for the Lancashire Safeguarding Children Board intended to address areas of serious concern highlighted by the review particularly in regard to the capacity of the local children's social work service. The review has identified aspects of decision-making and practice that appear to be symptomatic of systemic issues that have been identified in previous reviews and audits.

138. The workload and the experience of social workers and their supervisors are a particular area for discussion in the findings relating to management and agency to agency systems. The issues relating to children's social care services are particularly significant given the role this service has in leading and co-ordinating enquiries, assessment and formulating and implementing plans to keep children safe. Whilst individual professionals must always be aware of their personal accountability it is equally the case that individual professional performance will be enhanced or impaired by factors that are beyond a single individual's control.

139. The purpose of using the following framework is to identify the underlying patterns that appear to be significant for local practice in Lancashire.

a) Cognitive influence and human bias;

b) Family and professional contact and interaction;

c) Responses to incidents and information;

d) Frameworks and tools for informing professional judgments and decision making;

e) Management and agency to agency systems.

140. In providing the reflections and challenges to the Lancashire Safeguarding Children Board there is an expectation that the Board will provide a response to the key findings:

a) Does the Board accept the finding?

b) How is the Board to take this forward? If not, to explain why.

c) Who is best placed to do this?

d) What are the timescales for response?

e) How and when will it be reported?

141. The Lancashire Safeguarding Children Board will determine how this information is managed and communicated to relevant stakeholders. This report recommends that the Lancashire Safeguarding Children Board discuss the key findings and make a formal response that is also published.

4.1 Cognitive influence and human bias

Understanding domestic abuse is not about conflict management but coercion and control; developing curious and sceptical mind-sets;

142. Previous serious case reviews locally and nationally have highlighted the latent dangers of professionals adopting unduly optimistic mind-sets and the associated risks of disguised compliance from parents who are unwilling or unable to make changes to aspects of their lifestyle that represent risk to their child but want to avoid further intervention.

143. Health and social care professionals face a complex and difficult challenge of working to gain the trust of adults who have a deep mistrust of professionals and face complex and multiple problems. Professionals need empathy and the ability to establish a relationship with adults who often have a deep distrust of professionals who also have to develop and maintain a degree of sceptical curiosity and objectivity or risk colluding.

144. Empathy that provides no challenge for example in regard to evidence of substance misuse can quickly create the conditions for collusion to take place. In this case the repeated incidents of alcohol abuse and domestic abuse showed a long-term pattern of behaviour.

145. One of the social care professionals described that with hindsight there would be ‘a less romantic analysis of information’. This appears to describe a tendency to see the best in people and to want to encourage and reinforce the stated intentions of a parent to make necessary changes.

146. Internal audits in children’s social care services have described ‘domestic abuse issues not always being taken seriously’. This may be a contributory factor in the number of re-referrals being made to children’s social care services from the police in particular. In this case, there was a high reliance on

continuing with voluntary agreements that in general were unable to provide sufficiently secure and long term arrangements for the children.

147. It is concerning that the response to domestic abuse was to frame it as an issue for 'conflict management' such as in the CIN plan in March 2013 rather than an indication of coercive behaviour. Father's propensity to use violence to gain control in regard to the domestic abuse and crime was not apparently recognised in any of the assessments that were completed.

148. Framing the behaviour as episodes of violence often exacerbated by alcohol created the latent conditions for thinking of the behaviour and its effects as primarily physical rather than understanding the emotional impact on the children in particular.

149. Preoccupation with physical indicators such as how the children looked was another manifestation of this.

150. Domestic abuse is a term that covers a wide range of attitude, behaviour and language. Recognising and then conducting sufficiently thorough inquiries and assessments that include children is essential.

4.2 Responses to incidents or information

Rigour and extent of enquiries and assessments involving health and education; absence of rigorous and reflective multi-agency discussion.

151. The review highlighted significant gaps in how enquiries and assessments were conducted following different incidents or information reports. This is a family where there had been 18 incidents of domestic abuse, numerous arrests in relation to crime, alcohol and drugs. Some key services such as the GP practice were unaware of this history.

152. The enquiries were largely undertaken as a single agency exercise by children's social care services with very limited contact with other professionals and services. The GP practice was never contacted as part of the enquiries or during any of the assessments. The GP practice were not invited to child protection conferences and were not asked to provide information. They were not told about the child protection plan.

153. The enquiries that were completed were focussed on establishing if there were concerns about the children rather than more proactively seeking out the views, wishes and feelings of the older children in regard to what was occurring at home. By all accounts the children were physically cared for much of the time although experienced the trauma of being abandoned by their father in a garden at night time. They also faced multiple care arrangements involving relatives and the use of foster carers.

