NORTH EAST LINCOLNSHIRE SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD L

CONTENTS

SECTION ONE - INTRODUCTION

1.1 Purpose of the Serious Case Review

This Serious Case Review (SCR) was commissioned by North East Lincolnshire Safeguarding Children Board (NELSCB) following a life threatening head injury causing permanent brain damage to a 22 month old girl referred to as child L. Child L is the third of four children having two older half-sisters and one younger brother. The family was known to several agencies within NEL. The purpose of this SCR was to examine the effectiveness of services provided for Child L and her half siblings; establishing how well agencies worked together and to identify deficits and lessons that can be learned to better safeguard other children.

1.2 Initiation of the Serious Case Review (SCR)

Following a recommendation by the NELSCB SCR Subgroup in April 2014, the Independent LSCB Chair, Sue Woolmore took the decision to commission an SCR under the criteria set out in Section 5 (2) (a) and (b) (I) LSCB Regulations 2006 and Working Together to Safeguard Children guidance, 2013, and the NELSCB Safeguarding Board Procedures as follows:

- *"Abuse or neglect of a child or young person is known or suspected and*
- *The child or young person has died or 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 or young person".*

The Department for Education (DfE) and the National SCR Panel were duly informed and a lead reviewer author, Mr Stephen Ashley, identified. Mr Ashley has extensive experience of conducting high level enquiries and reports into child protection, working as a senior police officer for thirty years and more recently working within Her Majesty's Inspectorate of Constabulary. In accordance with guidance, Mr Ashley is independent of NELSCB.

1.3 Terms of Reference

1.3.1 Subject of review

The main subject of this review is **CHILD L.** The period reviewed was from May 2012 to January 2014 and spans the time during which involvement with the family went beyond universal activity up to the date when Child L was injured. Whilst this was the scoped review period, relevant and contextual information falling outside of this timeframe was also included.

1.3.2 SCR Panel

A review panel was established and was consulted throughout to check progress of the review and to provide further information where required. The panel included a lead member from each of the following key agencies:

- A senior manager from North East Lincolnshire Social Care.
- A detective chief inspector from Humberside Police.
- The Designated Nurse for Safeguarding Children.
- Head of Safeguarding, Northern Lincolnshire and Goole NHS Foundation Trust.

- The Business Manager of the Local Children Safeguarding Board.

1.3.3 Methodology

This SCR considered all available evidence and included the views of frontline practitioners. The methodology was adapted to suit the circumstances of this review focusing on how well systems had worked, and where they could be improved.

1.3.4 Specific criteria identified:

1. To cover in detail the period from May 2012 to end January 2014.
2. To establish what information was available to the various agencies and how this information was used and shared between professionals
3. To consider risk assessment processes that were used following contacts with Child L and her siblings as part of the child protection process
4. What Early Help was available to the family
5. How agencies considered the information at their disposal to enable them to build a complete picture of the family unit and the risks posed by individuals within it
6. The degree to which agencies considered the voice of the child in decision-making
7. To consider how agencies have shaped services to deal with complex family units

1.3.5 Agency involvement

The following key agencies submitted detailed chronologies supported by a covering report:

- North East Lincolnshire Children's Social Care
- Humberside Police
- General Practitioners
- Open Door
- Education
- North East Lincolnshire Council, Children's Health Provision
- Northern Lincolnshire and Goole NHS Foundation Trust
- Children's Centres

1.3.6 Parallel Investigations

Throughout the SCR, Humberside Police were conducting criminal investigations. Full cognisance was taken of Crown Prosection guidance for dealing with potential witnesses and the author liaised regularly with police to avoid compromising criminal investigation.

1.3.7 Other Family members

Half-sister to Child L – **Child M**
Half-sister to Child L – **Child N**
Full brother to Child L – **Child O**
Mother of all 4 children – **ML**
Father of Child L and O, and partner of ML – **MP**
Father of Child M – **FM**
Father of Child N – **FN**

1.3.8 Family Engagement

Unusually there was no engagement with the parents of Child L. Invitations were sent to key family members, including parents and grandparents, to participate in the review but no replies were received. Further invitations were sent some months later but again no replies were received.

SECTION 2- BACKGROUND TO THE REVIEW

2.1 Summary of Multi-agency activity: Child L and her siblings were known only to universal services up until May 2012 but between 2009 and 2014 the family lived at 5 different addresses. Following a non-accidental injury to Child M in June 2012, Children L, M and N were made subject to a Child Protection Plan, initially under the category of physical harm, later changing to emotional harm until March 2013. After March 2013, all of the children (Child O being added on his birth) became subject to a Child in Need (CIN) Plan until January 2014, at which point the case was closed to Children's Social Care.

Professional interventions and contacts with Child L and her family were numerous, and involved various agencies, initially at universal level in respect of child M and N, and later at child protection level. This period was followed by provision at Child in Need level for child L and her siblings. The most significant events and episodes have been summarised below.

2.2 Significant episode 1 – injuries to child M: 2nd May 2012 – at the age of 3 ½ Child M was referred to Paediatrics by the General Practitioner (GP) following attendance with swelling to her face. ML's claims that the injuries occurred accidentally appeared plausible and Child M was discharged home. When child M was seen the following day with ML and Child L for L's immunisations, a black eye was noted to Child M. ML explained that Child M had already been seen at hospital and the injuries were caused when Child M had "temper tantrums".

ML was advised to speak to the health visitor and the practice notified the health visitor (HV). The black eye was subsequently reported 'anonymously' to Children's Social Care. The HV liaised with the caller and shared information about the injury and action already taken.

21st May 2012: Child M attended Accident and Emergency (A&E) with a cut to her chin. ML again explained that the injury had occurred during a "temper tantrum". No referral was made to Children's Social Care and the injury was not connected to the previous occurrence.

25th May 2012: A practice nurse referred concerns to Children's Social Care following Child M attending the surgery (for removal of steri-strips to chin). MP was observed to verbally abuse Child N, calling her a "bastard" and using the "F word" to her. On being challenged by the practice nurse, ML felt that MPs behaviour was acceptable as Child N had been "answering back". In addition to the observed behaviour, the practice nurse advised the Social Worker that the HV had that day, made a visit to the family home and ML was unable to satisfactorily explain Child M's recent injuries. Following the referral, Children's Social Care made a number of failed visits, continuing to attempt to see Child M up to 12th June.

