Serious Case Review

Overview Report

Child LG

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Publication Date: 24 April 2018

This serious case review was commissioned by the Independent Chair of Lancashire Safeguarding Children Board (LSCB) on 29th February 2016, in agreement with the recommendation of the LSCB Serious Case Review Sub Group that the circumstances surrounding the serious injury to a child met the criteria for a serious case review.

Subject of the review: Child LG

Circumstances and history resulting in the review

At the time of writing the subject child, to be known as Child LG, lives in foster care as a result of being accommodated by Children's Social Care, after suspected physical abuse in early 2016. This resulted in LG being hospitalised with serious internal head injuries.

LG was born in 2015 in the Lancashire area, LG's birth Mother and Father lived together at the time and there were other older children in the family, including two siblings living in the same household. These two children will be known as Sibling 1 who was pre-school age and a half sibling, to be known as Sibling 2, who was secondary school age. Sibling 2 had a different father to LG and Sibling 1. Mother's other older children lived with relatives elsewhere.

When Mother became pregnant with LG the family as described above were living in another part of the country. Their home, and the school of Sibling 2 was in one local authority area (LA 1) and the family resided there for a number of months. They moved briefly into the neighbouring local authority area (LA 2) for just two months prior to the move to Lancashire, where Mother received most of her ante-natal care, and where LG was born.

Towards the end of 2014 when living in LA 1 two allegations were made against Sibling 2; one involved familial sexual abuse (but not in the immediate family household), and the other separate allegation was linked to school regarding an online images offence. Both incidents were referred to Children's Social Care and the Police, and due to the locations of the separate allegations investigations were conducted by two separate Police Constabularies. Unfortunately Sibling 2 did not attend school for several months after the allegations were made.
Due to the sexual concerns being prior to the agreed serious case review timeframe the decisions and actions, and services provided have not been scrutinised in detail. This was a joint decision made by the review panel which included representatives of the other areas involved, see below in methodology. However, the impact of the allegations, subsequent responses and how this affected Child LG and the family will be reflected throughout the report.

After the move from LA 1 area and a brief time in LA 2 area the family moved and settled in Lancashire. Eventually both Sibling 2 and Sibling 1 commenced school and nursery there. Mother, and sometimes Father, was seen by Health professionals throughout the pregnancy and some but not all family history was shared from their time in areas LA 1 and LA 2. Liaison did take place within health teams across the different areas but there was limited communication between the previous and new school for Sibling 2. There was no initial information sharing or contact between Children's Social Care in LA1 and LA2, with Lancashire Children Social Care. At the time of the move to Lancashire the family were not "open" to Children's Social Care in any area and no formal transfer-in process was required. This will be explored later.

Most ante-natal care was provided in Lancashire, the family were seen regularly and received support and advice from health professionals as standard.

After being born Child LG was discharged from hospital after a short stay and was cared for at home by both Mother and Father, who mostly engaged with all health professionals. When LG was nearly one month old a referral was made to Children's Social Care regarding possible risks within the family, as the information regarding the sexual abuse allegations had been referred by a new health visitor who had become involved. Checks were undertaken by Children's Social Care and it

was concluded that Mother and Father were acting appropriately in terms of safeguarding at home, managing any risks and supporting Sibling 2.

Sadly early in 2016 an incident occurred leading to LG being seriously injured. The full circumstances are not yet known and the Police are continuing their enquiries. However there is a suspicion that the injuries to LG, a non- mobile child at the time, were inflicted and not the result of an accidental cause.

Legal Context:

A serious case review was commissioned by Lancashire Safeguarding Children Board, following agreement at Lancashire Serious Case Review Sub Group in accordance with Working Together to Safeguard Children (Department for Education 2015).

Regulation 5 of the Local Safeguarding Children Boards (LSCB) Regulations 2006 sets out the functions for LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5. (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
   (2) For the purposes of paragraph (1)(e) a serious case is one where:
   (a) abuse or neglect of a child is known or suspected; and
   (b) either (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The methodology used was based on the Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012).
This is a formal process that allows practitioners to reflect on cases in an informed and supportive way. Documenting the history of the child and family is not the primary purpose of the review. Instead it is an effective learning tool for Local Safeguarding Children Boards to use where it is more important to consider how agencies worked together. The detail of the analysis undertaken of the case is not the focus of the reports which are succinct and centre on learning and improving practice.

However, because a review has been held, it does not mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice. The role of Safeguarding Boards is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the Board may identify additional learning issues or actions of strategic importance. These may be included in the final review report or in an action plan as appropriate.

The decision to conduct the serious case review in this way was considered and agreed by the Lancashire Safeguarding Children Board following the change in statutory guidance as a result of *The Munro Review of Child Protection: Final Report: A Child Centred System, May 2011.* Munro suggests that Local Safeguarding Children Boards should use any learning model which is consistent with the principles in the *Working Together to Safeguarded Children Guidance: Learning and Improving, HM Government 2015.*

Methodology:

Following notification of the circumstances of Child LG in this case, and agreement by the chair of the Lancashire Safeguarding Children Board to undertake a serious case review, a review panel (known as the Panel) was established in accordance with guidance. This was Chaired by Vicki Evans, a Detective Chief Inspector with Lancashire Constabulary's Public Protection Team. The Panel included representation from relevant organisations within Health, Children's Social Care, Education, the Police, the GP service and representatives from the two Local Safeguarding Children Board areas (LA 1 and LA 2). Amanda Clarke, an independent reviewer (the Reviewer) from Derbyshire was commissioned to work with the Panel and to undertake the review.

The Panel identified the review timeframe as commencing 10th June 2015 which is when Mother booked as pregnant in Lancashire, and ending 26th January 2016 which is when the serious injuries to LG were disclosed. Full terms of reference for the review are included as Annex 1.

All relevant agencies reviewed their records and provided timelines of significant events and analysis of their involvement. These were considered by the Panel and provided opportunity for Panel members to raise questions and clarify understanding of the circumstances of the case and of the separate services provided. The agency timelines were merged and used to produce an interagency timeline. This was carefully analysed by the Reviewer with the Panel and informed of the areas of interest that required further exploration and consideration. The process also allowed for the identification of the key practitioners required to attend a learning event in order to understand the detail of the single and interagency practice in this case.

The Reviewer attempted to meet with the Mother and Father of LG, and with Sibling 2 to gain an understanding of their experiences of the services offered to them, and services provided to LG. At time of writing Sibling 2 and Father had declined to be involved in the review process. Mother was eventually spoken to by the Reviewer on the telephone some weeks after the learning event and Mother's thoughts are summarised at relevant points throughout the report.

This valuable insight into LG's, and the family's, experiences was shared with the Panel at draft report stage. Account was taken of the views when writing the final report and formulating recommendations and the Reviewer is grateful for Mother's contribution.

