CUMBRIA LSCB
CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

September 2017

**Serious Case Review in relation to Children P**

Response from Cumbria Local Safeguarding Children Board (LSCB)

In April 2015, Cumbria LSCB began a Serious Case Review (SCR) in relation to the services that were provided to Children P and their family. The review scrutinised the work of the following agencies:

- Children's Services
- General Practitioner
- Cumbria Health On Call
- North West Ambulance Service
- Police
- Probation
- School
- Health Visiting Service CPFT
- School Nurse CPFT
- Child Adolescent Mental Health Service CPFT
- A&E North Cumbria University Hospital NHS Trust
- Maternity Services NCUHT
- Outpatients (Fracture Ophthalmology NCUHT)
- Children's Ward NCUHT
- Barnardo's Carlisle
- Royal Victoria Infirmary Newcastle

The full findings of the SCR are set out in the overview report which has been published alongside this response.

Given the practice considered in this review is some 4-8 years ago, a considerable amount has changed to improve practice across the LSCB and its member agencies, and the lessons and recommendations from this SCR are reflective of that.

I set out below how the LSCB has changed its practice since the period covered by this Review:

- Although two previous Ofsted inspections (in 2012 and 2013) gave Cumbria an "Inadequate" rating, Ofsted judged Child Protection in the Local Authority and the LSCB as 'Requires Improvement' in March 2015 (report May 2015).

- The Multi-Agency Safeguarding Hub (MASH), which did not exist at the time covered by this SCR, is now very well-embedded operationally and is providing multiagency MASH assessment ensuring that children are better supported. It has been continually reviewed and improved since it was put in place. This enhances the partnership approach to safeguarding children and the sharing of information. The MASH has been the subject of increased external scrutiny from DfE, Ofsted and other government departments with positive feedback.
- Improved use of Early Help Plans through Safeguarding Hub focus on supporting Early Help with better alignment of the assessment and planning processes and the development of Early Help Panels is ensuring step up and step down is both safe and appropriate.

In addition, I have asked for, and received, detailed assurances from the agencies who contributed to the review, as to the changed practice since the time of this Review. That information is available if required.

The table below sets out the main points of learning from the Serious Case Review for the LSCB and how the LSCB will ensure practice improves across all services for Children in Cumbria, with dates when impacts are expected to be realised.
The work to implement the recommendations and to monitor their impact on practice will become part of the long term work of the LSCB and member agencies. The implementation of these recommendations will be managed through the Board's Business Group and the long-term implications will be tested through the Board's Performance Management and Quality Assurance Group to evidence the expected impacts and these will be reported in the Board's Annual Reports.

**Gill Rigg**
Independent Chair – Cumbria LSCB
September 2017

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## LSCB RESPONSE

## THEME 1: Agencies responses to concerns of sexual abuse

| **Finding P1** |
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| In this case as the category of harm changed from sexual abuse to neglect, the sexual abuse was no longer explicit within the Child protection Plans for the children and therefore this became almost 'hidden' from practitioners. |
| **Lesson P1.1** |
| When a child protection plan category changes it is incumbent upon the conference chair to ensure that the new plan takes account of the history and any outstanding actions including assessments that have not been addressed within the previous plan. |
| **LSCB Context / Actions already taken/ LSCB Action** |
| • Current action plan owned by the LSCB focused on child protection numbers aimed at improving SMART planning, IRO oversight and avoiding loss of issues.<br>• Conference Chair (IRO) will take responsibility to ensure no CP plan will change category without formal agreement that previous risk factors have been mitigated. |
| **How will we know** |
| 1. The Local Authority will forward plan an audit of CP where category has changed during the lifetime of the plan to ensure that risks have been mitigated and that all information has been appropriately recorded. Results of this will be reported to the LSCB. |
| **Finding P2** |
| In this case there appeared to be a lack of knowledge and confidence in dealing with sexual abuse, which included recognising age appropriate sexual behaviour in young children |
| **Lesson P2.1** |
| Practitioners and managers must equip themselves with up to date knowledge of child sexual abuse including age appropriate sexual behaviour in children. |
| **Lesson P2.2** |
| A history of sexual abuse must be taken into account in risk assessments to determine the carer's ability to keep children safe. |
| **LSCB Context / Actions already taken/ LSCB Action** |
| • Training for front line managers has been undertaken<br>• Tools, policy and guidance have been amended to reflect this SCR<br>• Relevant E-learning packages are available on the LSCB website<br>**LSCB ACTIONS**<br>• LSCB to publish a 5 minute briefing on the subject of sexual abuse and signpost practitioners to relevant LSCB resources.<br>• Future Practitioner Forum to focus on sexual behaviour and development of children and associated vulnerabilities with input from the Cumbria SARC. |
| **How will we know** |
| 1. Evidence of practice change which will be tested through a future QAG audit to ensure use of policy and tools. |

