North East Lincolnshire LSCB Local Safeguarding Children Board

Serious Case Review Report

Child T

This report will be published in line with statutory guidance. In order to preserve the anonymity for the child in this family, the author has:

- Used initials to represent people
- Avoided the exact use of dates

Contents

Designation	Referred to as:
Subject Child	Child T
Mother of Subject Child	MT
Father of Subject Child	FT
Mother's Partner	MP2
Maternal half sibling of subject child	S1
Father of maternal half sibling	MP1
Partner of mother of subject Child at time of incident	MP2
Paternal Grandmother and step-maternal Grandfather	PGM, PGP
Maternal Grandmother and Maternal Grandfather	MGP
Maternal Aunt	MA

1. Introduction

1.1 This Serious Case Review (SCR) concerns Child T who died aged 4 years old in 2013 whilst in the care of the mother, MT, and the mother's partner MP2. Both MT and MP2 had a long standing history of substance abuse and were not known by any agency to be in a relationship prior to the death of Child T. Child T is the second child born to MT and the first born to the father FT. MT's first born child and half sibling to Child T, S1, lived with MT's former partner, MP1, who is the father of S1. S1 was removed from the care of MT aged 2 year and 10 months.

1.2 Whilst MT was pregnant with Child T, plans were underway for the permanent care of S1, who remained on a Child Protection Plan after Child T was born. For 13 months following Child T's birth, statutory services remained involved via a Child in Need plan. At 3 years old, Child T again became a Child in Need following a referral from MT's Drug Service concerning MT failing to access the service for over three months.

1.3 In the intervening years, Child T accessed universal services, being twice referred to Children's Social Care (CSC): once when aged 21 months for a serious domestic abuse incident between FT and MT, and again when a relative had concerns for MT's care of Child T.

1.4 Child T died aged 4 years 1 month whilst staying at MP2's home. She was discovered lifeless and taken to hospital by ambulance with extensive bruising to her buttocks, a bruise to the head and significant brain swelling. Although both MT and MP2 were on methadone prescription, police found large quantities of prescribed and non-prescribed drugs in the home and evidence indicative of Child T being given drugs.

1.5 MT and MP2 remained on police bail whilst expert medical reports were considered alongside Child T's post mortem. Police investigations were extensive, involving numerous medical experts. As a result MT and MP2 were eventually charged with Neglect, Child Cruelty and drugs offences and a criminal trial date set for late 2016.

2. Decision Making Process and Methodology

2.1 The Serious Case Review and dedicated panel was initiated in July 2013 and an Independent Reviewer appointed. Reports and chronologies were provided by all agencies involved with Child T, MT and MP2 and to obtain a broad perspective, the independent reviewer also held two direct meetings with relevant practitioners.

2.2 It was decided to delay finalising the SCR pending completion of criminal investigations to allow critical information to be shared with practitioners. From March 2014, police liaised closely with the LSCB Business Co-ordinator but complex medical findings and enquiries further delayed both the consultation with family members and the information being shared with practitioners until May 2015.

2.3 The practitioners' then belief, i.e. that Child T's circumstances had deteriorated sharply over the last few weeks before her death, were refuted when medical evidence showed a range of drugs had been found within easy access of Child T at MP2's property. Expert evidence indicated that she had been repeatedly exposed to and ingested heroin, methadone, ketamine and various benzodiazepines however experts could not agree the length of time she had been exposed, one believed 6 weeks the other up to 6 months.

2.4 The second practitioner's meeting was enhanced by a presentation by Humberside Police Senior investigating officers, on evidential findings that highlighted parental disguised compliance and helped practitioners reflect on this, on the ways in which to tackle disguised compliance and the barriers to doing this.

2.5 The Reviewer and LSCB Business Co-ordinator met with Child T's maternal and paternal grandparents, maternal aunt, father and paternal uncle. The relatives were distressed, but contributed fully by giving their perspective on events around Child T's death. Due to ongoing criminal proceedings, MT and MP2 could not be included

3. Scope and Terms of Reference

3.1 Terms of reference were decided based on the known facts and case history and established to consider the following key areas and determine from:

3.1.1 Agency activity prior to the birth of Child T

- Whether historical information was used effectively to inform pre- birth planning for Child T and were indicators of harm fully considered, specifically in relation to longstanding drug misuse and previous parenting experience.
- What multi-agency mechanisms were/are in place to support multi-agency working and what rationale was used to support professional judgements in respect of invoking multi-agency procedures.
    - Were professionals satisfied by multi-agency responses?
    - Was challenge used where necessary?

