CUMBRIA LSCB
CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

13 June 2016

**Serious Case Review in relation to the death in 2012 of Child N.**

Response from Cumbria Local Safeguarding Children Board (LSCB)

In May 2014, Cumbria LSCB began a Serious Case Review (SCR) in relation to the services that were provided to Child N and/or her family. This review should have commenced at an earlier point, but the application of the threshold criteria had been misunderstood. This case was reviewed by the incoming LSCB Chair in March 2014 and the review then commenced. The review reviewed the work of the following agencies:

- University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) – which provided midwifery, child health and emergency department services
- GP Medical Practice – which provided primary care support to Child N and her family
- Schools and Early Years services
- Children's Services – which provide Social Care Support prior to 2007
- Cumbria Partnership Foundation Trust (CPFT) – which provided Community Health Services for Children, including Health Visiting Services
- Cumbria Police - prior involvement

The full findings of the SCR are set out in the overview report which has been published in full alongside this response. The publication of this report was delayed in order to ensure that it did not prejudice the criminal investigation and other proceedings into Child N's death. As indicated above, there was a delay in the initiation of an SCR in this case – this is explained in the report and I would confirm that that the LSCB has significantly improved its SCR processes to ensure that this would not happen in the future. In particular:

- The Case Review Subgroup (the subgroup of the LSCB responsible for making recommendations for SCR) is now jointly chaired by a senior Police Officer and the Designated Nurse for Safeguarding from Cumbria Clinical Commissioning Group – this helps to assure ourselves that there is excellent oversight of all cases and that decisions are taken appropriately
- Where the senior officer from any agency has also had dealings with a case being considered by the Case Review Subgroup, the member removes

themselves from the meeting and another officer attends – this ensures that there is no conflict of interest.

- The chair of the subgroup then writes to myself as the Independent Chair of the LSCB with the recommendation from the subgroup, which I then consider, and usually ask another chair from another LSCB to "peer check" my decision, to ensure consistency and impartiality. This happens for cases where a decision has been taken to undertake a SCR, and also where my decision is that the case does not meet the criteria for a SCR.
- These decisions are then communicated to the Department for Education for consideration and ratification by the National Panel of Experts.

Given the practice considered in this review is some 4-5 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 Child N's death:

- Although two previous Ofsted inspections gave Cumbria an "Inadequate" rating (covering the time that Child N died) Ofsted judged safeguarding in both the Local Authority and the LSCB as 'Requires Improvement' in March 2015 (report May 2015).
- Agencies are now working to a revised Working Together document published in March 2015. This has an increased focus on the definition of seriously harmed for the purpose of making a decision regarding SCRs
- The SCR report references that Child N's mother may have been sexually exploited aged 15. Knowledge and recognition of Child Sexual Exploitation, both nationally and in Cumbria has grown significantly since 2000 and it is possible that if the abuse had been recognised then agencies would have made an appropriate response. (See Ofsted Report May 2015 p12)
- The Multi-Agency Safeguarding Hub (MASH) is now operational and is providing multi-agency 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 visited recently by myself as the Independent Chair of the LSCB, and I was very positive about its progress, and it has also been the subject of external scrutiny 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

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 Child N's tragic death. 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
2nd June, 2016

## LSCB Action plan response

## THEME 1: Recognising and assessing Risk and Need

| **Finding N1** |
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| Complexity of risk and need is not always obvious within a family. However Child N's mother had experienced significant historical traumas and loss which were, in themselves, clear indicators that her parenting may have been compromised and that her children could be at risk. (N1) |
| **Lesson N1.1** |
| Professionals working with pregnant and new mothers need to consider the long term impact of unresolved childhood trauma and abuse on future parenting capacity. |
| **LSCB Actions** |
| The LSCB will conduct a thematic review of the CLA cohort of girls with a specific focus on a) preventing teenage pregnancy and b) where girls do become pregnant developing and adapting new ways of working which would include consideration of therapeutic interventions, family fostering arrangements, and highly personalised gender specific and tailored support packages for mothers who have been looked after and/or experienced neglect, trauma and abuse. (July 2016)<br><br>The LSCB will complete an audit of 3 families with a similar profile to Child N's family to see how parenting capacity is being assessed and responded to. (October 2016). The LSCB will ensure that single agency activity continues to be implemented. |
| **How will we know** |
| The results of the audit and the review will show how need, risk and parenting capacity is assessed and responded to appropriately for this most vulnerable group. |

| **Finding N2** |
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| The use of family history, chronology and genealogy to identify patterns of risk should be promoted through multi-agency partnerships and used at the earliest opportunity. (N2) |
| **Lesson N2.1** |
| Professionals should use family history, chronology and genealogy to identify patterns of risk |
| **LSCB Actions** |
| The LSCB will seek assurance that all agencies have reminded front-line staff and supervisors that they must always take into account the family history and context and how they have done this. (June 2016)<br><br>The LSCB will include the use of family history and context in its training, newsletters and other multi-agency communications.<br><br>The multi-agency LSCB Quality Audits templates will include how history and family context has been used in assessments to ensure that this is being reflected in current practice. (From September 2016) |
| **How will we know** |
| The multi-agency audit will show that cases include a good re-assessment that is timely, gather multi-agency information, inform decision-making and take account of historic context of the family. |