## THEME 2: Interagency working to safeguard and assess risk in relation to parental alcohol and substance misuse

| **Finding P3** |
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| In this case the assessments appear to have been adult focussed with little attention to the impact of their issues on their parenting and safety of the children. |
| **Lesson P3.1** |
| Parental alcohol and substance misuse assessments should be multi-agency and practitioners must ensure that resultant plans are child focussed, timely, address the risks to children in order to effectively safeguard them. |
| **LSCB Context / Actions already taken/ LSCB Action** |
| • Parental alcohol and substance misuse learning now available via e-learning and face to face training through the LSCB<br>• LSCB and partner agencies have improved focus on voice of the child<br>• Children's Services has evidence of better SMART planning for children<br>**LSCB ACTIONS**<br>• LSCB to undertake a programme of awareness raising across the partnership of the effects of parental alcohol and substance misuse on the lived experience of children through Practitioner Forum and Newsletters over the coming 12 months<br>• Following the QAG audit that has been completed – deliver the final actions that were added to the LSCB Audit Tracker to evidence the impact of the learning. |
| **How will we know** |
| 1. SMART planning will evidence addressing adult alcohol and substance misuse<br>2. We will see evidence of closer working with adult alcohol and substance misuse teams and Children's Services<br>3. Analysis of Early Help Assessments, Referrals and contacts to the Hub will show increases in terms of children identified as living with parental alcohol and substance misuse<br>4. Improved outcomes for children and young people living with parental alcohol and substance misuse tested through a future QAG audit (2018) to follow up from the previous audit |

## THEME 3: Professional understanding of neglect to protect children

| **Finding P4** |
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| This case was characterised by chronic and extreme neglect within a highly dysfunctional family system. Professionals failed to take into account other risks facing the children that were heightened by the neglectful environment. |
| **Lesson P4.1** |
| Practitioners should consistently use chronologies and LSCB Neglect Tools to understand and assess the emerging pattern of risks over time. |
| **LSCB Context / Actions already taken/ LSCB Action** |
| • The LSCB has developed and published a Neglect Strategy, policy and tools and these were influenced by the findings of this SCR.<br>• Neglect Conference held in 2017<br>• Face to face learning is being rolled out through relevant mechanisms |
| **How will we know** |
| 1. We will see evidence of use and effectiveness of the neglect graded care profile in QAG audits – question to be added to relevant audit tools. |
| **Finding P5** |
| Risk assessment and analysis should have evidenced the lack of parenting capacity and in the absence of thorough assessment, plans drifted and there was a delay in decisive action to protect the children. |
| **Lesson P5.1** |
| Risk assessment, analysis and decision making in cases of neglect must be child focussed. |
| **LSCB Context / Actions already taken/ LSCB Action** |
| See 4.1 Above |
| **How will we know** |
| See 4.1 above |

## THEME 4: Granting Residence Order

| **Finding P6** |
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| In this case, the order was initially supported by the local authority however a number of troubling incidents preceded granting of the order, which should have alerted professionals to the fact that the order was not in the children's best interests. |
| **Lesson P6.1** |
| Where private law orders are supported by a local authority, managers and practitioners must continue to assess whether the order remains in the child's best interest and should this position alter, timely action must be taken to inform the court of the revised position. |
| **LSCB Context / Actions already taken/ LSCB Action** |
| • Children's Services have improved their PLO process<br>• Robust Legal Placement Panel now in place with good process, oversight and rigour<br>• Improved Court timeliness is now evident |
| **How will we know** |
| 1. Statistics will evidence improved court timeliness and decision making<br>2. Regular reporting into the LSCB from the Family Justice Board will show that Court processes continue to improve and there will be good evidence of improved outcomes for children |

## THEME 5: Multi-agency meetings

| **Finding P7** |
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| In this case, in the face of longstanding and apparently overwhelming adult problems in this family, it is questionable whether those in attendance at multi-agency meetings, effectively scrutinised, update and implement the child protection plans. |
| **Lesson P7.1** |
| Multi-agency meetings are an essential part of the child protection planning process and therefore multi-agency professionals must ensure that the child protection plan is child focussed and implemented as a detailed working tool. |
| **LSCB Context / Actions already taken/ LSCB Action** |
| See P1.1 above |
| **How will we know** |
| See P1.1 above |