3.1.2 Discharge from hospital post birth

- What multi-agency processes were used in planning for the post discharge welfare of Child T?
- To what extend did the plan for discharge address risk factors such as previous parenting history and the effects of continued drug misuse?
- Were agencies in agreement, was challenge used where necessary?

3.1.3 Decision to close to Children's Social Care- Episode 1

- To what extent was each agency aware and or consulted about this decision?
- Consider the rationale and whether the risk assessment was robust at that time?
- What mechanisms were or could have been put in place to maintain oversight of Child T's welfare at a lower continuum of need?

3.1.4 Domestic Abuse Incident

- What was each agencies' knowledge of this incident?
- Was the mother offered services as a victim of domestic violence, was her vulnerability to future problematic relationships acknowledged?
- What services were /are now available for victims of domestic abuse?
- To what extent did multi-agency partners contribute to the assessment and agree with outcomes?

3.1.5 Referral from Family Member

- Was the referral responded to rigorously?
- Was historical information accessed and considered as part of analysis?
- Were multi-agency partners aware of this referral and was decision making supported?

3.1.6 Referral from Drug Agency –Child In Need Meeting and closure of case to Children's Social Care

- Was historical and current information used to support assessment and analysis of risk?
- To what extent were multi-agency partners engaged and in agreement with the case closure?
- What mechanisms were or could have been put in place to maintain oversight of Child T's welfare at a lower continuum of need?

3.1.7 Child T's absence from nursery school

- What was school procedure in respect of unauthorised absence – and what processes were followed?
- Did the school have concerns about child T , if so, what were they and were these shared in a reasonable and timely manner?
- What is the role of educational welfare service for children below statutory school age?

3.1.8 What was known to agencies about MP2 in the preceding year

- Was he perceived as a risk by any agency?
- What would be the impact of his long standing medical history and treatment?
- What was known about his domestic circumstances and what processes are generally in place to establish this with vulnerable patients/service users?

3.2 The timeframe scoped for the Review was October 2008 to June 2013, inclusive of Child T's life and ante-natal period. Contributors were also invited to include relevant contextual information pre-dating this in relation to violence, substance misuse, domestic abuse, criminality, mental health and previous child protection activity.

4. Overview of what was known to Agencies

4.1 Pre Birth Of Child T

4.1.1 MT is dual heritage and was adopted by a white British family with siblings of differing racial dual heritage. Child T's maternal grandparents believe the adoption impacted significantly on MT's childhood experiences of racism growing up in a predominantly white town. By around 15 years old, MT was taking risky behaviours and showing signs of drug addiction. Child T's maternal grandparents self-referred for post adoption service, but eventually had to pay privately for support services.

4.1.2 MT left home to live with MP1, and her drug use increased but her parents helped her to return to her home area when S1 was around 1 year old. The family was aware MT was accessing drug addiction services and continued to support her and S1 as best they could. Records describe MT as an articulate woman, whose smart presentation indicated someone who functioned well and took care of herself.

4.1.3 At 17 months old S1 was placed on a Child Protection Plan for Neglect due to the impact of MT's drug use on parenting. When S1 was 2½, police attended due to a report of a female and child heard screaming and a male shouting threats. MT alleged that FT had damaged the property and assaulted MT by punching and kicking her for which he was arrested. Having witnessed the incident, S1 was distressed and a referral was made to CSC. MT was 3 months pregnant and went to Women's Refuge for 1 month, but reportedly was 'disengaged', intimidating to staff & residents and would shout and swear at S1. FT would later claim that these allegations were false however he accepted he had 'slapped her'. In any event FT was not prosecuted after the case was referred to the Crown Prosecution Service.

4.1.4 MT was removed from the Refuge by police, stating she did not want the baby and wished to terminate the pregnancy. Police Powers of Protection were used and S1 was placed briefly in emergency foster care, swiftly moving to live with a maternal relative. S1 was deemed to be at risk of significant harm. MT failed to engage with a parenting assessment and so the local authority supported MP1 with a Residence Order application. The Maternal Grandparents felt all of these events related directly to MT's identity issues and early life experiences from her transracial background.

4.1.5 Following a review Child Protection Conference, S1's case transferred to the area in which MP1 lived. MT was 7 months pregnant, but conference made no recommendations for the unborn child. A joint visit to MT by Health Visitor and Midwife prompted a referral to CSC as after S1's removal, MT had referred herself to Addaction Drug Services. She was assessed as suitable for a Structured Day Programme, so had self-referred for specialist services at The Junction Drug Service.