12th June 2012: Child M attended A&E with a swollen arm. ML said she had fallen off some bins the previous day. ML had placed the arm in a sling and given Child M Ibuprofen. Examination revealed a fracture to the arm that may have been from an injury of 1-2 weeks earlier. This was referred to Children's Social Care and section 47 strategy meeting followed. Child M was placed with extended family and medical examinations subsequently confirmed that the fracture had occurred between 1 to 2 weeks earlier. It was further identified that child M also had a number of old bruises to the head and police commenced investigations.

On the 6th July 2012 an initial case conference took place and Child L, M and N were placed on a Child Protection (CP) plan at risk of physical harm. On 31st August a review case conference decided that Child M and N would remain on the CP plan, at risk of emotional harm. The category changed as both children were by then living with their respective fathers. Child L remained on a plan for physical harm as she was placed with Maternal Aunt whilst it had been agreed that her parents would continue to have supervised access.

During October and November a number of child protection visits and Core Groups took place. MP attended hospital following a suicide attempt and was referred to Open Minds for mental health issues. ML had also threatened suicide but it remains unclear whether this threat was serious. The police were called to her address by a friend concerned for her welfare but she was found safe and well. Both MP and ML voluntarily engaged in various programmes, including stress management, health and safety classes and 'on-line' Triple P parenting programme, which they reported having completed but which was 'unsupervised'.

2.2.1 Significant episode 2 - Children Return Home 2: On 6th December 2012, Children's Social Care recorded a decision that Child L, M and N could return to their parent's care, based on there having been no further referrals and both parents having made efforts to improve their parenting capacity. FM refused to agree for Child M to return, so she remained with her father. Child M was asked by a social worker if she wished to return but she stated she did not want to return to the care of her mother and MP because: "*MP is naughty*". The week before Christmas, ML informed social care she was pregnant.

A number of social work visits took place during January 2013 and on 8th February 2013, a Core Group meeting was held that concluded there were no concerns regarding Child L, parents were engaging with services and whilst there were concerns around Child N's progress at school, these were being addressed. FM was refusing to allow contact between Child M and ML and consideration being given to formal mediation and potential legal proceedings. Over the next few weeks the family engaged with the Family Resource Service. They were also preparing to move home and engaged in meetings around contact with Child M. MP was reportedly on a training course and seeking employment.

2.2.2 Significant episode 3 - Stepping Down from Child Protection Plan: 20th February 2013 a Child Protection Review Conference took place. There was a split decision by professionals so the conference was re-convened 10 days later to review the case. At the reconvened conference, professionals again failed to agree. At this point, the family was undertaking direct and intensive work with the Family Resource Service (FRS) and a strategy meeting had also been held for the unborn Baby O.

A further Case Conference was held on 27th March where a unanimous decision was reached to remove Children L, M, N and unborn Baby O from the Child Protection Plan to be managed at CIN level. Family Resource Services continued intensive work with the family until the end of October 2013.

In May 2013 Child L's parents married and moved house, remaining in Grimsby. On the 28th May Child O was born and went to live at home with his family. Intensive work continued with the family until the end of the year. Child O regularly attended post-natal clinics and received universal services. The Children and Family Court Advisory and Support Service (CAFCASS) was engaged with the family regarding the ongoing dispute over residency of Child M.

On 13th October 2013 a Directions Hearing took place at Grimsby County Court. The social worker had completed a court report and recommended that a residence order should be granted in favour of ML, with FM being awarded contact rights. The court supported the recommendations but with the parents having shared residence of Child M, living with ML and staying with FM on alternate weekends. FM did not oppose this ruling.

18th October 2013: Family Resources Services (FRS) held a meeting with the family and in light of the progress made by ML and MP it was agreed that FRS role would end. On the same day, staff working at Child M's nursery reported comments and disclosures by Child M that she did not want to return home because she was afraid MP would hurt her. A CIN meeting was held where it was agreed that Child M should however be returned home to ML as planned. The social worker attended nursery and spoke to Child M who made a number of allegations of assault by MP on previous occasions. These were discussed with the police but no action considered necessary. Child M was returned to the care of ML that weekend. On the 25th October 2013 FRS formally ended involvement with the family.

2.2.3 Significant episode 4 Child in Need (CIN) Case Closure: 3rd January 2014, Child L attended A&E with a leg injury that parents attributed to a fall down *four carpeted steps*. Hospital data systems failed to link Child L with other injuries to siblings, nor did it alert staff to Child L's CIN plan. Following examination Child L was discharged to her parent's care.

6th January 2014 Child O attended GP for a respiratory infection. Two days later he missed his 7-9 month assessment. The same day ML visited her GP complaining of poor appetite, sleeping problems and depressed mood. No links were made with the children's issues.

17th January 2014 at a CIN meeting attended by health visitor, Child N's school and Social Care, it was noted there were no concerns raised during home visits and the children were developing normally. It was acknowledged that Child L had recently attended A&E with a leg injury having 'fallen down the stairs', but no concerns noted. It was also noted that Baby O had missed his health check. All parties present agreed the case should be closed with no further support. The case was closed 7 days later on 24th January.

2.2.4 Significant episode 5 - Injuries to Child L: On 27th January Child L was admitted to A&Ewith a significant life threatening and life changing head injury. Examination revealed a healed fracture of right femur, healed fracture of right clavicle, compression fractures of several lower thoracic vertebrae, bruising to the lower back and a number of severe injuries representing at least two episodes of trauma separated by months. A Strategy meeting was held the following day and a police investigation was launched. All of the children were removed from the care of ML and MP.

SECTION 3 - FINDINGS

3.1 Overall Finding: The Finding of Fact found Child L to have been grievously injured by one or both parents violently assaulting her. The SCR found a combination of failings within safeguarding systems and by individuals that led to Child L being insufficiently protected from abusive treatment received whilst in the care of her parents. Despite some contextual mitigation surrounding the ineffectiveness within the systems, it was failures to share information, naïve professional practice and failure to comply with guidance and procedures that collectively led to insufficient safeguards being put in place for Child L and her siblings.

3.2 The Voice of the Child: This review has established that the 'voice of the child' was given insufficient weight and took second place to the express needs and wishes of the carers. This led to flawed decision-making that failed to take account of children's express concerns.

