June 2019

Serious Case Review in relation to Child BE

Response from Cumbria Local Safeguarding Children Board (LSCB)

In March 2017, Cumbria LSCB began a Serious Case Review (SCR) in relation to the services that were provided to Child BE and their family. The review scrutinised the work of the following agencies:

- Children's Services
- General Practitioner
- Cumbria Health On Call
- North West Ambulance - 111Service
- Police
- Health Visiting Service Cumbria Partnership Foundation Trust (CPFT)
- Central Manchester University Hospitals
- University Hospitals of Morecambe Bay

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

There has been a delay in the publication of this SCR due to ongoing legal proceedings. Given the practice considered in this review is now from 2 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.

The table below sets out the main points of learning from the SCR 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 (PMQA) Group to evidence the expected impacts and these will be reported in the Board's Annual Report and its successor annual reports.

Gill Rigg
Independent Chair – Cumbria LSCB
June 2019

LSCB RESPONSE

THEME 1: Effectiveness at Multi-agency meetings

Finding BE1
Key information was not shared across the professional network involved with the child and family. There were missed opportunities to share information which would have enabled key agencies to understand the risk to Child BE. Discussions about risk centred around the older siblings. **The centrality of communication and information sharing to effective safeguarding practice was identified in this case. Information was missing, not sought, or withheld, compromising the effectiveness of assessments and planning, Some of the agencies involved with the family were unaware of Child BE's Child in Need status.**
Recommendation BE1
The LSCB should seek assurance regarding processes to support Child in Need planning. This should include invitations, the sharing of plans and minutes and recording systems and the sharing of assessments between agencies.
Lesson BE1.1
Risk was assessed using a variety of tools within different agencies; a more in depth risk assessment should have taken place. The agencies across the LSCB should use a common approach and an agreed tool to assess where Domestic Abuse is a factor.
Lesson BE1.2
Multi-agency meetings were taking place but the purpose of the plan and the follow up of key actions were missed**.** This case highlighted inconsistencies in the way meetings are recorded and inadequate assessment of risk.
LSCB Context / Actions already taken/ LSCB Action
LSCB to conduct a Child in Need Multi-agency audit concentrating on Step up and step down to and from Child in Need) and Early Help (EH). The LSCB has agreed to embed the Domestic Abuse Risk Assessment Tool for Children, (DARAC) which is a child focussed tool.
How will we know
The use of DARAC and Domestic Abuse, Stalking and Honour Based Violence (DASH) will be evident in the audits and assessments. Multi-agency audit will demonstrate information sharing and involvement with all relevant agencies.

THEME 2: Quality of Assessments

Finding BE2
Due to Child BE's very young age the majority of the information that could be used to make an assessment of risk to him pertained to his family history. In this case the history was long and complex, involving children of other relationships. Assessments were based on self-reporting rather than making assessments on recorded history.
Recommendation BE2
The LSCB takes into account in its learning from this case the key points from this case as directly related to Child L and Child N in taking account of: i) The link between parents and their previous relationships for all children of the household in assessments ii) The use of genograms (as highlighted in the Signs of Safety methodology as endorsed by the LSCB)
LSCB Context / Actions already taken/ LSCB Action
LSCB to seek assurance from partners regarding the possibility of evidencing or measuring this, or mitigation to ensure this is appropriately considered. Specific question to be added to Quality Assurance Group (QAG) audit templates for all audits. The LSCB will continue to implement Signs of Safety across the partnership.
How will we know
The Multi-agency audits will show that cases include a good assessment that is timely, gather multi-agency information, inform decision-making and take account of historic context of the family.
Lesson BE2.1
On completion of a Child in Need Plan professionals must consider who else needs to know this information. The analysis that is used to inform assessments should also be shared with other professionals that are involved with the family.
Lesson BE2.2
To be effective, assessments must incorporate both information gathering and analysis of that information to understand risk and to formulate effective plans.
LSCB Context / Actions already taken/ LSCB Action
LSCB will publish a newsletter following the publication of this review – including a lesson regarding the importance of sharing analysis to inform assessments. LSCB to consider the "Guidance for conferences/reviews" and expand this to Team Around the Family (TAF) and Child in Need meetings. LSCB to further embed training and support in analysis and decision making.
How will we know?
Multi-agency 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.

THEME 3: Lack of focus on the child

Finding BE3
In this case there was a lack of focus on Child BE. Eliciting the voice of BE's siblings was a priority. Due to the complex history and needs of the parents the practitioners' dominant focus became the parents.
Recommendation BE3
The LSCB should make arrangements to disseminate key messages from this review as widely as possible, including:- ➢ Managers considering the impact of holiday periods and absence on services and on-going pieces of work ➢ Curiosity / challenge of parental accounts ➢ Allowing parents agenda to deflect from safeguarding aims ➢ Seeking the support of safeguarding leads when resolving professional disagreement ➢ Injuries to non-mobile infants should always be reported to Children's Social Care regardless of a plausible explanation being given
Lesson BE3.1
Without professional curiosity professionals fail to recognise risks and the focus shifts away from the child and onto the parent.
Lesson BE3.2
Effective safeguarding supervision needs to balance support and challenge and is facilitated by systems for clearly recording and reviewing concerns relating to individual children.
LSCB Context / Actions already taken/ LSCB Action
A great deal of single agency learning has been brought forward regarding transition between midwife and health visitor, centile charts and genograms, The ophthalmology emergency eye clinics now use the non-mobile baby screening tool for direct admissions that have been sent from the community. Improvements have also been made to arrangements for safeguarding training and safeguarding supervision, which is pleasing to note. **<u>Actions</u>** LSCB will publish a newsletter/5 minute briefing following this review which will include the links to the relevant LSCB policies such as; disguised Compliance; Immobile Infants and Escalation Policies. Practitioner Forums to use this SCR as a basis of one of their rounds of meetings.
How will we know
Practitioner survey will demonstrate an increase in effective supervision. Multi-agency audit will see an improvement in management oversight.

THEME 4: Trigger Trio

Finding B4
Domestic abuse, substance misuse and parental mental health issues were prevalent in this serious case review. There were some concerns linked with historical information about domestic abuse however, practitioners were not always rigorous in assessing and following through on all identified risks including domestic abuse. Living with Domestic Abuse is harmful to children.
Learning B4
There is cumulative risk of harm to a child when different parental and environmental risk factors are present over periods of time. These include; ➢ Domestic abuse ➢ Parental mental health problems ➢ Drug and alcohol misuse ➢ Adverse childhood experiences ➢ A history of criminality, particularly violent crime
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. ➢ LSCB training on DARAC. ➢ LSCB and partner agencies have improved focus on voice of the child **<u>Actions</u>** LSCB to further embed the understanding of the impact of the effects of parental alcohol and substance misuse, domestic abuse and parental mental health on the lived experience of children.
How will we know
Audits will evidence the use of the DARAC. Assessments will identify the cumulative effects on the child.

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. Policies and procedures (P&P) will be reviewed to ensure the lessons are included	Learning & Improvement Subgroup Policy and Procedures group Subgroup		Practitioners should use the lessons from this review in their everyday interactions with children, young people and their families 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		
	A specific newsletter will be published to cover the lessons from this review and other recent SCR			
	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.			