4.1.6 CSC started an Initial Assessment (IA) for the unborn baby. There was ongoing liaison between CSC, the Junction, and Health agencies about MT's drug use, cooperation with professionals and engagement with antenatal appointments. The Junction was concerned about MT's refusing drug testing and her dishonesty about drug use. CSC initiated the Public Law Outline and MT and FT received a Letter of Intent and expectations of required action to avert legal action in respect of Child T including:-

- MT & FT to attend the Junction and Addaction
- MT to provide urine samples as required and use only those drugs prescribed
- MT to allow access to the home by health visitor, Midwife and social worker
- MT to work with a family support worker on parenting skills

Although not addressed in the PLO Letter of Intent, social work records indicate the risk of domestic violence was also discussed with both MT and FT. Prior to Child T's birth, the couple reported they had separated although they continued to attend appointments together and FT stated that he wanted to resume their relationship.

4.1.7 Risks identified by the Initial Assessment included: late registration with maternity services; failed antenatal appointments; MT's historical lack of engagement with services, her drug taking, her failure to demonstrate capacity to change her parenting of S1 and previous domestic abuse incidents. It is noted however, that MT and FT were positive about the birth and made appropriate preparation for the baby.

4.1.8 Assessments concluded that MT should access a parenting course and that both parents needed to sustain negative drug test results. A further assessment was recommended, but a Core Assessment was never completed.

4.1.9 A further Pre-Action Legal Meeting was held a month before Child T's birth, but there are no minutes of this, so the outcome is unclear although records indicate a perceived improvement in engagement with drugs services.

4.1.10 Three weeks before Child T's birth, a multi-agency pre-birth planning meeting, attended by midwife, health visitor, social worker for Child T, Addaction and the Junction - identified risks as: drug use; domestic violence and relapse to previous lifestyle. However, no agency requested or challenged why an unborn baby Child Protection Conference was not called, but agreed Child T would be discharged to MT and FT's care but if concerns persisted, would be discharged to the paternal grandmother.

4.2 Discharge From Hospital Post Birth

4.2.1 Child T suffered drug withdrawal symptoms. At a Discharge Planning Meeting held 11 days after the birth, the Junction, paediatrics and social worker heard that MT had ignored medical advice and been found several times co-sleeping with Child T. CSC have no record of this meeting. On day 24 Child T was discharged to the care of Paternal Grandmother after a second discharge planning meeting. Although it seems that both CSC and Health Agencies attended there are no minutes of that meeting.

4.2.2 Social Work case records show several concerns of professionals prior to discharge, of FT appearing 'under the influence of drugs, MT co-sleeping with Child T, MT missing drugs testing and suspected of falsifying results, but due to lack of meeting minutes, the rationale for discharging Child T to Paternal Grandmother's care with FT and MT is unclear. The concerns raised suggest it was a planned arrangement yet no written plan was put in place. The Paternal Grandmother lived in another LA, so there was a change of health visitor. 2 months later, it was agreed in social work supervision for Child T to return to MT and FT's sole care. There was no Core Assessment and 4 weeks prior to this move to their sole care, MT and FT had gone off agencies' radars', by not returning calls nor attending meetings.

4.3 Decision to close to Children's Social Care – Episode 1 (Child T 13 months old)

4.3.1 In the 9 months between Child T returning to the care of MT and FT and the case being closed to CSC, 4 Child in Need meetings were held but not all had the relevant professionals in attendance, with the final meeting attended by only the social worker and health visitor. MT and FT continued using illicit drugs although at first did return to drug services after relapses, indicative of motivation that was not sustained. At the point of the Child in Need Plan being ceased, professionals believed that both FT and MT were stable on a methadone programme.

4.3.2 Throughout this period, the physical care of Child T was observed to be good and in both social work and health visiting records, observations note good attachment between Child T and her parents. Child T was presented for medical treatments appropriately and there were no obvious indicators that her care was compromised by parental drug misuse. MT had registered with and taken up some Children's Centre services but at the point of case closure, although 4 agencies remained involved, there was no step-down nor a plan for lower threshold family support.

4.4 Domestic Abuse Incident

4.4.1 Child T was 21 months old when a relative reported a serious incident to police that had occurred the previous day. MT had told FT she planned to leave and take Child T with her. During the course of the incident FT started a chainsaw that he then waved in front of MT and Child T. MT reported her and Child T being very distressed and FT was charged with threatening behaviour and cultivation of cannabis and remanded to custody.