3.3 Family Support: The provision of support for the family was uncoordinated, a Common Assessment Framework (CAF) was not completed and at no time was a 'Think Family' approach taken to ensure that the needs both of adults and children were consistently met.

3.4 Police Investigation: The police investigation was flawed. Decision-making was taken at a 'low level' and failed to involve Crown Prosecution Services. The manner in which decisions were shared with other professionals was poor and impacted adversely on the way in which the case was managed. This, combined with how other agencies interpreted police decisions, impacted significantly on subsequent case management by professionals and ultimately also on the final outcome for Child L.

3.5 The Planning, Assessment, Process and Governance System: Legislative requirements, expectations on individual services and the basic principles of safeguarding and promoting the welfare of children prescribed in guidance were too often either overlooked or ignored.

3.6 Confirmation Bias: The case handover by social work to support services was inadequate, adopting an over-optimistic assessment of risk and need, rather than a balanced judgement.

3.7 Communication: despite evidence from interviewing professionals and learning events that good working relationships existed in NEL, this needed improving, particularly within the context of information sharing and the understanding and conduct of strategy meetings.

3.8 Professional Curiosity: Whilst there were several instances of practitioners conducting themselves professionally, they often failed to take 'the next step' or engage professional curiosity when examining the evidence before them. As a result, they failed to fully appreciate the needs of the children, missing several opportunities to take appropriate and protective action, particularly with regard to accepting inadequate explanations for injuries.

3.9 Leadership and Oversight: This case lacked robust oversight by senior managers and there was little evidence of effective supervision. The SCR found managers needed to be mindful of their level of engagement and leadership they provide to frontline professionals.

SECTION 4 - RECOMMENDATIONS AND LEARNING AND ACTION TAKEN

The findings and recommendations from the Child L Serious Case Review were accepted in their entirety by the NELSCB in December 2014. The Leadership Board commissioned the LSCB Serious Case Review Sub Group to develop and implement an action plan in response to

the recommendations, to embed learning and to inform practice. Progress and impact against the action plan has been overseen by the LSCB's Leadership Board. In addition, all agencies involved within the SCR have submitted regular reports to the SCR subgroup of the extent to which learning points relevant to their organisations, have been embedded.

4.1 Recommendation One

The LSCB should conduct a learning event to deal with specific learning points arising from this review. Individual agencies should formulate SMART action plans to ensure they are addressed. The LSCB learning and improvement group should monitor these action plans.

Four interagency Practice Forums were held in May 2015 where the key findings from the SCRs were shared with managers and practitioners and awareness raised. The Learning was separated into four distinct areas: Assessment, Resistant Parenting, Challenge, Escalation and Think Family. The event evaluated positively with practitioners reporting the immediate impact on practice. A report was presented to the LSCB Leadership Board on the impact and difference made as a result of the learning from the review.

The LSCB Serious Case Review Sub Group developed a SCR action plan based on the recommendations and Learning Points from the SCR. The action plan has been implemented and progress and impact measured by the standing SCR group. There are a number of learning points contained in this review and they are listed below:

Police

- *Changes to the structure of child protection services in Humberside Police should be monitored by the Local Safeguarding Children Board to ensure that new structures are able to deal with workload. The police representative on the LSCB should provide regular performance information on this team.*
- *Humberside Police should consider requesting a peer review to be conducted by the College of Policing into the effectiveness of their new structures.*
- *Humberside Police should ensure that the lessons of this case are included in the training for all detectives and front line officers.*

The police submitted a report to the SCR Sub Group evidencing action taken against the points above. As part of the restructure recruitment took place and further resources were placed in the Protecting Vulnerable People Unit. Updates on this SCR were given to all supervisors within the PVP with a requirement to disseminate to PVP staff. SCRs are a standing agenda item on the PVP Steering Group. The lessons from this SCR and others are incorporated into the training.

Health

Systems to identify children entering A&E who may be at risk, need to be reviewed, to ensure that front line professionals can identify children and their siblings subject to child protection, as quickly as possible, in a busy working environment. The Northern Lincolnshire and Goole NHS Trust submitted a report to the standing SCR group on the above review.

06.03.2015: System (symphony) reviewed. Previously a flag was placed on the system when a child was placed on a CP plan or became LAC and then removed at the end of that episode. As from 1st February when the flag is removed, it is replaced by a flag stating 'Previously' on

a CP plan or 'Previously' LAC. In addition to the above, from April 2016 the flags shown on symphony will also be shown on Web V (one of the key hospital systems used for inpatients). This will ensure that if a patient is admitted, the staff caring for the patient are aware of the safeguarding issues that impact on the patient.

Education

- *It is essential that at all levels - education professionals, including those at nursery level, maintain accurate records of safeguarding concerns and appraise social care of those concerns in a timely manner.*
- *Education professionals should triangulate their views of a child with fellow professionals' views of siblings and half siblings*

The learning from SCRs has been disseminated to schools through both the LSCB Safeguarding Education Sub Group and the Schools Child Protection Coordinator meetings. Best practice guidance on Recording Child Protection welfare concerns has been developed and shared with schools. There is evidence of effective record keeping within schools within LSCB interagency case audits. Schools are part of the Signs of Safety roll out which supports the identification and management of risk. In addition to this, on 2nd November 2015, we launched the Single Assessment. This is a holistic multi-agency model and single assessment framework that will support a continuous process of robust assessment.

Social Care

Every Child Protection and Child In Need plan should comprise of a clear care plan that is SMART and should incorporate key milestones with outcomes identified.

Children's Safeguarding and Reviewing Services (CSRS) manager in conjunction with the Safeguarding Services jointly reviewed the Child Protection Plan format which has been revised to complement the Signs of Safety and Single Assessment processes. From January 2016, the CSRS manager introduced IRO peer audit and management oversight audit processes to monitor the quality of CP plans, promote consistency in quality and oversee relevance and timeliness.

Themed workshops have been held within CSRS to achieve consistency in CP planning and a model has been agreed with guidance on "What a Good Plan Looks Like," so that IROs are aware of requirements and expectations and can benchmark the quality of their plans. In addition to the above, the CSRS is also working on the evaluation process following conference which includes consultation with parents on the relevance of the plan and the inclusivity of conference process with a questionnaire designed to elicit the service user experience.