The learning event was held in October 2016 and was attended by 13 professionals. Most, but not all, practitioners had had direct involvement with Child LG and/ or the family. There was representation from LA 2 at the learning event and representatives from both Safeguarding Children Boards in LA 1 and LA 2 have been key contributors to the review as a whole. The Reviewer facilitated the learning event assisted by the Chair of the Panel and officers from Lancashire Safeguarding Children Board. The event was organised in line with Welsh Government guidance (Child Practice Reviews: Organising and Facilitating Learning Events, December 2012) and minutes were recorded. With the support of Panel members and the Lancashire Safeguarding Children Board team, further enquiries were made with health professionals who were unable to attend the learning event, and this information is included in the report.

Following the learning event, the Reviewer collated and analysed the learning to date for discussion with the Panel. Practice issues and themes originally identified by the Panel were re-examined in the light of the findings of the review. This provided opportunity to identify issues requiring further clarification with practitioners or managers. In reviewing the findings, the Panel gave consideration to what could be done differently to further improve future practice. A draft report was provided to the Panel in advance of the Panel meeting in November 2016.

The Reviewer will offer to meet again with significant family members of LG to provide an opportunity to see a copy of the report when agreed by the Lancashire Safeguarding Children Board. Learning from the full report will be made publically available after consideration by the Lancashire Safeguarding Children Board of any issues affecting publication.

ANALYSIS: Practice & Organisational Issues Identified

Child LG and family had received services from a number of agencies during the period of the review. Scrutiny of the timeline, information shared and reflections at the Panel meetings and the learning event have highlighted areas of good practice and also provided an opportunity for wider learning to emerge about the ways in which services work together. The following is an analysis of the issues identified:

1. Prevention of non-accidental head injuries in babies.

The head injuries suffered by Child LG were significant. As stated earlier, the Police investigation is ongoing and has included interviews with family members as to the circumstances of LG becoming seriously harmed.

From information in the agency timelines collated for the review and experiences shared at the learning event, it is clear that Mother, Father and LG once born, were seen by a number of health professionals over the period of the review. Records demonstrate that adequate care was provided to the family in terms of pre and post-natal visits and appointments. There was some non-attendance at scheduled appointments by Mother (recorded as DNA- Did Not Attend), but most were explained by the family. All DNAs were followed up by Health professionals and Mother was strongly reminded about the importance of regular attendance.

Across the country new parents and carers are provided with consistent information regarding different aspects of care of babies, for example safe sleep guidance, and information regarding sudden infant death syndrome (SIDs) and associated risks. There is evidence that both parents of LG were present when such advice and support was shared by health professionals in the first few weeks of LG's life, and Mother did say, in her contribution to the review, that she recalled being given advice.

The provision of guidance regarding safe handling, and in particular prevention of non-accidental head injuries in babies, is less consistent throughout the country. In some local safeguarding children board areas it has been agreed that awareness programmes such as *"Don't Shake the Baby"* are implemented and health partners work together to raise awareness of the risks. In one area, for example, all new parents are required to view a short information DVD prior to being discharged from hospital with their baby. A protocol is in place to ensure the date of the viewing is

documented and that there is follow up of parents who may not have had the opportunity to see the film, for example if a home birth took place. The awareness DVD is complimented by the use of leaflets and posters which are widely available across the whole safeguarding partnership, including in children's centres and GP surgeries.

The NSPCC has also developed a short film which is used in other areas. *"Coping with Crying",* prepares parents for the stress they might feel when their baby cries and helps them to cope better. It aims to prevent non-accidental injuries. An evaluation suggests there is evidence that *Coping with Crying* "has a positive impact on parents' knowledge, attitudes and behaviour", *Evaluation of Coping with Crying: Final Report, Coster, D, Bryson, C. and Purdon, S. London: NSPCC (2016).*

Child LG's case centres on a 3 month old baby who suffered what is suspected to be a non-accidental head injury but the circumstances prior to and at the time of the incident are not absolutely known. Non-accidental head injury remains the most common cause of fatal child maltreatment. An analysis by the NSPCC released in November 2013, puts the number of babies under one suffering from a serious non-accidental head injury in England and Wales each year at approximately 24 per 100,000 live births. At least half of the survivors have significant neurological impairments. The final prognosis regarding LG's future health needs is not yet known.

A serious case review, *Child K*, took place in *Nottingham City Safeguarding Children Board area in 2015* which focussed on similar themes. When babies are shaken, thrown or handled roughly this can result in what is called non-accidental head injuries. It is the leading cause of death and long-term disability for babies who are harmed *(Sidebotham and Fleming, 2007)* but this form of child abuse differs in a number of ways from other more common forms of abuse. Differences include one single event may cause a catastrophic outcome; there is frequently no intent to harm the child; and the immediate and follow on outcome is worse than with other causes of head injury in childhood *(Bruce & Zimmerman 1989).* In the majority of cases the primary trigger is linked to inconsolable crying *(Dias et al 2005).*

Whilst it is recognised that shaken baby events are a crime, they are also a Public Health issue. There are a number of research studies which highlight the effectiveness of Public Health programmes which focus on the prevention of *Shaken Baby Syndrome (Centre for Disease Control and Prevention – United States 2010).*

A number of effective strategies have been suggested by research which helps to raise awareness and educate parents and carers about the serious impact of baby shaking injuries, to inform them about crying behaviour, and safe ways to reduce and prevent baby shaking events. Strategies have included hospital- based primary prevention programmes which target parents of newborn babies, see above.

The Lancashire Safeguarding Children Board jointly with the Pan Lancashire Child Death Overview Panel, Public Health and Health partners should review relevant research, alongside consideration of the local context; in order to decide the most effective method to raise awareness with parents and families of the dangers of shaking a baby, and how to cope with an inconsolable crying baby.

2. Information sharing

The concerns of sexualised behaviour, as above, came to the attention of services in LA 1 in late 2014. Mother and another family member acted appropriately by reporting the alleged familial incident to the Police and information about the separate school online images incident followed soon after. As stated earlier the sexual abuse allegations and responses, in LA 1 and subsequently LA 2, have not been examined in detail as these are outside the agreed timeframe and focus of the review. However information supplied by agencies within both LA 1 and LA 2 indicate the initial and first actions taken, regarding the allegations was appropriate.

In early 2015 it is recorded in area LA 1 that the case regarding Sibling 2 would be managed at *Child in Need* level.

A child is defined as a child in need in law, if he or she is unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services form the local authority; his or her health is likely to be significantly impaired, or further impaired, without the provision of services from the local authority; he or she has a disability, Section 17 Children Act 1989.