| **Finding 2** |
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| Injuries to immobile infants were treated in isolation |
| **Lesson N2.1** |
| When immobile infants are presented multiple times with what appear accidental injuries – professionals should consider further enquiries and/or a Child Protection Referral, and/or an Early Help Assessment (EHA). (It is worth noting that should an EHA be considered and parents/carers refuse to co-operate and any help and support offered that in itself may raise the level of concern). |
| **LSCB Actions** |
| The LSCB will review and refresh our policy regarding injuries to immobile infants to include an early help response. (August 2016). (N3)<br><br>Each LSCB agency is compatible with and reflects the revised LSCB Policy on injuries to immobile infants, and assurances will be sought as to the implementation of this (July 2016).<br><br>The LSCB will forward plan an audit for early 2017 to test this policy is being used at early help and that it is having appropriate impacts. (March 2017) |
| **How will we know** |
| Assessment and response to injuries on immobile infants will be appropriate and ensure that children are safeguarded. |

## THEME 2: Responding to Risk and Need

| **Finding 3** |
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| In this case there was very little professional curiosity and scepticism around fathers and other males who associated with changing, high need or complex families particularly where there has been a history of sexual exploitation or abuse. |

| **Lesson N3.1 (Linked to L2.2)** |
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| Multi-agency assessments should include understanding of the whole family and regular visitors to the home, alongside observations of multi-agency professionals who are involved with the family. (Single Agency) |
| **LSCB Actions** |
| Using the learning from this serious case review – the LSCB will ask agencies to confirm that practitioners demonstrate professional curiosity and scepticism around males who are associated with high need or complex families particularly where there has been a history of sexual exploitation or other forms of abuse. This approach would also need to be responsive and recognise the dynamic nature of need and risk in the context of a rapidly growing family where there have been a number of male partners/ fathers. Despite the fact that no risks were identified in this case, relevant LSCB partners will develop guidance for 'cause for concern triggers' between agencies to ensure that triggers are commonly understood and standard responses are described. (N5)<br><br>The LSCB will refresh the current protocol for requesting information regarding family (household) members and significant regular visitors – the check is currently undertaken by the police, the LSCB to consider using the Early Help Panels, Early Help Team and/or the Safeguarding Hub. (LSCB Business Group) (September 2016) (linked to L2.2)<br><br>The LSCB will include a further question in its audits to evidence that significant adults who are involved in the lives of children are identified and assessed as part of the assessment and planning for the children. (to be included in template from June 2016) (linked to L2.2) |
| **How will we know** |
| Audits will show that significant adults who are involved in the lives of children are identified and assessed as part of the assessment and planning for the children. (linked to L2.2) |

## THEME 3: Support and Supervision

| **Finding 4** |
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| In this case there was little understanding of the need and risk in women with MCN's profile such as mothers who have own child removed and a large number of subsequent children – this could have been discussed through supervision and reflective support. |
| **Lesson N4.1** |
| Use reflective techniques in supervision to ensure that complex and changing family dynamics are continually considered |
| **LSCB Action** |
| The LSCB will seek assurance regarding single agency mechanisms and quality assurance of supervision. (September 2016)<br><br>The LSCB will continue to support multi-agency opportunities for Health Visitors, social workers and midwives to meet and discuss thematic and case issues through Practitioner Forums and Early Help Panels ensuring that they have access to extended/enhanced supervision and multi-agency group support. (N7) (ongoing through the LSCB Business Plan).<br><br>In particular Practitioner Forums and Early help Panels will use the learning from this serious case review to provide opportunities for frontline practitioners and their supervisors to further their understanding of need and risk in women with MCN's profile such as mothers who are care leavers, own child removed, a large number of subsequent children.(N6) (ongoing through the LSCB Business Plan) |
| **How will we know** |
| The LSCB conducts regular surveys of staff and will include a question to ascertain how well this is being addressed in practice (Jan 2017) |

**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 |
|---|---|---|---|---|
| The LSCB will ensure that the lessons identified in this SCR are publicised, included in learning materials and disseminated throughout the practitioners 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 &Procedures Subgroup | **October 2016**<br><br>**August 2016** | 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.<br><br>A specific newsletter will be published to cover the lessons from this review and other recent SCR<br><br>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. | Communications and Engagement Subgroup | **August 2016**<br><br>**Sept 2016**<br><br>**Through-out 2016-17** | |
| | Assurance will be sought from all agencies that the lessons from this SCR are being used – this will be done through the 2016-17 Safeguarding Audit (Section 11) | Performance Management and Quality Assurance Group | **May 2017** | |