The CSRS is also undertaking audits of the long-term and complex cases subject to CP plans with a focus on ensuring that cases are progressed appropriately and the right children are on the right plan at the right time to maximise risk management. In addition to the CSRS, social workers have good practice guidance in respect of assessments and plans to ensure that plans are informed by assessment and that they are SMART.

The Single Assessment is now in place in North East Lincolnshire. The single assessment has clear points that management oversight and direction is required to ensure that there is no

drift or delay and that all key concerns are addressed within the assessment. It also allows the social worker additional time to assess, analyse and plan for children.

Weekly case file audits quality assure all assessments within the service. All social workers are required to undertake LSCB training in respect of DA, levels one and two. Additional skills based training is being undertaken for social workers in respect of how to practically manage cases where DA is a feature. We will also be strengthening training in respect of Challenge and appreciative enquiry as a key skills base.

Signs of Safety, Restorative Practice, FGC and OBA (Outcome Based Accountability) are bieng embedded across the Children's workforce in NEL Council. All of these approaches lend themselves to developing a more inquisitive approach to work with children and families and to ensuring that actions are proportionate to achieving outcomes. All agencies involved with a child and family are spoken to at the point of referral to the MASH. GP's are also notified of enquiries through the MASH Health Representative.

Social Care must review their policy and system for case closure as a matter of urgency.

Closure panels are operational within CASS to ensure that all outcomes are met for a child and family, that the appropriate team remains around the family and that all professionals are in agreement to the case to be closed through a CIN closure meeting.

Supervision practice should be reviewed and regularly audited to ensure that management *oversight is evidenced along with the impact it has on the case.*

The ASYE programme offers bespoke training and support to NQSW. This is in addition to regular supervision from their manager. Managers allocate cases using case weighting, their knowledge of the skills of social workers and will only progress social workers to hold complex cases when there has been a review of their capabilities at six months. The ASYE programme is subject to review and development and scrutiny by external agencies. Supervision is monitored through case file audits, themed audits and the Performance monitoring and Accountability Framework.

Multi-agency Leadership

- Consider a leadership conference to review appropriate collective leadership.
- Review escalation processes.
- Provide clarity to front line professionals about levels of intrusive supervision.

The LSCB Leadership Board fully considered the learning from the SCR and were actively involved in developing the SCR action plan. The standing SCR Sub Group have provided regular progress reports to the Leadership Board. The SCR Practice Forums were directed at both managers and practitioners.

The LSCB Escalation process has been reviewed, revised and re published. The use of the protocol and need for professional challenge has been reinforced with all agencies through the SCR Practice Learning Forums and is monitored within LSCB inter agency audit activity and promoted via the adults procedures launch and via the Child Protection Coordinator meetings for schools.

The SCR Practice Forums have provided a focus on safeguarding supervision. Supervision is as key element of all safeguarding interagency audits. An audit of safeguarding supervision has been completed. The audit showed that for the most part, supervision was good and practitioners felt supported in their assessments and decision making. With the exception of schools, practitioners have regular safeguarding supervision. Practitioners in some service areas, for example children's social care (CASS) and Independent Review (IRO) also benefit from peer supervision, whilst school staff seek peer supervision with professionals from other agencies. Safeguarding supervision within schools is being explored further at the School's Child protection Coordinators Meetings.

4.2 Recommendation Two

NELSCB should consider the regular audit of the application of the Working Together guidance to ensure quality and consistency. They should develop a SMART action plan for improvement.

Working Together 2013 provides agencies with the framework for the management of child protection cases. It has statutory backing and applies to all of the relevant agencies engaged in protecting children. The system of assessment and management through case conferences, strategy, core group and child in need meetings is clear and unequivocal. It is essential that these processes are working effectively and efficiently.

The LSCB should consider an internal review, or a peer review under arrangements through the Local Government Association, to establish what measures may need to be put in place be made to improve case conference management. It should specifically examine the following areas:

- Agency assessments,
- Quality of agency reports and
- Timeliness of assessments and agency reports.

Agency attendance and reports to conference (underpinned by the single assessment process) have been subject to audit with outcomes and themes being reported to LSCB and the IRO's Quality Assurance Notification process in place for Social Work Services has been agreed for roll-out to other partner agencies with regard to reports for conference, attendance at CPCC and contribution to conference decision making.

An audit with regard to looking at the impact of substitute professionals attendance at conference was undertaken and led to a revision of procedures. Reports will also go to relevant agencies where professional attendance at conference is not sufficient or where the professionals attending are not appropriate to the case or child being considered. All conference processes and procedures have been reviewed to ensure that where there is split decision making or there is dispute between the chair of the conference and other members, an escalation process is used appropriately.

Consistency of the agency personnel attending key meetings.

This was considered during the audit being undertaken by CSRS and action taken as outlined above with regard to the Quality Assurance Notification process and OBA reports to LSCB operational board.

The system of review used by the conference chairs to ensure actions become outcomes.

The CSRS and IRO conference tracking processes have been reviewed and standards set for IROs and administrative staff to ensure delays or lack of progress is identified swiftly and addressed between conferences.

The system in place to ensure periodic full case review.

Cases held on CP caseloads will be subject to random full case review via the Learning and Good Practice LSCB subgroup and cases have been and will continue to be audited by IROs on a frequency agreed by the CSRS.

What measures are in place before 'stepping down' occurs.

Using the Signs of Safety approach as discussed within this report, CSC are ensuring that throughout the life of a case we are identifying need (Danger Statement), working with the family as to how we keep the child safe and then we are evaluating what difference we have made before any step down can take place. This is supported by a number of opportunities for there to be management oversight of a case prior to step down at any level such as the Single Assessment management review points, authorisation of assessments, CIN, CP, LAC and step down panels as well as RAM panels and Case Conferences.

The systematic approach taken to engage all professionals and agencies (in this case Child *M's nursery staff were not consulted).*

The level of understanding by agencies and staff of the Working Together will be addressed via the workshops to be held in March 2016. Practitioners were advised of the key changes to Working Together 2015.

An audit of compliance with Working Together.

The NEL Safeguarding children policy and procedures have been revised in line with Working Together 2015. Compliance with policies and procedures is a key element of LSCB interagency audits

The use of core groups and mid-conference meetings, to ensure that agencies share relevant information and are able to understand the position of other agencies.