4.4.2 The police completed a risk assessment and referred to CSC and to an Independent Domestic Violence Advocate (IDVA). A Multi Agency Risk Assessment Conference (MARAC) agreed MT should be encouraged and supported by agencies to move to a safe place out of the area. FT's remand to custody however resulted in MT returning quickly to the family home after only a brief period in the Women's Refuge.

4.4.3 CSC undertook an Initial Assessment focused on the risk posed by FT and MT's ability to protect Child T, in particular by maintaining their separation. Records evidence multi-agency consultation between health visitor, Children's Centre, police and IDVA. MT's future vulnerabilities were to be tackled via a plan for her to attend the Freedom Programme, designed to address vulnerability to abusive relationships.

4.4.4 Two further Child in Need Meetings took place but Drugs Services were not consulted nor invited to attend. MT's appearance was described as well, happy and not indicative of being under the influence of drugs. The IDVA supported MT to move home and MT pledging to allow no contact with FT. A decision was made within 3 months to close the case as it was concluded that because the couple had separated, the risk had been eliminated. 4 months after the incident, FT was sentenced to a Protection from Harassment Order with conditional arrest powers not to have contact with MT directly unless through a solicitor to arrange contact with Child T.

4.4.5 Following FT's release from custody, the Probation service contacted CSC on 2 occasions; one five months after the incident and then two months later: stating FT was having contact with Child T and that MT had instigated this. Initially a letter was sent to MT emphasising the 'no-contact' expectation and the 'consequences should it occur'. The second time, contact was made with the Health Visitor who had no concerns about Child T. A second letter was sent to MT but no direct contact made nor questions asked to establish if contact or the relationship had resumed. FT has since confirmed that he and MT were having ongoing contact throughout this period.

4.5 Referral from Family Member

4.5.1 Child T was almost 3½ when a relative made referrals to CSC that MT was smoking cannabis, was lying in bed whilst Child T was left alone and was using hairspray and perfume on Child T. The social worker was told by the Junction that MT was doing well in a recovery programme and had been observed once with Child T and they had no concern. A decision for no further action was made based on 'no further evidence to substantiate the allegations'. The Health Visitor was notified of the allegations and the Junctions information and requested to contact CSC if there were further concerns or information to substantiate the allegations.

4.6 Referral from Drug Agency – Child In Need Meeting and closure of case to Children's Social Care

4.6.1 Child T was 3 years 7 months when The Junction raised concerns that MT had disengaged and not attended for some weeks. The Junction had delayed discharging MT because she was not registered with a GP, which they felt would impede her accessing treatment. MT had said her disengagement was because she wished to attend a venue where everyone was in treatment. MT had also denied being in a relationship, though it is now known that by then she was in a relationship with MP2.

The Nursery reported Child T presenting as neat and in full uniform, but rather quiet and sometimes unkind to other children. Her attendance was sporadic and averaged up to 3 sessions a week out of a possible 5. Records show that during this assessment Child T was spoken to alone by the social worker.

4.6.2 Eight weeks later a Child in Need meeting noted that in the intervening period MT had tested positive for methadone only. A decision was made at a CAF to offer support but MT declined this. Neither the Junction nor the Health Visitor was in attendance although CSC advised all relevant agencies by letter of the closure.

A week later, MT shared concerns about her own mental health with her worker at The Junction. She subsequently missed 3 scheduled appointments, not attending again prior to Child T's death. FT told the review that MT informed him about the Child in Need meeting, and on his advice recorded it on her I-pad and he later viewed a recording of this meeting.

4.7 Child T's Absence from Nursery School

4.7.1 Child T attended nursery from age 3¼ but had failed to return after school holidays a week before her death. The review found that patchy attendance is not uncommon for nursery age children so parents are encouraged to fully use Foundation Stage places but since it is not compulsory, poor attendance is not formally sanctioned. In Child T's case, a meeting is recorded with MT where the value of regular attendance was promoted, in the context of preparing for Reception class later that year.

4.7.2 When Child T failed to return, the Head Teacher and Child-Protection Co-ordinator, decided to ask the Education Welfare Officer to accompany MT to a meeting at the school to address

attendance issue. Due to unforeseen circumstances, the meeting did not go ahead and no further opportunity arose prior to Child T's death.

4.7.3 FT was in prison when Child T died but family told the review that she was taken to a prison visit by paternal grandmother and uncle about 10 days before her death.