154. The input of information from early years, education and health professionals is an important aspect of checking developmental and other indicators of a child's well-being.

155. The issue of limited involvement by community health professionals in enquiries or assessments had been highlighted in an internal audit which found they were 'rarely consulted'. One out of 17 cases looked had included contact with the GP practice.

156. In addition to the gaps and inconsistencies in the professionals participating in meetings such as child protection conferences it is evident that professionals never talk with each other than at meetings that also involved the family. This appears to reflect a culture of transparency. It means that professionals do not have adequate opportunity to interrogate evidence and information or develop hypotheses or strategies.

4.3 Frameworks and tools for informing professional judgment and decision making

The reliance of assessments on narrative about recent events; use of chronologies with insufficient attention to history, collating evidence and providing analysis about vulnerability and resilience; understanding the significance and implications of domestic and substance abuse on young children; the use of family group conferencing in child protection.

157. Previous serious case reviews have described a tendency for practitioners to work in the moment; focussing on current or very recent events or information even when there is significant and relevant history to be explored. Three core assessments provide virtually no information about the parents' history.

158. The assessments offer little collated information about evidence of vulnerability and resilience and relies on generalised assertions that family support is good.

159. For example in regard to parental assessment it is well known that a history of domestic abuse are significant substance misuse are important factors associated with child vulnerability. Other factors such as whether either parent had ever experienced abuse as children, been looked after, economic and social isolation or psychiatric health have not been explored in this case. The parents' attitude to professional help was assumed to be good; arguably there is some evidence of disguised compliance. For example, it is clear that mother continued to drink in spite of agreements not to and disguised the fact that she and father were having far more contact when allegedly separated.

160. In regard to an assessment of the children it is known that young children and an early onset of abuse is particularly significant in regard to their safety and well-being. Sources of resilience include a higher IQ, good self-esteem and positive relationship with a sibling. These indicators of resilience appear to be

present for the older child but is not explicitly addressed. The quality of attachment which is a very significant protective factor for children is not addressed but rather how the mother 'shows warmth' to her children. The fact that adults can and will modify their behaviour to influence or misdirect professionals is a recurring theme in reviews and needs to be understood and taken into account.

161. In regard to wider environmental factors sources of vulnerability are poor neighbourhood, poor social support as well as poverty and social isolation. There is no description of these factors. Sources of resilience such as a good school was a factor for the older child. Factors such as whether there was a committed adult, a strong community and good services are not explicitly addressed.

162. The substance misuse and domestic abuse are recognised as risk factors although reliance is given to both parents desisting from both.

163. The prevailing mind-set of professionals will influence their choice of tools and strategies. The mind-set in this case was that the mother in particular needed support rather than a more authoritative intervention to address the longstanding issues in regard to substance misuse and domestic abuse. It is not apparent that enough work was done on issues such as the quality and style of emotional care and attachment of each the children for example.

164. The decision to use the county's family group conference service is not clearly enough explained. Its use in the case was significant; it is a family led decision making process that is intended to 'make reasonable and safe plans for the children'.

165. The ethos is upon a solution focussed approach that seeks to emphasis and develop the strengths of a family in taking responsibility for children. It is questionable whether it is compatible with the authoritative approach that a child protection plan requires in the protective phase of enquiries, assessment and the child protection conference if children are to be effectively protected. Any framework needs to ensure that an appropriate balance is achieved in collating and analysing information about deficits, risk and vulnerability to children alongside areas of strength and reliance.

166. When the social worker, their manager, the conference chair and the core group are confident that the parents are giving genuine cooperation with the staff, then a family support approach is appropriate, as long as there is continued awareness that the assumptions may be mistaken. This requires a much more sceptical approach to the testing of evidence; it is not enough for parents to give verbal reassurances about change or to rely just on one set of data such as the physical condition of children.

167. The use of family group conferencing is a well-established strategy and supported with research evidence from the UK and internationally. It has been shown to work well in engaging families in developing their resilience and problem solving approaches and support. There is mixed evidence in regard to FGC providing sustained improvement for children in complex families especially if the FGC is not used as one part of ongoing support.

168. It was difficult to discern an overall strategy in the use of family group conferences and how it linked to other help or assessment. The absence of an adequate family history that explored for example intergenerational substance misuse as well as looking for clearer evidence of how the family could provide positive support.

4.4 Management and agency to agency systems

Capacity of children's social care services and approach to workload management; professional contact outside of core weekday hours

169. Child G lived in a part of the county that has the second highest numbers and rates of children at risk of significant harm and subject to a child protection plan of almost twice the county average. It is an area where there are more repeat referrals of concerns about children.