In between Case Conferences, multi-agency core groups are held at regular intervals to ensure that CP plans are progressing, remain relevant and any new actions are identified. The CP plan is where the agency Safety Goals are set (as the bottom line) and these link directly to the Family Safety Plan which families are supported to complete and progress by the Team Around The Family (TAF). In addition the Local Authority holds CP panels that are attended by managers to review Child Protection plans and ensure that cases are progressing in a timely manner with a clear focus on outcomes. The timeliness of Core Groups is monitored through the Performance Monitoring and Accountability Framework.

The process of challenge and escalation where conference participants cannot reach consensus decisions or fail to evidence their decisions.

The escalation process has been reviewed in procedures and is being promoted via audits and action plans and will be included in multi-agency workshops to be held in March 2016.

4.3 Recommendation Three

LSCB should review its Early Help and support programmes for Troubled Families and ensure that a 'Think Family' approach is adopted by agencies. Specifically, that a coordinated support programme should be developed and recorded for each child on a Child Protection or Child in Need plan.

This review found that although a number of agencies engaged well with the family and provided various levels of support, the family had a wide range of needs and no coordinated plan existed to ensure that all of those needs were met. The Director of Public Health, chair of the Health and Wellbeing Board (HWBB), LSCB chair and Director of Children's Services should immediately consider these proposals and formulate an action plan for presentation at the next LSCB and HWBB.

Prevention and Early Intervention (PEI) is a priority for the NEL LSCB. The NEL PEI Strategy was launched in 2013 by the Children's Partnership Board. The aim of the strategy is to respond to the needs of children and families who are "Vulnerable" to poor life outcomes and to put the right services in place before things get worse. Progress against the strategy is reported to the Health and Wellbeing Board by the Children's Partnership Board. The LSCB Leadership Board receives quarterly progress reports from the Children's Partnership Board.

The 'Creating Strong Communities Programme" which is funded by the Social Care Innovation Fund underpins the PEI Strategy. The programme has four elements, which are being implemented in NEL, these being:

- *Signs of Safety (SOS)– tool to communicate with families to identify/ manage risk*
- *Restorative Practice – focus on resolving conflict via challenge*
- *Family Group Conferencing – families are supported to address their issues via dialogue*
- *Outcome Based Accountability (OBA) – focus on outcomes rather than process*

The LSCB should complete a family support needs assessment immediately and ensure that its requirements are in place by the end March 2015. *There have been a number of developments as part of the PEI strategy which support a "Think Family" coordinated approach to the needs of children and families at each level of need;*

- *Children's Centres are now Family Hubs offering information, advice and guidance and bringing together services from pre-birth to adulthood (0-19yrs)*
- *Introduction of additional threshold of need "Universal Plus" to support families earlier*
- *Development new Family Support Pathway / revision of Threshold of need document*
- *The introduction of a single assessment and plan replacing the CAF*
- *Training to the children's workforce on SOS, OBA, Restorative Practice*

4.4 Recommendation Four

Local training should reflect the lessons from this review, - in particular the need for an understanding of the effects of confirmation bias; professional curiosity and communication.

This review has found that individuals within agencies were less effective because they had not been trained in the 'softer' or more less concrete aspects of child protection. The importance of understanding how confirmation bias affects decision-making; taking time to ask some extra questions; triangulating the evidence; being more curious, are essential attributes in professionals in all agencies at all levels.

Open and honest communication between professionals is essential if decision-making is to reflect the facts. In this case vital information was lost because effective communication did not always take place. Specifically; the LSCB should ask agencies to urgently conduct an audit and review of training packages and report their findings through the LSCB.

All LSCB member agencies were invited to and attended the LSCB SCR practice forums which focused on the key learning and on less concrete aspects of child protection. This included "Confirmation Bias, Professional Curiosity, Over Optimism and Disguised Compliance"

The LSCB Learning and Development Sub Group completed an inter-agency training audit in Summer 2015. It was evident that agencies were identifying practitioner training needs. Agencies also identified where they felt there were gaps in LSCB training which informs the Annual Review.

Packages should reflect the findings of this and other serious case reviews.

LSCB interagency training has been reviewed as a result of learning from this and other SCRs including Domestic Abuse level 1 & 2 and Resistant Parenting. The use of the Escalation concern and conflict resolution Escalation Procedure.

Annual audits, by agencies, of training should be reported through the LSCB.

The LSCB Learning and Development sub group undertake an annual interagency training audit which is presented to the LSCB Operational Board.

Joint training models should be considered to improve communication.

This is an on-going process that should be overseen by the LSCB as part of it's Learning and Improvement Framework. The framework should incorporate the above elements. The chair of the LSCB Learning and Improvement sub group should report to the chair of the LSCB by the end of February 2015 with clear proposals to take this work forward across all agencies.

The chair of the Learning and Development sub group provides regular reports to the Operational Board. A whole System review of LSCB training aligned to Creating Stronger Communities began in November 2015.

The audits conducted by each agency must feed into this review and form part of the final report presented to the LSCB. The chair of the Learning and Improvement sub group should convene a meeting with agencies by the end of 2014 to allocate tasks and produce an action plan and timetable. The LSCB inter agency training audit was presented to the LSCB Operational Board in October 2015. The findings from the LSCB annual training audit inform the learning within the Learning and Improvement Framework.

The LSCB should consider a one day learning event for front line practitioners and their supervisors to disseminate the learning of this serious case review and other similar cases.

Four interagency Practice Forums were held in May 2015 where the key findings from the SCRs were shared with managers and practitioners and awareness raised. The Learning was separated into four distinct areas, Assessment, Resistant Parenting, Challenge, Escalation and Think Family. The event evaluated very well with practitioners reporting the immediate impact on practice. A report was presented to the LSCB Leadership Board on the impact and difference made as a result of the learning from the review. Further SCR practice forums will be held to disseminate learning from National SCRs as they arise.

Section 5 - Agency Progress Reports

Each agency was asked to provide a brief summary document of changes that are in place or underway as a result of this review and the issues that are emerging. The question posed to agencies was "What is better now?". These are not comprehensive documents providing the detail of the changes but do provide an insight into the way services have responded. Where appropriate some of the changes are referred to in the main body of the report. This is not a response to the recommendations in this report or by any means the limit of the work being undertaken.