A child and family assessment was completed in LA 1 but then a recommendation is recorded that the case should be stepped down and be managed by a Team Around the Child approach to resolve difficulties within families and prevent the need for specialist services. Education was noted as taking the lead role in coordinating the Team Around the Child process and involvement by the Intensive Family Support Team in LA 1 was agreed.

Intensive family support (in LA 1) work alongside families to help them form a plan for keeping children and young people safe, healthy enough to thrive and eventually achieving their potential in education, training and employment.

At this time the family moved to LA 2 and records show that the case had been closed to LA 1 Children's Social Care as the family were thought to be being supported within LA 1 by a Team Around the Child process and Intensive Family Support. A referral was made by LA 1 Children's Social Care to LA 2 Children's Social Care which included the current position for the family and service provision at the time of the move.

On receipt of the referral from LA 1 it was established by LA 2 from the LA 1 referrer that there was no further role for Children's Social Care in LA 2 on the basis that the case was closed to LA 1 Children's Social Care prior to the family moving, and the case had been fully assessed by that (LA 1) area. Although the family had moved across neighbouring local authority areas Sibling 2 was due to remain at the same secondary school located in LA 1, and thus the Team Around the Child process which was recorded as being led by the school of Sibling 2 was assumed to be continuing. LA 2 Children's Social Care took no further action with the family for the short time the family resided there.

Lancashire Safeguarding Children Board are grateful for the contribution made to the LG serious case review by the Safeguarding Children Boards in areas LA 1 and LA 2. The Boards located in those areas may wish to enquire further regarding the involvement of local agencies with the family of LG in 2014/ 2015, prior to this serious case review's time frame.

Whilst living briefly in LA 2 the pregnancy of unborn LG became known as Mother is recorded as attending a scan within that area. The family are known to have moved to Lancashire by early summer 2015 as Mother booked her pregnancy in the area at that time.

Transfer of information, and particularly information relating to risks and concerns within the family, was problematic at times for this case. Issues for individual agencies will be explored below.

<u>Information sharing within Children's Social Care</u>

As the brief sequence of events above shows, some information of involvement with the family was shared between Children's Social Care teams in LA 1 and LA 2. However, LA 2 Children's Social Care understood, from information provided, that the case had been fully assessed in LA 1 and was not at a required level for any further intervention by LA 2.

When LG's family moved to Lancashire LA 2 did not seek to share any information with Lancashire Children's Social Care as there was nothing new to share from LA 2's perspective. The original

concerns linked to sexualised behaviour had been stepped down after an assessment in LA 1 and were agreed to be managed at an early help level. There was an assumption that the family had continued to be supported by the early help Team Around the Child process led by Sibling 2's school, whilst living briefly in LA 2. Unfortunately it appears that support had been limited and Sibling 2 had not been attending school for a number of months.

At the learning event professionals discussed protocols regarding transfer of information when families move who are thought to be being managed at an early help level. The authority being left by a family (in this case LA 2) are not obliged to inform the new authority (in this case Lancashire) that a family is moving, unless there is a Child in Need plan or Child Protection Plan in place. The panel, which consisted of senior safeguarding professionals based in three different local authority areas, agreed that there was a lack of formal transfer protocols for cases where child protection processes are not continuing. This can create problems for robust information sharing, when families move who have been identified as requiring early help.

At the time of the move to Lancashire LG's family were not at a Child in Need level. In fact the concerns relating to Sibling 2's alleged sexualised behaviour had been assessed and the family were judged as able to provide appropriate protection and support. Mother quoted that she was told by Children's Social Care in LA 1 that "the family had been signed off" and that the case regarding Sibling 2 was closed. She said this was due to them (the family) "managing well". Therefore as there was no Child in Need involvement the requirement to share information where "there is reasonable cause to believe that a child may be suffering or at risk of significant harm;" *Lancashire Safeguarding Children Board Safeguarding Procedures, 1.4 Information Sharing and Confidentiality,* was not met. Sibling 1 and unborn LG were not believed to be at risk of significant harm at the time.

Professionals at the learning event however were anxious that families could be moving across borders carrying recent concerns and possible risks which were not being shared between professionals, as a certain threshold of need had not been met. Representatives from Lancashire's Children's Social Care Contact and Referral Team were sympathetic to the concerns but said the reality is that sharing all information held at all levels of need was unmanageable and not proportionate.

Working Together 2015 Chapter 1, 23 highlights "early sharing of information is the key to providing effective early help where there are emerging problems". This statement could be said to fit well with the circumstances of LG's family, who already had concerns of alleged sexualised behaviour within the family and possible (undiagnosed) mental health issues for Sibling 2, as raised by Mother and Father. There were also emerging problems of a move across areas, housing issues and a new pregnancy. However, as stated above there was no procedural requirement for a formal transfer of case information between areas. As a result none of the information known about the family was shared between Children's Social Care in LA 2, where the family last lived, and the new area Lancashire. Therefore no early action was taken.

The Lancashire Early Help Board should consider leading a joint exercise with other Local Safeguarding Children Boards and relevant professionals to explore the development of a protocol which enables effective sharing of information on families moving across boundaries who are receiving early help services.

<u>Information sharing between Education Settings</u>

Prior to the start of the review timeframe Sibling 2 was a student at a secondary school in LA 1 and remained there on roll when the family moved the short distance to LA 2. The online sexual abuse concern was linked to the school and allegedly occurred when the family lived in LA 1, around the same time that the familial sexual abuse allegation became known. The school was aware of the

involvement of partner agencies regarding the two separate sexual abuse concerns and records show that, in consultation with the family, plans were put in place in order that Sibling 2 could return safely to school.

Unfortunately a representative from the school in LA 1 was unable to attend the learning event and the staff member involved at the time has since left. It has not been possible to obtain a clear picture of the school's perspective of their role in the Team Around the Child process which was one of the final outcomes of the LA 1's Children's Social Care intervention. It is known that Sibling 2's attendance at school after the sexual abuse concerns was less than 50 % and that there was no attendance after late spring/ early summer 2015.

Sibling 2 started school in Lancashire in the new Autumn term 2015. A request was made within the first 10 days of term by the Lancashire school, to the previous school in LA 1, for Sibling 2's school records. The new school in Lancashire had no knowledge of either of the sexual abuse concerns, including the online images concern which was actually linked to the previous school. Information of the concerns had not been shared either verbally or in writing by the LA 1 school and the family chose not to share any details either. Mother said she wanted Sibling 2 to have "a fresh start" at the new school. The other issues for the family, including behavioural problems of Sibling 2, housing issues and the latest pregnancy were also unknown to the new school. As mentioned above, Lancashire Children's Social Care being unaware of any previous concerns, were unable to share any information with the new school.

Sibling 1 also commenced attendance at a Lancashire nursery and the new nursery were not aware at that time of any previous safeguarding concerns for the family. The nursery disclosed that it was not routine practice for them to make enquiries with Children's Social Care about new families unless there was a genuine reason to do so.