4.8 What was known to agencies about MP2 in the preceding year

4.8.1 MP2 was known to adult mental health team (MHT) for 4 years prior to Child T's death, for substance abuse, depression, benzodiazepines abuse, multiple drug misuse and Generalised Anxiety Disorder, and Post-Traumatic Stress Disorder (PTSD) symptoms. He was treated with medication but a year before Child T's death, his diagnosis changed to PTSD and multiple drug misuse. His treatment plan was altered to reflect the new diagnosis. Throughout his contact with MHT, staff were unaware he was in a relationship but knew he had high support from his mother and struggled with self-care and mental health problems through years of chaotic drug misuse.

4.8.2 Although known to the Junction, the MHT only became aware of MP2's relationship with MT after Child T's death. MP2 was described as shy, somewhat reclusive and perceived as finding social relationships difficult. He had two spent convictions, one for possession of drugs and one for causing grievous bodily harm with intent. No information known to any agency suggesting MP2 might pose a specific risk to others.

4.9 Significant Information Post Incident

4.9.1 Following Child T's death, police inquiries found that several neighbours had reported concern about MT's attitude towards her and that she was resented and mistreated.

5. Analysis

5.1 MT has two children and has been addicted to drugs since her late teens. She has a history of a chaotic lifestyle, incompatible with safe parenting including taking and suspected drug-dealing; allowing violent drug dealers to live at her home, avoidance of professional agencies and an inability to establish children's routines. Despite many concerns about MT's ability to parent S1 safely, a full picture of her care of S1 emerged only as observed by Women's Refuge, when concerns escalated quickly yet within 3 months CSC made a decision to cease the parenting assessment of MT.

Protective measures taken in respect of S1 had little impact on agency responses to MT's pregnancy of Child T. Despite Initial Assessments identifying significant areas of risk for the baby, these were not fully recognised. No Strategy Meeting or Child Protection Conference followed despite being required for the following reasons:

- S1 had been removed from MT's care five months previously and only 2 months previously a decision made that S1 needed permanence away from MT because she was not engaging in an assessment of her parenting capacity
- Previous steps to initiate the Public Law Outline
- Evidence that MT's drug taking was impacting on her emotional availability to S1
- MT had presented late and was not accessing pre-natal care
- The Junction reporting MT was being dishonest about her drug taking
- The domestic abuse perpetrated by FT and minimised by FT and MT
- FT who was also a chaotic drug user with a criminal history related to drugs

All of the above combined with the vulnerability of a new born baby should have led to a robust protection plan for Child T, and a comprehensive parenting assessment. The absence of both is indicative of ineffective management oversight in CSC as well as ineffectual engagement or

challenge from partner agencies, particularly given that all agencies were aware of earlier decisions regarding S1.

The recommended Core Assessment was never completed due to sickness of the social worker, so subsequent plans left Child T in MT's and FT's care without parenting assessments or a safe Child in Need Plan. Multi-Agency Pre Birth planning underplayed the risks to Child T and subsequent multi-agency meetings lacked the assessment necessary to inform decision making. Discharge Planning meetings agreed a naively optimistic plan for Child T to remain in the care of MT and FT.

5.2 Robust assessment is vital to safe planning. Without this, practice lacked clarity and focus and inevitably left Child T at serious risk of harm. Ineffective assessment and analysis features often in Serious Case Reviews, as does failure to identify or act on other factors affecting parenting capacity such as substance misuse, domestic violence and mental health problems. Robust assessment requires practitioners to:

- Be open minded and take an independent approach to the evidence
- Reflect and critically analyse all of the information
- Collate and coordinate large amounts of information to extract key findings
- Deploy knowledge and expertise in child protection and social work theory
- Be given and to take the time and opportunity for rigorous critical thinking

It is known that systemic factors can impact adversely on practitioner ability to think critically and reflect and effective supervision is vital to analytical, critical and reflective thinking in practice. CSC's review report indicates high caseloads at this time, and although management oversight was perceived to be good, this is not borne out by the omission of assessments and the drastic consequences of this.

5.3 The effects on MT's ability to bond with Child T following the loss of one child and the birth of T within a four month period, was never addressed. MT's long history of non-engagement with services, and like many parents wishing to hide aspects of her life from agencies, using controlled engagement as a strategy, was, from MT's parent's perspective, an extension of her lifelong struggle as an adopted dual heritage woman in a mainly white community.

All of these issues potentially impacted on MT's emotional capacity to parent and trust childcare agencies and may explain why substance misuse offered some escape. A thorough assessment should have explored such issues.

5.4 Although the Initial Assessment accepted MT and FT were no longer a couple, at the planning meeting five weeks later, they presented as a couple characterised by domestic abuse and drug addiction. It is difficult therefore to see a rationale as to why this case was not managed at child protection level.