5.1 Children's Social Care

The Multi Agency Safeguarding Hub (MASH) is in operation, its purpose to ensure timely sharing of information and intelligence, which will improve decision making at the point of referral into the children's safeguarding team. MASH is staffed by 5 Principal Social Workers, a police detective sergeant, a health professional, a worker from Integrated Services and a Parenting Advisor with links to the Family Hubs. These workers are able to access their own data base of information, enabling speedy sharing of relevant history on the child and their family. We have also developed virtual links with Housing, Fire and Rescue service, Drug and Alcohol agencies and YPSS.

In addition to the MASH we now have a Families First Access Point (FFAP). The FFAP will ensure support to service users and professionals on cases where there are no immediate safeguarding concerns but support, advice and guidance is required. The FFAP work closely with the MASH.

The Principal Social Worker in MASH is the key decision maker on all new referrals to the service. Extensive work has been undertaken in ensure that they clearly record on all referrals management directions as to the level of assessment required, the purpose of the assessment, checks that still need to be undertaken and the risks and protective factors that should be addressed by the social worker when completing the assessment.

A weekly Service Review Challenge Meeting (SRCM) is held chaired by the CASS Service Manager/ or Family Hub Coordinator and involving the MASH/ FFAP partnership. The purpose of this meeting is to review decision making, spot audit, capture themes and challenge findings.

The Challenge meeting:

- Offers transparency for all agencies
- A safe venue to challenge for all professionals
- Multi-agency weekly audit of the front door
- Reiterates thresholds

- Develops clear actions for agencies which are case specific but also inform professional and service improvement

The **Peer Review** cited the challenge meetings as innovative and there is continuous improvement of these arrangements. The Challenge meetings are opened up to partners on a monthly basis to ensure that we are engaging in conversations with partner agencies , to challenge and be challenged and to learn from one another. These meetings are chaired by a Head of Service.

We are also undertaking a series of visits to partner agencies, particularly focusing on adult services, to make additional virtual links to the MASH to ensure that referrals to CSC are timely and thorough and that there are key partners involved in the decision making of a case from referral through to closure. This is to strengthen our already strong links with partner agencies and the Think Family Approach. The Think Family agenda recognises and promotes the importance of a whole-family approach which is built on the principles of 'Reaching out: think family' :

- No wrong door – contact with any service offers an open door into a system of joined-up support. This is based on more coordination between adult and children's services.
- Looking at the whole family – services working with both adults and children take into account family circumstances and responsibilities. For example, an alcohol treatment service combines treatment with parenting classes while supervised childcare is provided for the children.
- Providing support tailored to need – working with families to agree a package of support best suited to their particular situation.
- Building on family strengths – practitioners work in partnerships with families recognising and promoting resilience and helping them to build their capabilities. For example, family group conferencing is used to empower a family to negotiate their own solution to a problem

Allocation of cases from the MASH are made by the management team from the MASH and Children's Assessment and Safeguarding Service (CASS) on a daily basis. The CASS social worker remains with the case from the point of allocation to the point of closure, whether that is step down to Single Assessment or universal service or through to adoption.

CASS has had a significant level of financial investment enabling us to employ additional social workers and managers over the last two years. This has in turn significantly reduced caseloads for social workers across the service. Caseloads continue to decrease as social workers start with the service. We have now appointed against all posts and are fully staffed

CASS have developed a bespoke Induction package for new social workers to the service to compliment the Corporate Induction. In addition, the Local Authority has a well-developed programme of support and continued training and development for newly qualified social workers(ASYE).

Every social worker has a named PSW who is their supervisor. They have between 6 and 7 staff to supervise which is usual across LA's. We have a supervision framework in place which includes weekly supervision for the first 6 weeks for new staff members and then

fortnightly after for the first 6 weeks. Their supervisor is not the ASYE PSW. The ASYE PSW is in a separate training role, who oversees the ASYE programme of training and support, and is in addition to their case supervision. The ASYE focuses on the professional development of the social worker and not the case supervision.

The ASYE programme is very structured we offer a high level of "back to basics" training for social workers and bespoke specialist training. It is a very well structured and productive programme of support for ASYE. Social workers have also been able to access bespoke training on assessments and analysis. In addition to the LSCB Domestic Violence training that all social workers undertake as part of their induction, we will be commissioning bespoke training specifically for social workers in the area of Domestic Abuse.

First Line Managers of social workers have undertaken a bespoke package of training and development to develop their skills and knowledge as managers and leaders and to drive forward change within the service.

We have developed a robust transfer process of cases where the worker is leaving the authority/ maternity leave. Cases are identified for transfer prior to the worker leaving the authority and handover visits and case file audits are undertaken prior to all transfers. This transfer process is subject to audit.

The Quality Framework is a series of measures and arrangements to ensure that vulnerable children's services are timely, of a high quality, appropriate to meet identified needs, give value for money and safeguard the welfare of children and young people leading to improved outcomes for vulnerable children and their families.

A variety of measures will contribute to the overall quality assurance process:

- Quality standards
- Supervision
- Staff development
- Recruitment & Selection
- Audit
- National and local indicator performance management
- Case reviews
- Service User feedback
- Customer care
- Contract management
- Elected member scrutiny
- LSCB
- Budget monitoring
- External scrutiny

We have a robust Audit and observation Calendar now established in CASS. Audits are undertaken by internal managers and an external auditor. We have recently undertaken several multi agency case file audits also. The results of all audits are shared on a quarterly basis with the Deputy Chief Exec (who is the DCS also), Assistant Director CS, Head of Safeguarding, Head of LAC and CDS and Head of Integrated Services. Audits highlight strengths and area's for improvement and discussion is held as to how we will meet the unmet need.

Within the audit meetings, as described above, data is also interrogated to inform all parties of the current picture which our data is telling us and to aid discussion in order to shape a collective response as to how we will strengthen practice. Performance Data is used by the service in the form of work books for the service as a whole and also work sheets which the PSW's receive on a weekly basis in order to manage cases and develop their staff group.

The CASS Service have also established a number of panels to review cases within the service. There are now CIN, Closure, CP, RAM and LAC panels in place The purpose of these panels is to Map cases (under the SoS framework) with the social worker and their manager to ensure that the right decisions are being made at the right time for children and their families. A representative from Early Help will also attend these panels to ensure that services outside of statutory intervention are responding appropriately to meet a child and family's needs. We will ensure that there is a team around the family at all times whether at a Universal, Targeted or Statutory Intervention level.