The Lancashire school for Sibling 2 made numerous contacts to the previous school in LA 1 in an attempt to obtain Sibling 2's school records. The Lancashire school only became aware of the online sexual abuse concern in late Autumn when the health visitor who had attended the family soon after LG's birth shared information with school regarding the online concern which had been discussed on her primary family visit. The other (familial) sexual abuse concern was not shared with the school and reasons for this are explored below. A month later, after LG's birth, the Lancashire school were made aware of the familial sexual abuse concern relating to Sibling 2 after a different health visitor referred the sexual abuse information received from the family to Children's Social Care. This required enquiries to be made with the Lancashire school who were then informed of the full history.

Having received the full information of the concerns about Sibling 2 and family the Lancashire school again contacted the previous school. They were told that "information could not be shared as no other students were thought to be at risk". They claimed this was on the advice of the investigating Police Constabulary, which was not Lancashire. It is apparent that a misunderstanding or lack of knowledge of information sharing protocols existed in both schools, but particularly in LA 1.

School records were eventually shared from the LA 1 school to the Lancashire school in early 2016 but only after a formal request when the injuries to Child LG were reported and were under investigation.

There is no suggestion that the two sexual abuse concerns, the wider issues for the family and the injuries to LG are connected. However it is unacceptable that a new school had to wait for the significant incident with LG to occur within the family before gaining access to a new student's (Sibling 2's) records. Furthermore, the Lancashire school were aware of sexual concerns which may have had a direct impact on other Lancashire students two months before obtaining the whole

school records of Sibling 2, even though requests were made to the LA 1 school as soon as that information became known in Lancashire.

Keeping Children Safe in Education, Department for Education, Part 2: 61 September 2016 (first published March 2015) states *"*as part of meeting a child's needs, it is important for governing bodies and proprietors to recognise the importance of information sharing between professionals and local agencies". This guidance was not implemented at the time of Sibling 2's move between areas and schools but *Section 175 of the Education Act 2002* was, and still is, relevant. This places "a duty on local authorities (in relation to their education functions and governing bodies of maintained schools) to exercise their functions with a view to safeguarding and promoting the welfare of children who are pupils at a school".

By not sharing the school records, and more specifically the safeguarding concerns which had related to Sibling 2 whilst at the LA 1 school, there was a missed opportunity to allow the new school to make proper arrangements to support Sibling 2 and to ensure the safety of other students.

Lancashire Safeguarding Children Board, and the Safeguarding Children Boards in LA 1 and LA 2 should work with Education partners to ensure there is sufficient awareness in every education setting of information sharing protocols, including timescales for the effective sharing of school records when children move schools.

The Safeguarding Children Board for LA 1 with Education partners should ensure the school of Sibling 2 in the LA 1 area is aware of the contents of this serious case review in order that any opportunities for learning can be taken.

<u>Information sharing between Health Partners relevant to this review</u>

i. Health visiting

At the start of review's timeframe when the family moved to Lancashire there was some documented information sharing across borders with liaison between health visiting teams in LA 2 and Lancashire. This is standard operating policy of Lancashire Care NHS Foundation Trust (LCFT). The health needs of Sibling 1 were discussed and very brief information was shared that there had been some early help support in the recent past with Education as lead professional, see above.

At the initial transfer-in home visit to the family, when Mother would have been 22 weeks pregnant with LG, there was no mention of the sexual abuse concerns. Mother did share that Sibling 2, in her opinion, sometimes had behaviour issues. This visit was summer 2015. There was professional liaison between health visitors in Lancashire and LA 2 area soon after when it is noted that there was previous Social Care involvement shared "due to allegations of a sexual nature but the case had been closed".

The health visitor followed up the information for advice through the Safeguarding Advice and Consultancy Services Team within the LCFT and it was agreed that a targeted assessment would be undertaken. The school nurse saw the family soon after and completed the targeted assessment visit, as a result of the initial concerns gathered by the health visitor and checked out through the Internal Advice and Consultancy Team. At that time school nurses were attached to a particular area with a number of schools allocated. Mother shared with the school nurse details of both sexual abuse concerns and also some non-recent concerns regarding Sibling 2's general behaviour. Mother said Children's Social Care in LA 1 area had closed the case. When speaking to the Reviewer in her contribution to the review Mother could not recall talking about the sexual abuse concerns at that time, as she had wanted "to put it all behind them" (the family).

The health visitor and school nurse met afterwards but were unclear as to what information could be shared with other agencies about the sexual concerns. Further difficulties included that the school summer holidays were then underway so the new school for Sibling 2 was closed and it was thought that information could not be passed there. At the learning event the Lancashire school involved did comment that they have an attendance worker who assists in managing the school's most vulnerable families during school holidays but Sibling 2 had not yet officially joined the school. Long school closures can sometimes be a challenge for non-urgent safeguarding situations and information sharing.

The school nurse who had visited the family retired before the schools reopened after the summer break. This meant, other than discussing the family information with the health visitor, the sexual concerns and other information provided by Mother to the school nurse was not shared more widely. The possible risks to the unborn child LG, and to Sibling 1, due to Sibling 2's alleged sexualised behaviour therefore were not re-assessed. Further assessment may have been necessary due to the additional pressures on the family brought on by their change in circumstances including moving areas, different housing, change of school, and the pregnancy. This will be explored later in pre-birth processes. Furthermore, the new Lancashire school were unaware of potential risks in their school, due to no information being shared with them by the school nurse, who had retired and because the previous school had not transferred Sibling 2's school records.

At the learning event a local issue was highlighted regarding the school nursing service during the timeframe of the review. Professionals believed the service to be under resourced at the time with some staff not being replaced and sickness being a problem. The service was said to be operating on a reduced capacity at that time and arrangements had been put in place for health visiting staff to provide additional operational support. The school nurse who had visited LG's family for the targeted assessment retired soon after the visit. The health visitor replaced her as a temporary measure. This meant that the professional tasked to continue work with the family and follow up on initial sensitive information provided by Mother was a different person.

After LG was born in the autumn 2015 there was contact between the health visitor and school to discuss the general behaviour of Sibling 2 but still the previous concerns of a sexualised nature were not shared, nor the possible risks considered. The health visitor thought she was acting on the instruction of the investigating Police area (which was not Lancashire Constabulary) to the LA 1 school, who, it was claimed, had said the information could not be shared. It is now known that the enquiries by the Police investigating the familial sexual abuse allegation were still ongoing at the time around LG's birth which may have caused anxiety for some professionals in terms of confidentiality.