170. In the summer of 2013 there was an upsurge in the volume of referrals coinciding with several vacancies at social worker and team manager level. The vacancies at team manager levels had implications for other managers who were having to provide cover and professional support whilst team managers were being drawn into direct case involvement.

171. This has implications for all services but particularly children's social care services. The office responsible for this case has one of the higher turnover of social workers many of whom are relatively inexperienced and working with higher caseloads. The social worker allocated to Child G was recently qualified and began working with the caseload without the benefit of a structured induction. The team manager was also covering another team, providing support to an acting practice manager and covering for a vacancy at practice manager level.

172. Under those circumstances, it becomes less surprising that the quality of practice in regard to the conduct of enquiries and assessment were not adequate in this case. This included action from meetings that included the pre-proceedings public law outline and family group conference for example in carrying out assessments of relatives putting themselves forward as potential carers for the children.

173. Managers who participated in the review acknowledged that a chronology was never completed (and could have assisted in identifying the pattern of

incidents and non-compliance); the assessment was not of a good enough quality and therefore important decisions that included returning the children home were not based on thorough enough knowledge and information. Significant information such as the father not having paternity for Child G were not known until the care proceedings that followed the death of Child G.

174. Although the review was informed that recruitment to children's social work vacancies are not given any more priority than other vacancies within the local authority, senior managers dispute this to be the case. Senior managers felt that any delay occurred through for example IT systems rather than any delay in making decisions to advertise and recruit to posts. The review has also received information about the reorganisation of services that will result in reducing the number of managers; at some levels this will be as much as 50 per cent from the establishment that existed at the time of events examined by this review.

175. The administration of the child protection conferences was not adequate. The failure to identify all relevant services and professionals' left key people such as the GP practice outside the arrangements for protecting the children.

176. The attendance by professionals at key meetings such as child protection conferences who had little or no direct knowledge of the children or family further compounded matters.

177. It is striking how many of the incidents of serious concern occurred outside of the usual weekday office hours. It was the emergency services who dealt with the parents when they were at their most incapacitated condition through alcohol for example. Their behaviour with other health and social care professionals was different in that it did not involve such extremes of incapacity. Nobody made visits out of hours and or at unscheduled times. This meant they were always reliant on the parents keeping to their word. Even when mother arrived smelling of alcohol to the public law outline meeting this did not appear to disturb or disrupt the overall mind-set to her.

178. Allied to the absence of contact, support and oversight outside of core office hours there was a high reliance on the parents keeping to the agreements. This included abstaining from drinking and ensuring the children were not subjected to domestic abuse but was not monitored or checked. Important services such as the GP were unaware of the concerns and agreements and were therefore not in a position to contribute to the plan. The reliance of specialist practitioners dealing with issues such as substance misuse are reliant on self-reporting from service users and if there is no contact with other professionals will not know if information is correct or not including the circumstances under which a parent makes their first contact.

4.5 Issues for the Lancashire Safeguarding Children Board to consider in regard to learning and improvement

179. The challenges and reflections do not excluded individual services using the review as an opportunity to examine other aspects of policy, practice or processes and are in addition to any single agency action already reported to the Lancashire Safeguarding Children Board.

4.6 Recommendations

1. The Chair of the Lancashire Safeguarding Children Board should ask the Director of Children's Services to provide a report to the Board about the staffing position in children's social care services including an account of the changes being implemented to management and support staff across the county and in the area in which Child G was living. The report should also address specifically the arrangements for the induction and professional support for newly qualified social workers. This should be done within a month of this report being presented to the Lancashire Safeguarding Children Board.

2. The Chair of Lancashire Safeguarding Children Board should ensure that the Chief Executive of Lancashire County Council and relevant agencies are aware of the findings from this review and the issues in regard to recruiting and retaining a sufficiently experienced professional multi agency workforce to work with children at risk of significant harm and to ensure the appropriate level of professional support and supervision and provide a formal response to the Board. This should be done within one month of the report being presented to the Lancashire Safeguarding Children Board.

3. The circumstances and use of the family group conference service in cases where there are historical or current safeguarding concerns should be described in written protocols issued by the Lancashire Safeguarding Children Board.

4. The Lancashire Safeguarding Children Board should consult with the community safety partnerships about the quality, availability and take up of domestic abuse training offered by the community safety partnerships and the safeguarding children board particularly by professional staff undertaking assessments of risk to children.

4.7 Challenges for the Lancashire Safeguarding Children Board

1. To what extent is the Lancashire Safeguarding Children Board receiving information to alert them to potential vulnerability in critical child safeguarding services in the county?

2. Do the safeguarding procedures require greater clarity about the role of an independent reviewing officer before decisions are taken to return children to parents when subject of child protection plans?