On 3rd September 2014 we launched the use of the Single assessment. This gives a maximum of 45 working days for completion but with built in reviews of progress at 10 days and 25 working days. These reviews are undertaken by a manager. This ensures that assessments are thorough but remain timely to avoid drift and delay with clear managerial direction and analysis of risk. Reassessment also now takes place within CASS. All reassessments are triggered by a significant event and/or through the supervision of a case.

Examples of a significant event could be:

- Change of address
- Change of family dynamics- such as the birth of a child, new partner in the home
- A mental health episode of the child/ carer or a deterioration in that persons mental health
- A loss or bereavement of a birth or extended family member
- A S47 investigation (this is a compulsory reassessment)
- A case being open to CSC for 18 months or longer
- A number of injuries to a child (may not be deemed NAI formally)
- Domestic Abuse incident

Re Strategy Meetings are currently held to review a section 47 investigation. Children's Social Care will now reconvene a Strategy Discussion once the conclusion of a police investigation is known. The purpose the of the Re strategy Discussion is to ensure that all professionals (minimum police and health) involved with the child and family are able to meet to discuss all information, make informed decisions and develop a multi-agency plan as to how the case will progress to safeguard and promote the welfare of the child.

Our electronic social care system has been upgraded to include the new single assessment. The upgrade, although new to staff, is already enabling improved quality of recording; and in case files in general. Social workers have also been provided with social work guidance, using the SoS framework, to assist them to meet the expectations of quality within their recording. QA Audits throughout the last year demonstrate that case file recording is improving within the service.

We have made several improvements with our colleagues from the Children's Safeguarding and Reviewing Service (IRO) in respect of Quality Assurance. For example, any area's for improvement which the IRO may highlight through case file audit and/or the chairing of a

meeting will be subject to a Single Practice Alert sent immediately and directly to the social worker, their line manager and the service manager. The purpose being to ensure that all gaps are immediately filled and the plan for the child is progressed effectively by all parties.

We began a 3 year implementation of the Signs of Safety Framework in January 2014. This approach is based on the use of Strength Based interview techniques, and draws upon techniques from Solution Focused Brief therapy (SFBT). It aims to work collaboratively and in partnership with families and children to conduct risk assessments and produce action plans for increasing safety and reducing risk and danger by focusing on strengths, resources and networks that the family have. Many studies have identified substantial benefits that the SoS approach delivers, and these benefits form the over-arching objectives of what we aim to achieve through SoS implementation within North East Lincolnshire including:

- **Better outcomes for families:** increased safety and permanency
- Improved relationships between practitioners and families
- Increased family involvement in identifying solutions to improve safety for children
- Improved organisation, efficiency, and standardisation in children social care practices
- Increased practitioner clarity and decision-making
- Improvement in frontline staff morale
- Improved partnership-working and collaboration between child protection and other professionals
- Contribution to a longer-term reduction in the local Looked After Children population
- Reduction in the duration cases are open to Children's Social Care
- Improved identification, management and support for children and young people at risk of sexual exploitation
- Improved identification, management and support for children and young people at risk from domestic violence
- The Local Authority are also taking forward a Creating Stronger Communities model which is supported by the DfE social work innovation fund. This will see SoS further embedded in the children's workforce and developing the approaches of Restorative Practice, Outcome based Accountability and Family Group Conferencing. Transitions between CSC and Early help for children and families will become seamless with support, at an appropriate level for them, continuing throughout the spectrum of need.

5.2 Humberside Police

Changes implemented by Humberside Police prior to publication of this report:

- The Public Protection Unit referred to in this report, managed at local divisional level has been replaced by a Protecting Vulnerable People Unit (PVP) which is a force-wide unit with local bases managed centrally to one standard.
- There has been a substantial increase in investment and staffing levels allocated to the base covering NE Lincs.
- The force has undergone an external review of its contribution to Multi-Agency Safeguarding Hubs and is in the process of implementing recommendations. These include providing more admin staff to each site to allow supervisors to concentrate on information sharing and decision making.
- It is now a requirement to be a trained detective when applying to join the PVP as an investigator or first line supervisor.
- Workloads across the PVP are monitored on a weekly basis and acceptable levels of workload per officer are being developed.

- A training programme for all staff working within the PVP to keep staff highly trained and up to date with their training is being developed**.**

Amended update

- Further investment was made during early 2016 regarding providing additional resources to those already implemented within the PVP.
- We have placed additional administrative resources within the MASH to support the dedicated DS working in co-location with partner agencies.
- We now provide dedicated Supervisory cover 7 days a week in our MASH's to ensure that information is shared with partner agencies in a timely manner.

5.3 Children's Health Provision

The Named Nurse, Safeguarding Children has, between March and June of 2014, delivered to each of the health visiting and school nursing teams a presentation, "Record Keeping, Report Writing and Statements" which aimed to deliver key messages about the importance of record keeping and what constitutes a good report. 86% of staff have attended to date with further dates booked in order to deliver the same training with a deadline of January 2015 to those who were unable to attend initial sessions and for the cohort of newly qualified health visitors who have recently taken up their posts.

Included within these sessions has been a reminder to staff of the importance of identifying and recording ***significant*** events and the recording of any observed clinical symptoms which may have relevance to a child's health and development in the future. Staff have also been reminded of their responsibility for sharing appropriate information with relevant professionals, especially GP's who use a different electronic recording system, working with children and their families.

Level 3 Intercollegiate training in safeguarding children, delivered by the Safeguarding Children Health Team has been updated to incorporate messages from serious cases and is used to reinforce the messages to health staff about listening to the "voice of the child". The message is also given to those attending to initiate 'professional curiosity' with families about uncertainty surrounding events and also for professionals to challenge other professionals where there is any doubt about actions taken.

The Named Nurse, Safeguarding Children has undertaken an audit and review of the standards of record keeping across the service and is currently preparing feedback sessions for staff to share the findings. Some individuals have been contacted as part of the process to discuss findings that required immediate attention and an action plan has been produced to address issues that affect the wider workforce. The implementation of actions will be monitored and ensured by the Safeguarding Children Health Group which meets quarterly and has a separate, operational safeguarding group, which will also address issues raised from the audit.