## THEME 6: Interagency working to safeguard and assess risk in relation to domestic abuse between parents

| **Finding P8** |
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| The family dynamics were characterised by domestic abuse which was well known to professionals. The relevance of the significant age difference between the teenage (under 18) mother and older father, and the apparent power imbalance, which together with other risk indicators should have alerted professionals to the lived experience of the child. |
| **Lesson P8.1** |
| Practitioners should assess the risk of domestic abuse in teenage (under 18) intimate relationships to take account of factors such as: intergenerational domestic abuse, older partners, teenage parent's exposure to sexual, physical, emotional abuse and neglect |
| **Lesson P8.2** |
| Where the victim of domestic abuse is a teenager under 18, all agencies should always consider a referral to Early Help or MARAC, and MARAC decision-making must reflect the increased risk for this age group |
| **LSCB Context / Actions already taken/ LSCB Action** |
| • The Domestic Abuse Training Programme has been updated and includes age/power imbalance in relationships<br>• LSCB has a Domestic Abuse Subgroup which links to Safer Cumbria to ensure Cumbria's Domestic Abuse agenda is appropriately addressing the needs of children<br>• The LSCB has completed a programme of awareness raising to highlight the refreshed Domestic Abuse procedures and tools leading to a better understanding of Domestic Abuse for 16/17 year olds<br>• MARAC to complete an audit of 16/17 year olds and report the findings to the LSCB to include any issues with practice or gaps in services that may be apparent |
| **How will we know** |
| 1. There will be an increase in the number of 16/17 year olds being referred into MARAC |
| **Finding P9** |
| In this case the mother of the children was 17 when she first became a parent. In spite of what was known about her history and childhood experiences, consideration was not given to her own needs as a child. |
| **Lesson P9.1** |
| Professionals working with parents who are under 18 years of age should use family history, chronology and genealogy to identify patterns of risk to ascertain whether the parent should have their own plan addressing their needs as an individual child beyond an assessment of their parenting capacity – threshold decisions must be documented for both the parent and their child(ren) |
| **LSCB Context / Actions already taken/ LSCB Action** |
| • The LSCB has included the use of family history and context in its training, newsletters and other multi-agency communications. (linked to Child N)<br>• The multi-agency LSCB Quality Audits templates now include how history and family context has been used in assessments to ensure that this is being reflected in current practice. (From September 2016)<br>• The LSCB Local Protocol for Assessment to be amended to include the need for an |

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| individual plan for parents who are under the age of 18, at Early Help, CIN or CP depending on level of need (decisions to be documented against both the parent and child) based on their needs as a child.<br>• The links between this case and the Child E SCR are apparent and the LSCB will consider a review of cases where children who are known to services become parents to ensure that they has been assessed in their own right and lessons from the review have been taken into account. (QAG Audit 2018-19) |
| **How will we know** |
| 1. All parents who are under 18 with whom professionals are already working with will have an assessment based on their needs as a child. Any threshold decisions will be well-document for both the parent and the child. The number of parent (under 18) who supported on a plan will increase at all threshold levels. |

## How we will disseminate and evidence the learning

| Dissemination of the Learning | Specific Actions | Subgroup(s) or single agency | Deadline | Expected Impact and how it will be tested |
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| The LSCB will ensure that the lessons identified in this SCR are publicised, included in learning materials and disseminated throughout the practioners in the LSCB | Training materials will be reviewed to ensure the lessons are included.<br><br>Policies and procedures (P&P) will be reviewed to ensure the lessons are included | Learning & Improvement Subgroup<br><br>Policy and Procedures group Subgroup | October 2017<br><br>August 2017 | Practitioners should use the lessons from this review in their everyday interactions with children, young people and their families<br><br>The LSCB conducts regular surveys of staff and will include a question to ascertain how well the lessons from this review are known, understood and being addressed in practice. |
| | The website will be updated to reflect the lessons from this review. | Communications and Engagement Subgroup | Sept 2017 | |
| | A specific newsletter will be published to cover the lessons from this review and other recent SCR | | Sept 2017 | |
| | The LSCB will conduct a number of workshops and a conference to raise the profile of the lessons in this and the other SCR being published. | | Through-out 2017-18 | |
| | Assurance will be sought from all agencies that the lessons from this SCR are being used – this will be done through the 2017-18 Safeguarding Audit (Section 11) | Performance Management and Quality Assurance Group | July 2018 | |