The health visitor felt uncomfortable with not sharing the details of the full sexualised behaviour concerns as she contacted the Police to follow up the current (at that time) position of the investigation, who confirmed the enquiries were ongoing. She also discussed with the parents how they were safeguarding the younger children (Sibling 1 and LG) around Sibling 2.

When LG was nearly one month old a different health visitor attended the family home for a routine check. During the visit when mother disclosed the information about Sibling 2 and the previous sexual abuse concerns the new health visitor made an immediate referral to Children's Social Care to ensure appropriate risk assessments had taken place. The outcome of the referral will be analysed later.

ii. Midwifery

When Mother attended on her first contact with a midwife in Lancashire this was the booking visit. Mother was 17 weeks pregnant with LG at the time and a dating scan had already taken place in LA 2. The midwife did complete the routine social needs assessment, which assesses vulnerability,

but Mother did not disclose the family's previous Children's Social Care involvement or the Team Around the Child process in the LA1 area.

During the pregnancy it is positive that midwives completed and took notice of special circumstance forms. These are brightly coloured records which are inserted separately into a patient file to be noticed quickly by health professionals as a means of sharing any issues including safeguarding concerns. Special circumstance forms were completed for Mother during the pregnancy of LG due to a number of DNAs, and concerns raised by Mother regarding Sibling 2's difficult behaviour and the arrangements of Mother's older children living with extended family. Follow up enquiries were made appropriately after the information had been documented. A historic special circumstance form remained available in Mother's records from one of the previous pregnancies and the content is recorded as being noted during the latest pregnancy with LG.

The safeguarding information from LA 1 was not present in any pregnancy records as Mother was not pregnant with LG at the time of the concerns being raised. The Children's Social Care involvement relating to Sibling 2 in LA 1 had not led to any formal child protection process, therefore was not recorded, at the time, in any detail in health records, including the GP notes.

The local information sharing and liaison between health visiting and midwifery was discussed at the learning event. It was disclosed that information sharing had not always been effective in the past but that all agencies locally had worked hard to resolve the issue, with processes now in place to support better liaison. A case load midwife, a role which supports women with certain additional needs, was in post during the relevant timeframe, but was not considered to become involved as no unmet needs relating to safeguarding had been identified.

iii. GP

At the learning event and panel meetings the transfer of GP records was examined. When a family moves it was said that some delay can take place for notes to be passed to another area. This can be due both to a family not re-registering with a new GP, and the process involved for records transfer. Patient records only leave the old (previous) practice when a patient registers with a new practice, not just when they move to a different area. The new practice requests the records which are then transferred from the old practice to Primary Care Support England (PCSE) via a courier service. PCSE then forwards the records on to the new practice.

In Lancashire once a new registration has taken place, the records are passed to a notes summariser who will summarise and add the notes onto the system. The process takes time and can lead to delays. In the Lancashire GP practice where LG's family eventually registered the summarisers have safeguarding training and sit in a team with a GP lead and a GP safeguarding champion.

Mother of LG was the first member of the family to register with a GP in Lancashire in the early summer of 2015 due to the pregnancy. The Siblings of LG were not actually re- registered with the same GP practice until Autumn 2015 when they had been living in the area for at least 4 months. LG was registered at birth. The GP notes of Siblings 1 and 2 were not summarised, as described above, until late Autumn 2015 which was after LG was born. The safeguarding information in the notes was brief and the summariser said at the learning event that there was no specific information which gave cause for new concern. The recording in the GP notes, which was regarded as being correctly coded, suggested the family's case was closed. Hence no action was taken in terms of information sharing from the GP service.

Due to the process of transferring and summarising GP notes, which is affected by when families decide to re-register with a new GP, there will be a delay in transfer of important health and safeguarding information which may be present in GP records. In LG's family's case the safeguarding information in the notes was limited from when the family lived outside of Lancashire,

but regardless this was not available until much later, in fact after LG was born. Within that time professionals accessing the GP records had no knowledge of any previous safeguarding concerns and therefore any judgements made or action taken was without awareness of the full family circumstances.

It is positive that an alert has since been applied to the records of the children which indicates "child at risk" and will flag each time the record is opened.

The panel discussed information sharing between health professionals. The GP service was described as the "hub" for patients' medical information and therefore it is important that GPs should be kept as up to date as possible regarding all patients' treatment and particularly when safeguarding concerns are raised. In some areas health visitors and midwives have moved out of many GP practices to be located elsewhere and as a result communication between health professionals can be affected. It is encouraging that the Lancashire Clinical Commissioning Groups are working on an audit focussed on GP and health visitor communication which will help to explore the issue.

Information sharing by the Police

As said earlier the two separate sexual abuse concerns were required to be investigated by two separate Police Constabularies due to the location of any suspected offences. This is normal practice. The police action regarding the sexual concerns has not been explored in detail as being outside of the review timeframe agreed by the Panel. What is known is that the enquiry into the online images concern within the LA 1 school was concluded quickly and the family and professionals involved were all aware of the outcome.

The familial linked sexual concern involved a more detailed investigation. Unfortunately there was confusion over whether this enquiry was concluded. Records indicate that the family believed that the Police investigation was closed but then received contact from the investigating Police area in late Autumn 2015 that enquiries were continuing. Mother recalls this herself; she told the Reviewer she had thought both investigations were closed by the Police until officers attended for witness statements regarding the familial allegation around the time of LG's birth. What has since been confirmed is that the Police enquiries led to a file of evidence being submitted to the Crown Prosecution Service for advice in early 2016. A decision for no further action to be taken was received by the Police in Spring 2016. Mother said she was now aware of the Police outcome.

Unfortunately, there was no confirmed position, as for the family, regarding the Police investigation for all involved professionals until after the birth of LG, and even then this was limited information communicated by the family. No formal periodic updates appear to have been provided to any professionals. It is accepted that, due to the family's relocation, these were different professionals to those who were part of the original strategy meeting when the concerns were raised. However, the lack of information sharing and provision of valuable insight into possible continuing risks within the family, and at school, is of concern.

The Chair of the Lancashire Safeguarding Children Board should ensure the Head of West Yorkshire Police Public Protection Unit is made aware of the findings of this serious case review in order that any relevant areas for development can be identified regarding the force's involvement with the family and Sibling 2.

Information sharing: a conclusion

The impact of families moving areas and the involvement of different Local Authorities, Police Constabularies and Health Trusts can bring extra challenge to sharing quality information about family histories and risk. Additionally in the case of LG's family there was some confusion about

action taken previously, status of enquiries and anxiety for some professionals about what information was allowed to be shared. *Working Together 2015 Chapter 1, 24* states "fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children".

In the timeframe for the serious case review local protocols were in place supported by national guidance; *Information Sharing: Guidance for practitioners and managers (2008).* This was replaced in 2015 by *Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers, HM Government March15.*

Lord Laming, in *The Protection of Children in England: A Progress Report March 2009, 4.8,* emphasised that all frontline practitioners and managers across all sectors should "understand the circumstances in which they may lawfully share information about both children and parents, and that it is in the public interest to prioritise the safety and welfare of children".