Safeguarding Supervision processes have been strengthened within the Provision with additional training from the NSPCC having been undertaken by those offering safeguarding supervision to staff. The Safeguarding Children Health Group also monitors the uptake of this supervision.

5.4 General Practitioners Service

- Since this case GP training to level 3 has increased from 30% to greater than 80%.
- GP's now have responsibility to ensure their staff, are trained to appropriate level.
- As part of GP training we included case conference report writing and encouraged GP's to include relevant medical information regarding parents/other adults in the house i.e. Drugs, chronic illness and mental health issues.

5.5 Children's Safeguarding and Reviewing Service

Attendance Reporting, and Social work Practice at and between Conferences. The following changes have been implemented or commenced.

- Guidance on quoracy/consensus/unanimous decision making has been revised so that the right professional is at conference to make decisions rather than the right numbers of professionals.
- Guidance on reviewing and escalation to Senior Management has been revised
- Single Practice Alerts (SPA) has been implemented since November 2014 to address social work reports, plans, and mid-point conference practice including child protection visits, core groups and report quality and timeliness.
- Chair's challenge promoted and monitored via observed practice, supervision and guidance.
- Quality Assurance at Step-down from Child Protection to Child in Need being commenced from December 2014.
- Training in the Signs of Safety approach for conference chairs during December 2014.
- Work ongoing with partner agencies. NB Health and Education re robust evidence based decision making in conference
- Extend the principles of dual status and de planning based on Working Together guidance to ensure initial plan/criteria are reviewed along with a review of significant histories.

5.6 North East Lincolnshire Council Children's Centres

Children's Centres became Family Hubs as of 1 April 2015, remaining at the heart of every community, offering information, advice and guidance and bringing together services from pre-birth to adulthood (0-19yrs):-

- 5 geographical clusters incorporating 10 family hubs across the borough
- Covering 0-19 year age range offering Information, Advice and Guidance
- Prevention and Early Help level of need identified through single assessment meetings held within each cluster area on a weekly basis
- Approx 35,650 children and young people

The process for assessing and responding to the needs of children changed from Mon 2nd November 2015. Including:

- The introduction of an additional threshold of need (called Universal Plus) to support families earlier
- A new Family Support Pathway / Threshold of need document
- The introduction of a single assessment and plan

- family hubs implemented weekly multi-agency cluster area single assessment meetings for case allocation (is appropriate) and review, all case history is checked prior to meeting

Active promotion of Working Together 2015 guidelines across partner agencies that Safeguarding is everyone's responsibility and under S10 of the Children Act 2004 LA's have a responsibility to promote inter-agency cooperation to improve the welfare of children – the PEI strategy and associated revision of documents such as child concern model, threshold of needs document etc and implementation of a new single assessment aim to do just that by reinforcing the following:-

- "Early Help is everyone's business" - practitioners and their managers must respond directly with appropriate information, advice & guidance or help to support families in full. This can be done in conjunction with other providers, and support the family to access all services available to them.
- For Prevention and Early Intervention to work, single assessment authors must take ownership and keep the case in their sight

Single Assessment and plan:-
- Replaces CAF but uses a different approach and spans the entire journey of the child
- Based on simple "signs of safety" questioning
- Accompanied by practitioners guidance
- Single document builds as the family progresses on their journey
- Evidences all interventions and outcomes
- Acts as a referral to MASH (or Children's Disability Service) if needed

There is now a revised step down process from CASS and a new step up process. This covers the whole of the threshold levels. The step up process is:

- Single Assessment received by cluster and judgement on threshold level deemed that the child might be suffering, or may be at risk of suffering harm. In such circumstances, cluster team will contact single assessment author and advise to follow the Local Safeguarding Children Board (LSCB) safeguarding procedures without delay. Cluster will follow up with telephone contact to MASH
- Cluster Single Assessment Meeting (CSAM) – where the family /safety plan is not making progress/being effective in spite of a number interventions including family network meetings with clear goals not being reached, the coordinating professional should discuss within the CSAM and section 3 of the single assessment be completed and stepped up to MASH, recording actions on Capita
- Where any concerns or incidents occur during the involvement of prevention and early help support, the identifying practitioner should follow Local Safeguarding Children Board (LSCB) safeguarding procedures without delay and forward the single assessment with section 3 completed. It would be their responsibility to inform the relevant cluster single assessment meeting, to enable actions to be recorded on Capita

As of December 2015, the implementation of a FFAP (Family First Access Point)/Family Hub/MASH weekly challenge meeting

The Challenge Meeting
A weekly Internal Service Review Challenge, Support and Solution Meeting (SRCSSM) is held chaired by a Head of Service (or an appropriate manager) and involving the FFAP/ MASH

partnership and other interested parties. The purpose of this meeting is to review decision making, spot audit, capture themes and challenge findings.

The Challenge meeting:

- Offers transparency for all agencies
- A safe venue to challenge for all professionals
- Multi agency weekly audit of the front door
- Reiterates thresholds
- Develops clear actions for agencies which are case specific but also inform professional and service improvement
- Supports professionals working in the FFAP and MASH
- Develops solutions

The weekly internal challenge meeting will be replaced by the multi-agency monthly external meeting once per month.

Conflict Resolution

Where any professional/agency is in disagreement about the decision making of another professional/agency, then the LSCB concern and conflict resolution escalation procedure should be referred to.

Introduction of a Families First Access Point (FFAP) 18 January 2016.
FFAP is a Multi-Agency team that acts as the first point of access for parents, the community, professionals and other agencies when they have a worry or concern about a child or family (where a child or young person is **not** at significant risk of harm). This multi-agency team provide information, advice and guidance to the public, as well as professionals, ensuring early help is right first time, at universal, universal+ and vulnerable levels across the threshold of concern model.

Staffed by a multi-agency team of professionals and working closely with the MASH, the FFAP will be able to promptly and effectively offer information, advice and guidance to enable the most appropriate response to a child's individual needs.
If, from the initial information sharing, there is significant risk of harm to the child, then liaison with the MASH team will ensure all safeguarding activity and intervention is timely, proportionate and necessary.

Finally, all managers working in Family Hubs have attended the LSCB accredited supervision and management of neglect training.