The NEL Ofsted inspection in 2012 identified low ratios of Child Protection Plans to open cases and a tendency to manage high thresholds of risk under Child In Need procedures. The CSC agency report cited management oversight as good during early planning for Child T, but whilst supervisions took place, the strong indicators for this case to be managed at a higher threshold of intervention were not acted upon.

5.5 Soon after Child T's birth, FT's dishonesty about drug use became evident. Hospital staff suspected on occasions he was under the influence of substances. FT has disclosed to the review that neither he nor MT ever stopped using illegal drugs. Insufficient weight was given to MT's

suspected drug use and her refusal to accept advice on safe-sleeping. The link with drugs to early child death was discussed with MT several times by health staff and social workers, yet MT remained unresponsive.

5.6 Although the plan for Child T to be discharged from hospital to the care of MT and FT was changed due to concerns, and she was discharged to paternal grandparents, her legal status remained unchanged and FT and MT retained parental responsibility.

No assessment was made of the grandparents ability to protect nor whether they recognised the risks. Given that the discharge plans were based on concerns about the parent's ability to care safely for Child T, it seems incongruent that none of the parties to arrangements, had been assessed or entered into agreement with the Local Authority. During the Review, the Paternal Grandmother recollected being asked whether she could give up work but was unable.

The grandparents could recall no checks being made on them or their home and no agreement in place regarding what was expected of them. Whilst MT, FT and Child T lived with paternal grandparents, both grandparents worked fulltime and FT felt the arrangement increased the stresses as they were living in one small bedroom.

5.7 The family stayed 11 weeks at Paternal Grandmother's home during which time no Child in Need meeting took place. Records shows 1 social work contact on the day of discharge with 2 further social work visits made in weeks 2 and 4. In week 7 social work supervision records note the parents had been out of contact for 1 week and missed appointments with the Junction. 3 weeks later, telephone contact was made with FT, and 9 days later the family moved to their home.

The approach to assessment is vague. The family went to live with grandparents because of parenting concerns, and yet no objection was made to Child T being in their sole care. There were no completed core or parenting assessments, no multi-agency analysis of risk and no positive engagement or indicators of sustained change.

Social work records suggest that grandmother was to make contact if concerns arose, but this was a presumption, not an agreement. There was no assessment of 'ability to protect' and no attempt was made to seek feedback from the grandmother.

5.8 Statutory Guidance within Family and Friend Care 2010 stipulates that where unable to live with parents, children and their carers should receive support to safeguard and promote their welfare. In this case, grandparents were unclear about what was being asked and had no written undertaking or specific understanding about informing CSC.

Given the level of risk, informal placement of a new born baby should not have occurred and begs the question as to what the Local Authority would done had the parents refused to cooperate. The statutory guidance states the following:

Section 20(1) of the 1989 Act provides that every LA must provide accommodation for any child in need within their area who appears to them to require accommodation as a result of: (a) there being no person with parental responsibility for the child; (b) their being lost or having been abandoned; or (c) the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing them with suitable accommodation or care.

When a local authority is considering whether a child cared for by family and friends "requires accommodation", the question at (c) is particularly relevant: does the child appear to the

authority to require accommodation because the person who has been caring for the child is prevented from providing the child with suitable accommodation or care? If it appears to the authority that the child does require accommodation, then it must provide that accommodation.

Had Child T been accommodated, a number of measures would have followed including an assessment under Fostering regulations of grandparents as Connected Persons and scrupulous oversight of the placement under Care Planning, Placement and Case Review Regulations, and the appointment of an Independent Reviewing Officer who should have challenged the absence of assessments.

5.9 The decision to allow Child T to go into the sole care of MT and FT was not based on assessment. Records show CSC overemphasised indicators of resilience but without considering their context. Two indicators given disproportionate credence were that Child T appeared physically healthy and well cared for and that parents had not actually been seen when 'under the influence' of drugs. Notably, the basic physical care of S1 was never an issue of concern, nor has it been for Child T.

The parents' attitudes to drug dependency was well known and, as with many addicts, the drugs culture featured heavily. There was sound evidence that continued drug use would impact adversely on their parenting, compounded by a potential for further domestic abuse and the recent removal of S1. Despite regular urine testing for active drug use, professionals should have considered that experienced addicts often manipulate results and so accurate assessment of use, also requires observation of behaviour.