The Lancashire Safeguarding Children Board and the Safeguarding Children Boards in LA 1 and LA 2 should raise awareness of key information sharing requirements and explore ways of enhancing the confidence of all professionals regarding what information can be shared.

3. Use of pre-birth protocols

It is widely understood that very young babies are extremely vulnerable and that work carried out in the antenatal period to assess risk and to plan intervention will help to minimise harm. According to *The Triennial Analysis of Serious Case Reviews 2011 to 2014, Pathways to Harm, Pathways to Protection, Final Report May 2016, Peter Sidebotham, Marian Brandon et al,* the largest proportion of cases leading to serious case reviews related to children who were aged under one year. 120 of the 293 children (41%) were aged under one year at the time of their death, or incident of serious harm; and nearly half of these babies (43%) were under 3 months. "The high number of serious case reviews conducted with regard to babies under one year of age reflects the intrinsic vulnerability of the youngest babies who are dependent on their parents for care and survival".

A *Multi-Agency Pre-Birth Protocol* exists in the *Pan Lancashire Safeguarding Children Procedures, October 2012.* The protocol is to ensure that a clear system is in place to develop robust plans addressing the need for early support and services and to identify any risks to unborn children.

A pre-birth assessment for LG was not considered although the previous sexual concerns regarding a member of the family were brought to the attention of the school nurse in the summer of 2014 when mother was 24 weeks pregnant. Other concerns relating to behavioural difficulties and undiagnosed learning disabilities of Sibling 2 were also shared by Mother. At the time Sibling 2 was living in the same home as Mother, Father, unborn LG and the younger sibling (Sibling 1) and could have been viewed as a potential risk. Additional issues for the family at that point, which were already known to services, included frequent house moves, poor school attendance of Sibling 2, possible (but unsubstantiated) past drug and alcohol misuse, and suspected historical domestic abuse in a previous relationship of Mother.

A serious case review, *Child BW, Blackpool Safeguarding Children Board, 2016* has examined a similar theme in that no pre-birth assessment was considered or undertaken in that case.

The concerns and circumstances for LG and family met the criteria of several examples within the Pre-Birth Protocol when a pre-birth assessment should be considered in order that an assessment of identified risk factors can take place. It is positive that advice was sought by the health visitor after her conversations with the health visitor from the LA 2 area. A discussion took place between

the Lancashire health visitor and a safeguarding practitioner in the Safeguarding Advice and Consultancy Services Team within the LCFT but no consideration was given to the use of pre-birth processes, in view of all the known issues.

Whilst it is acknowledged earlier that there was confusion over what information should be shared regarding the sexual concerns, the specific information regarding sexualised behaviour linked with the other issues and circumstances for the family should have resulted in consideration at least of use of the pre-birth processes. Records examined, and discussions at the learning event, demonstrate that this consideration did not happen.

If a pre-birth assessment process had been commenced a meeting of all professionals involved would have been convened enabling the sharing of information and risks. Unfortunately, the pre-birth assessment process for Child LG was not instigated and consequently the multi-disciplinary assessment and planning did not take place.

The Lancashire Safeguarding Children Board should promote the use of the Pan Lancashire Multi-Agency Pre-Birth Protocol to (i) ensure all relevant staff are aware of the requirements and are confident in considering use of the protocol when required. (ii) An audit should take place 12 months after part (i) of this recommendation is completed to compare data of pre-birth assessments undertaken before and since the recommendation was made.

4. Closing a referral based on historic information/ Consideration of early help processes

The one involvement with the family by Lancashire Children's Social Care, prior to LG suffering serious injuries, was the referral which was made as a result of the new health visitor's contact with one month old LG and Mother in late Autumn 2015.

The referral was made by the health visitor as a Child in Need referral and was managed within the Contact and Referral Team. Checks were made with agencies and professionals involved in Lancashire, and for some, such as the current school this was the first time they were made fully aware of all the information relating to sexualised behaviour, and other concerns within the family. The Contact and Referral Team obtained information from Children's Social Care in LA 1 and the assessment undertaken there, nearly 12 months prior, was shared. On the basis of the assessment completed in the LA 1 area in early 2015, the decision by Lancashire Children's Social Care, in late Autumn 2015 was to close the case and for the referral to be classified as a contact record.

No new formal assessment was undertaken by Lancashire other than the checks completed at receipt of the referral. This was despite circumstances for the family having moved on by 11 months since the last full assessment. The family's current position included a new baby (LG) being recently born, a house move, Mother saying Sibling 2's behaviour was difficult to manage in a number of ways, Sibling 1 being demanding, and Mother's low mood as self-diagnosed and noted by health professionals.

The situation within the family, of which the above are only examples, should have been assessed holistically and in real (current) time. The issues highlighted by Mother and what was known by professionals indicate that the family were demonstrating at least *Level 2, additional support needs* as defined on the *Lancashire Continuum of Need.*

The Lancashire Continuum of Need (CON) allows practitioners to identify levels of need through the use of indicators related to outcomes. The CON also supports practitioners in determining how their service can best support and work alongside children, and their families. It allows practitioners to identify levels of need through the use of indicators related to outcomes. The CON provides

guidance as to what assessment and planning procedures follow at each level to meet or prevent the escalation of need and support de-escalation from statutory services, The Lancashire Continuum of Need and Thresholds Guidance.

The family at that time would have benefitted from a *Common Assessment Framework (CAF)* and there was an indication from their involvement with services previously that they (the family) would have engaged with a CAF process. However there is no evidence that this was a consideration in the decisions made by Children's Social Care. Feedback that the referral was to be closed was provided to the health visiting team 6 days after the referral was made.

The CAF is a shared assessment and planning tool for use across all Children's Services in Lancashire. It helps in the early identification of needs for children, young people and families. The CAF promotes a co-ordinated approach on how these needs should be met, The Lancashire Continuum of Need and Thresholds Guidance.

It should be highlighted that a CAF can be commenced by any professional involved with the children and family. Other Lancashire professionals, it seems, who were involved before, and at the same time as the referral had been made, had not made the decision to consider starting a CAF process to support the family. This was a missed opportunity by all involved.

In Lancashire there has been considerable scrutiny both internally and externally whether early help processes are embedded and fully understood by all professionals including how to invoke such a process. A multi-agency audit has recently taken place with a focus on the use of CAFs. The panel informed the Reviewer that a re-launch of early help processes is being considered. The Lancashire Safeguarding Children Board may choose to support the re-launch proposal on the basis of the findings of this serious case review relating to awareness and use of early help processes.