3. To what extent does the multi-agency ethos and culture promote the purpose and value of professionals having opportunities, including supervision, to discuss information and provide multi-agency challenge as part of the preparation and debriefing from multi-agency meetings such as child protection conferences or core groups? How does the Lancashire Safeguarding Children Board support the development of skills so that best use is made of multi-agency meetings?

4. To what extent is the Lancashire Safeguarding Children Board informed about availability of services and contact with families outside of core business weekday hours including the sudden unexpected death in childhood (SUDIC) service?

5. Does the Lancashire Safeguarding Children Board need to have further work undertaken on the consistency of professional attendance at critical multi-agency meetings such as child protection conferences and core groups and about the quality of information provided by the professionals who attend?

6. To what extent can the Lancashire Safeguarding Children Board scrutinise any further the quality of systems and the delivery of professional supervision provided to professionals in all agencies dealing directly with families and children subject of safeguarding assessments and child protection plans? Is the Board able to consider what is happening over time?

7. To what extent is the Lancashire Safeguarding Children Board satisfied that the learning and improvement from reviews and audits is being sufficiently used in improving services for safeguarding children in Lancashire?

5 APPENDICES

Appendix 1 agency action as a result of the serious case review

Children's Social Care

One of the actions identified by children's social care related to the number of newly qualified social workers, and trying to create stability in the workforce. To start working towards this, training has been offered and links built to the Universities. The recruitment and retention plan is also scheduled to be reviewed.

A further six actions were identified, and two of these have been completed: ensuring critical decisions were led by social work practice and not legal advice; and ensuring all relevant professionals are invited to child protection conferences. A further four actions are in progress: an analysis of CP activity in Preston; improving the quality of assessments; improving skills in assessing parental alcohol use, and issues around assessing the toxic trio. These actions were due for completion in November 2014 but have been extended.

Discover Drug and Alcohol Service

The Discover Drug and Alcohol Service identified four issues and each had a number of actions associated with them. These broadly relate to training and internal briefings for staff about 'the toxic trio', exploration of the possibility of sharing access to databases with local services, further work around the effectiveness of the 'routine notification' system and audits of compliance to ensure procedures are being followed to best effect. All of the actions had a deadline of December 2014.

Early Years' Service

The Early Years' service identified three areas for development and has progressed them all to a pilot stage. Two relate to how Early Years settings are involved with CP meetings by children's social care, and a new system is now being piloted in the Pendle area. The third action was about how Early Years providers can link more effectively with health visitors to share their knowledge about the children they work with, and a pilot is in operation in the Preston, Pendle, and Fylde and Wyre areas. The plan is to roll all these pilots out Countywide now.

GP

The GP service identified four actions and has completed three of them. The completed actions were about raising awareness of the need to provide reports to child protection conferences, ensuring records flagged those children and families subject of child protection processes and improving the systems between LCC and GPs to ensure invitations to conferences were being received.

The final action, which is near completion, is about how to improve the links and communication between GPs and school nurses/health visitors. There have been discussions about this and the issue will be reported nationally too, but on a local level plans are in place to develop these links.

Lancashire Constabulary

The Constabulary identified two actions from this review. The first related to how attendance at Child Protection Conferences was being recorded, and resources and training have been provided to improve this. The second issue was about Officer's involvement in the SUDC process, and training and ongoing development for relevant officers has been delivered.

Lancashire Care Foundation Trust

LCFT identified three issues that required actions as a result of this review. The first was about representation at 'separate' core group meetings (where parents have to have separate core group meetings) and the second related to the use of Bank staff and the consistency of representation at safeguarding meetings. Both of these actions have been partially completed – the relevant discussions and awareness raising has taken place for both issues and the associated safeguarding booklet and templates were due to be amended and signed off by April 2015.

The final action identified was to review the transfer out protocol so that transfer points when children moved into and out of foster care are appropriate. This action has been completed.

Lancashire Teaching Hospital

One of the actions identified by LTHT was that the lighting in the room used to examine the child's body was not adequate, and this was due to be reviewed and rectified by November 2014. The Hospital Alcohol Liaison Team (HALs) had two actions relating to the development of an information-sharing trigger list/process and the revision of their assessment tool to reflect issues of domestic abuse. Both of these actions were due for completion in November 2014.

The final action for LTHT was that all appropriate staff should undertake level 3 training about 'the toxic trio', and this was due to be delivered as part of the 2015 training programme.

National Probation Service

NPS listed six actions from this review. One has been completed, which related to the agreement of an information-sharing protocol and procedure with children's social care.

Five further actions were due to be completed by November 2014. Three of those actions related to an instruction going out to all NPS/CRC staff about requirements to update records in a timely and thorough manner. One action related to the management and systems around electronic curfews and the final action was to update procedures about the assessment of risks posed by offenders to children in short term foster care.