'Going missing' is a common indicator of concern and yet professionals failed to afford this any weight whilst seeing false positives in the family's presentation. There was a disregard for the entrenched history of drug use and of the heightened risk of relapse where a partner is also addicted. Assuring Child T's safety required evidence of sustained abstinence prior to the parents assuming sole care of Child T.

Insufficient weight was also given to the ongoing risk of domestic abuse, particularly given the alleged incident in MT's pregnancy and an absence of any victim or perpetrator focused work to reduce risk or assure parent's understanding of the risks to children.

5.10 A safe plan should have established the child's safety whilst comprehensive assessment focussed on the issues of concern and the parent's ability to achieve and sustain change. General Change theory Prochaska & DiClimenti Model of Change) identifies stages from which motivation, change and sustainability can be measured. There was nothing to suggest MT or FT ever acknowledged the need for change and yet, professionals seemed to believe them to be at an advanced stage in the change cycle.

Assessing change in addicted drug users is complex and the risks of relapse within a timeframe to suit the child's needs must be factored in . It is difficult to comprehend in this case how assessment informed key decision-making. A lack of management oversight combined with weak quality assurance processes, led to a lack of a suitable framework in which to assess the risks and a missed opportunity to manage risk.

The Health Visiting report suggests a pervasive culture that lacked challenge, leaving safeguarding responsibilities to CSC. Examination of practice demonstrates the imperative for all agencies to take responsibility for challenge and indicates why lead agencies must embrace challenge as a component of transparent, safe practice.

The CSC report suggests this lack of challenge extended across all agencies by agreeing to close the case when Child T was 13 months old. Partner agencies however noted they were not consulted, highlighting the need for better multi-agency working and the danger of 'assuming consent' without confirming via proper communications, direct meetings or recording views and opinions.

5.11 The second serious domestic abuse incident provided an opportunity for multi-agency professionals to consider Child T's welfare. It was violent and frightening for mother and child but the robust multi-agency response to MT as a victim was not as rigorous for Child T who was wholly dependent on MT for care and protection.

The incident exposed FT's continued drug misuse and the prevalence of drugs in the home. As with S1, Child T was exposed to a serious domestic violence incident and yet MT's reluctance to work with CSC should have been an indicator of concern. When the case closed 8 months earlier, FT was seen as a protective factor, yet his removal from the family did not prompt an assessment of MT's parenting capacity as sole carer.

The empathy shown to MT deflected focus away from the risks to Child T. FT became subject to a Probation Order but probation alerts to CSC re the potential ongoing risk to Child T were not effectively acted upon and information that the couple had reunited was never challenged despite a potential breach of FT's Restraining Order.

Although MT might have denied it, the professional failure to confront her no doubt eased the way for further deception. Concentrating only on MT as the victim enabled FT to remain as the 'hidden male'. The lack of professional contact with FT or MT enabled them to conceal their relationship. FT revealed that throughout this period, he was simultaneously seeing MT and Child T whilst pretending to negotiate 'official' contact via solicitors.

5.12 16 months later, when Child T was 2½, she was referred by family to CSC. It is a common feature of Serious Case Reviews that referrals by families are afforded less weight than those made by professionals. On checking records, no further action was taken because there was 'no further evidence to substantiate the allegations' that MT was staying in bed, smoking cannabis and neglecting Child T. It is troubling to note again that MT was never confronted or even asked if any of this was happening.

Although MT was unlikely to have admitted to the allegations, triggering an Initial Assessment would at least have allowed an assessor to consider the allegations and response in the context of other historical information and professional observation.

The review found that practitioners adopted a mind-set of wanting evidence in support of allegations before acting rather than searching for evidence to refute the allegations before dismissing their validity. Practitioners acknowledged that children would be better protected by being receptive to information being plausible either until it is proved to be unfounded or where good assessment finds no substantiation.

This process requires critical thinking and professional curiosity to reach a confident judgement. Referrals from family members should be deemed as significant events in that relatives deciding to or making referrals, is inherently difficult particularly where as in this case, the family was also involved in offering ongoing support.

Unlike professionals who are dissatisfied with the responses to a referral and can challenge and escalate their concerns, members of the public or relatives have no such option. In this case, the

family's contact with CSC was rare and this may have engendered a feeling of mistrust and fear that their concerns would not be taken seriously nor properly investigated. In essence, this is what seems to have happened.

Professionals must ask what other purpose a family member's referral could have other than to alert agencies to the child's welfare? It has since emerged that at the time of this referral, Child T was indeed in danger and was being administered drugs.