5. Recording of attendees at appointments during pregnancy

The timeframe of the serious case review has allowed focus on the ante natal care provided to Mother. The care provided by health professionals during the pregnancy met local standards and expectations. Earlier in the report positive note was made regarding follow up of appointments not attended (DNAs) and the use of special circumstances forms.

However, opportunities to record who was involved in the lives of Mother, the unborn Child LG and the wider family were not always taken. On four occasions during the pregnancy there is no note of who accompanied Mother to appointments, which means the record was not completed in full. At two later appointments near to the birth of LG, Father is named as being present, and it is known that he was regularly involved around appointments in the ante natal period. Mother did share with the Reviewer that, in her view, Father was supportive and attentive regarding health appointments during the pregnancy of Child LG. She also said that health professionals took notice of Father and included him fully in the appointment as much as possible. This is positive patient feedback.

However, recording who accompanies women to appointments is good practice, which is why recording templates have "accompanied by" sections for completion in patient notes. The "accompanied by" section was introduced into hand held records to demonstrate why routine enquiries about domestic abuse were not taken with women, in appointments where another adult attended and it was felt inappropriate to ask about domestic abuse.

Moreover recording adults who accompany women can provide valuable information and insight into who is involved in the lives of the new mother and unborn child.

There has been considerable research into the involvement of fathers and "hidden men". *Learning from Case Reviews: Summary of Risk Factors and Learning for Improved Practice Around 'Hidden'*

Men - NSPCC March 2015 highlights that professionals do not always talk enough to other people involved in a child's life. This is just as relevant to an unborn child such as LG, and to any adult accompanying a pregnant woman, not just fathers. Enquiring with an adult who is present with an expectant Mother; asking for their name and relationship or role, can result in a dialogue and rapport being created and possibly important information being shared. The opposite of this means information could be missed or another perspective on the situation ignored.

The Lancashire Safeguarding Children Board should request that an audit is conducted by relevant Health partners, with findings reported to the Board, to focus on records in maternity notes whether Mothers are accompanied and by whom.

Good Practice Identified

Good practice was identified during the review by professionals at the learning event and the Panel where professional commitment, persistence and professional curiosity resulted in an enhanced service:

- The newly involved health visitor made an immediate referral to Children's Social Care after being told about the previous sexual allegations to ensure risks to the new born LG and Sibling 1 had been appropriately assessed.

Conclusion

The findings of this serious case review do not indicate that the outcome of the case could have been predicted by any individual or organisation involved at the time. However, there were missed opportunities to assess the risks within the family predominantly caused by a lack of understanding of information sharing protocols in circumstances where safeguarding is an issue.

Scrutiny of practice always provides an opportunity to reflect on ways in which services can be further improved. As a result of the significant incident(s) involving Child LG there is an opportunity to develop an awareness raising programme to prevent similar injuries occurring and to offer support and advice to families. This will hopefully assist in the prevention of similar incidences in the future. This recommendation, together with others below, has been made based on the learning from the case.

Recommendations

In order to promote the learning from this case the review identified the following actions for Lancashire Safeguarding Children Board and its member agencies:

1. The Lancashire Safeguarding Children Board jointly with the Pan Lancashire Child Death Overview Panel, Public Health and Health partners should review relevant research, alongside consideration of the local context; in order to decide the most effective method to raise awareness with parents and families of the dangers of shaking a baby, and how to cope with an inconsolable crying baby;

Intended outcome: Parents and carers have clear information to enable them to consider their actions carefully when responding to and handling babies in challenging circumstances, to prevent incidents where risk of/ or actual harm could occur.

2. The Lancashire Early Help Board should consider leading a joint exercise with other Local Safeguarding Children Boards and relevant professionals to explore the development of a protocol which enables effective sharing of information on families moving across boundaries who are receiving early help services;

Intended outcome: Information regarding concerns and risks within families which has led to early help support in one area is appropriately shared across borders when families move to ensure continued and effective support is available if required.

3. Lancashire Safeguarding Children Board and the Safeguarding Children Boards in LA 1 and LA 2 should work with Education partners to ensure there is sufficient awareness in every education setting of information sharing protocols, including timescales for the effective sharing of school records when children move schools;

Intended outcome: Information is shared in a timely manner on all students who transfer between settings, particularly those affected by safeguarding concerns, in order that students and families can be supported and any risks can be managed appropriately.

4. The Chair of the Lancashire Safeguarding Children Board should ensure the Head of West Yorkshire Police Public Protection Unit is made aware of the findings of this serious case review in order that any relevant areas for development can be identified regarding the force's involvement with the family;

Intended outcome: The Police are able to identify any learning points from the investigation regarding Sibling 2 and the wider family and take appropriate action. This will ensure other similar enquiries are managed in a robust and timely way including when families move areas and across borders.

5. The Lancashire Safeguarding Children Board and the Safeguarding Children Boards in LA 1 and LA 2 should raise awareness of key information sharing requirements and explore ways of enhancing the confidence of all professionals regarding what information can be shared;

Intended outcome: All safeguarding professionals are aware of requirements and their obligations for sharing information and have confidence to appropriately share information and challenge others who are not adhering to information sharing protocols.

6. The Lancashire Safeguarding Children Board should (i) promote the use of the Pan Lancashire Multi-Agency Pre-Birth Protocol to ensure all relevant staff are aware of the requirements and are confident in considering use of the protocol when required. (ii) An audit should take place 12 months after part (i) is completed to compare data of pre-birth assessments undertaken before and since the recommendation was made;

Intended outcome: Knowledge and use of the pre-birth protocol is enhanced across Lancashire and the number of pre-birth assessments completed increases, improving the assessment of risks and needs, and overall outcomes of unborn babies.

7. The Lancashire Safeguarding Children Board should request that an audit is conducted by relevant health partners, with findings reported to the Board, to focus on records in maternity notes whether Mothers are accompanied and by whom;

Intended outcome: Data is gathered regarding the recording of names and roles of adults accompanying pregnant women to appointments. Areas for development regarding this expectation can then be identified and actioned ensuring improved communication with pregnant women and those accompanying them, and a fuller assessment of circumstances for unborn babies being obtained.

8. The Lancashire Safeguarding Children Board should ensure the Safeguarding Children Boards in the areas of LA 1 and LA 2 are aware of the findings of this serious case review in order that they may consider any further enquiries or scrutiny required regarding the involvement of local agencies with the family of LG in 2014/ 2015.

Intended outcome: The relevant Local Safeguarding Children Boards coordinates partner agencies in the local areas who were involved with LG's family to examine the learning themes highlighted within the LG serious case review and identify any appropriate actions to be taken for improved practice in the future.

References

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- Child K serious case review, Nottingham City Safeguarding Children Board, 2015
- Unexpected Death in Childhood, Sidebotham and Fleming, 2007
- Shaken Impact Syndrome, Bruce & Zimmerman, 1989
- Preventing Abusive Head Trauma Among Infants and Young Children: A Hospital-Based Parent Education Programme, Dias et al, 2005
- Shaken Baby Syndrome (Centre for Disease Control and Prevention: United States 2010
- The Children Act 1989
- Lancashire Safeguarding Children Board Safeguarding Procedures
- Keeping Children Safe in Education, Department for Education, March 2015
- Section 175 of the Education Act 2002
- Information Sharing: Guidance for practitioners and managers, HM Government 2008
- Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers, HM Government March15
- The Protection of Children in England: A Progress Report, March 2009
- The Triennial Analysis of Serious Case Reviews 2011 to 2014, Pathways to Harm, Pathways to Protection, Final Report, Peter Sidebotham, Marian Brandon et al, May 2016
- Multi-Agency Pre-Birth Protocol, Pan Lancashire Safeguarding Children Procedures, October 2012
- Child BW serious case review, Blackpool Safeguarding Children Board, 2016
- The Lancashire Continuum of Need and Thresholds Guidance
- Learning from Case Reviews: Summary of Risk Factors and Learning for Improved Practice Around ‘Hidden’ Men: NSPCC, March 2015.

Statement by Reviewer

REVIEWER
Amanda Clarke (Independent)

Statement of independence from the case
Quality Assurance statement of qualification

I make the following statement that
prior to my involvement with this learning review:-

- I have not been directly concerned with the child or family, or have given professional advice on the case.
- I have had no immediate line management of the practitioner(s) involved.
- I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.
- The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.

Reviewer (Signature)	***A.Clarke***
Name	**Amanda Clarke**
Date	**12th December 2016**
Chair of Review Panel (Signature)	**V. Evans**
Name	**Vicki Evans**
Date	**12th December 2016**

Annex 1

Terms of Reference
Serious Case Review Child LG

Introduction
This Review is being commissioned by the Chair of Lancashire Local Safeguarding Children Board (LSCB) in accordance with the learning and improvement framework for LSCBs described in Working Together to Safeguard Children guidance (HM Government 2015). The Serious Case Review will be undertaken based on concise Child Practice Review methodology in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi-agency Child Practice Reviews (Welsh Government 2012).

A multi-agency panel established by Lancashire LSCB will conduct the review and report progress to the Board through its Chair.

Membership will include an independent Lead Reviewer and representatives from key agencies with involvement.

Organisation	Role
Independent	Lead Reviewer
Panel Chair Lancashire Constabulary	Detective Chief Inspector, PPU, Development and Compliance Team
Children Social Care, Lancashire County Council	Quality and Review Manager
LA 1 Safeguarding Children's Board	Business Manager
East Lancashire CCG	Designated Doctor for Safeguarding
East Lancashire CCG	Named GP for Safeguarding Children
East Lancashire Hospital Trust	Safeguarding Children Practitioner
Lancashire Care Foundation Trust	Safeguarding Operational Lead Nurse
Lancashire Care Foundation Trust	Specialist Safeguarding Practitioner
Lancashire Constabulary	Review Officer
Lancashire Safeguarding Business Unit	Business Co-ordinator
Lancashire Safeguarding Business Unit	Business Support Officer
LA 2 Safeguarding Children's Board	Business Manager
Safeguarding, Inspection & Audit, Lancashire County Council	Early Support Education Co-ordinator

Timeframe for the review
The review will cover the timeframe of **10/06/2015 to 25/01/2016**. Any significant incident relevant to the case but prior to the start date of the timeframe may be included in the analysis completed by each agency.

Subject(s) of the review

Child LG

Significant others

Full Sibling- Sibling 1
Half Sibling- Sibling 2
Half Sibling
Half Sibling
Mother
Father

The purpose of the review is to: -

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the LSCB;
- Examine the effectiveness of information sharing and working relationships between agencies and within agencies;
- Examine the effectiveness of case handovers/transfers, information sharing and working relationships across borders;
- Examine inter-agency working and service provision, including quality of assessments, for the child and the parenting capacity of all possible carers within the child's family;
- Explore the consideration and use of early help processes, and whether this was effective;
- Determine the extent to which decisions and actions were focussed on the subject child, including decisions and actions made pre-birth;
- Explore whether thresholds applied regarding information and referrals relating to the family were appropriately considered, applied satisfactorily and whether responses were effective;
- Examine to what extent safe sleep and safe handling advice and support was provided to the carers, and what consideration was given as to who should receive such support;
- Explore whether "Think Family" principles and additional vulnerabilities were considered by all professionals working with the subject, the subject's family and extended family;
- Examine responses to, and the management of, non-engagement and non-attendance at appointments by family members;

- Examine the involvement of other significant family members in the life of the child, and family support provided to the subject family;

- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard children;

- Identify any actions required by the LSCB to promote learning to support and improve systems and practice.

Tasks specific to the review panel:

1. To set the time frame for the review, see above;

2. Agencies that have been involved with the child and family will provide information of significant contacts by preparing an agency timeline with a focus on the purpose and scope of the review, see above;

3. Other agencies/services may be asked to provide a timeline following review of the information provided;

4. Agency timelines will include a brief analysis of relevant context, issues or events, and an indication of any conclusions reached. Information about action already undertaken or recommendations for future improvements in systems or practice may be included if appropriate. A case summary may include any relevant additional background information from significant events outside the timeframe for the review;

5. Agency timelines will be merged to create a composite timeline and used by the Panel to undertake an initial analysis of the case and form hypotheses of themes;

6. A full and accurate genogram of the subject family will be prepared for the panel and to assist the learning event;

7. The Panel, through the Chair and Lead Reviewer will seek contributions to the review from appropriate family members and provide feedback to the relevant family members at the conclusion of the review process;

8. The Panel will plan with the Lead Reviewer a learning event for practitioners' to include identifying attendees and the arrangements for preparing and supporting them prior to the learning event and feedback following the event;

9. The learning event will explore hypotheses, draw out themes and key learning from the case including any recommendations for the development or improvement to systems or practice;

10. The Panel will receive and consider the draft SCR report prepared by the Lead Reviewer, to ensure that the terms of reference for the review have been met, initial hypotheses addressed and any additional learning is identified and included in the final report;

11. The Panel will agree conclusions from the review and an outline action plan and make arrangements with the Lead reviewer for presentation to the LSCB for consideration and agreement;

12. The Panel will plan arrangements for feedback to the family and the practitioners in attendance at the learning event and share the contents of the report following the

conclusion of the review, and before publication;

13. The Panel will take account of any criminal investigations or proceedings related to the Case;

14. The Chair of the LSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed. It is anticipated that there will be no public disclosure of information other than the SCR report for publication.