5.13 The subsequent referral by the Junction led to a 2 month period of Child in Need activity. It is noteworthy that this was the first time that school became aware of the family's history with agencies. The case closure by CSC was agreed at a Child In Need Meeting, attended by the social worker, health visitor, head teacher, MT and PGM.

The assessment did include family members but failed to include all agencies. Despite MT's skills at feigning compliance, The Junction's concerns about parental disengagement were communicated but did not result in preventing Child T remaining at high risk or agencies being led to believe that MT's contact with FT was purely around his access to Child T. The truth is, their relationship was such that it extended to MT sharing with him a recording of the Child in Need meeting.

5.14 The review found that MT and Child T moved in with MP2 one week prior to the death but no family member or professional knew of this relationship. FT, who was in prison at this time, had heard they were associated but unaware they were in an intimate relationship. MP2's home was not close to the nursery school so this might have been why Child T stopped attending after the holiday.

Although nursery attendance is not compulsory, non-attendance of very young children within this context should raise welfare concerns. Although the school maintained that this pattern of attendance was not uncommon, the school had begun to note this as a concern and considering what measures might effect change.

5.15 The significant issues of evaluation in the Review lie in the multi-agency responses to the birth of Child T, which show how a series of inactions led to a plan that lacked a focus on risk. The absence of early assessment meant that agencies had no evidence of MT's capacity for change or successful parenting nor of FT's potential for successful parenting.

This loose approach to assessing parenting capacity allowed FT and MT to 'hide' the negatives from statutory agencies and exhibit 'token engagement' by occasionally presenting well on several occasions.

Disguised compliance is a term increasingly used amongst childcare agencies to describe the process of parents hiding dangerous or poor parenting practice by actively working to deceive and undermine professional involvement.

Professionals maintaining a culture of 'healthy scepticism' and practising to embed this as a cultural norm is essential to practitioners recognising and tackle this subversive behaviour. This review has enabled multi-agency professionals to reflect on the how MT managed to mislead professionals with apparent ease. The review has also shown more disturbingly however, that despite the significant history known to various agencies, no single practitioner or service knew what life was like for Child T or the extent to which she was exposed to risk and harm on a daily basis.

6. Learning from the Review

Although completed in 2016, the review focused on multi-agency working over the years from 2006 to 2013. Whilst lessons from this Review are accepted by the involved agencies, the review has acknowledged the many aspects of practice, processes and multi-agency systems that have been revised since 2013, some as a result of this review and some within more general developments. The perspective of individual agencies is reflected in section 7 of this report, and the following findings arose from the specific circumstances to the Review.

6.1 Robust assessment is key to understanding family functioning and assessing parental capacity to change and should be a standard and routine approach for every child subject to a multi-agency plan.

Plans for children that lack robust assessment inevitably lead to poor outcomes. Multi-agency partners need to be skilled in models of assessment and critical thinking to make confident, safe and predictive judgements for children.

This review suggested a need for a greater understanding of the established pathways for assessment amongst multi-agency partners as well as a culture that welcomes and supports challenge and does not leave CSC to take sole responsibility for key decisions for safeguarding and protecting children.

Assessments involving substance abusing parents require that daily routines and lifestyles are understood from the child's perspective and position within the family framework to fully appreciate the risk factors for the child.

Management oversight of practice and plans must be built into the structures that support intervention and assessment and promote professional curiosity and critical thinking necessary to ensure robust decisions and plans to keep children safe.

Practitioners must remain alert to the common pitfall when working with 'hard to engage parents' of interpreting small acts of co-operation over-optimistically and maintain an 'open mind' and critical perspective on the significance of such acts.

6.2 In all instances where siblings are born to children subject to a Child Protection Plan, or there is an unborn baby, a pro-active decision must be made as to whether a Child Protection Conference/Plan is indicated for the unborn baby or sibling child.

The significance of not holding a Child Protection Conference in respect of Child T pre or post birth was a critical factor in Child T's subsequent journey through services. Put simply, S1 was better protected as a result of child protection planning processes, than Child T whose case was managed in the CIN framework. Compliance with multi-agency processes combined with the quality assurance and management oversight of Case Conference guided and disposed practitioners to achieve safe outcomes.

6.3 In instances where an intervention determines that a parent cannot exercise their choice and parental responsibility with regard to where their child resides, looked after arrangements should be invoked.

The impact of not utilising Looked After status for Child T was significant in that a vulnerable baby was 'placed' informally without assessment in a situation that eventually exposed her to extreme safeguarding risks. The informal nature of this arrangement resulted in missing an opportunity for the oversight and challenge of an Independent Reviewing Officer. It also reinforced the parent's belief that CSC did not see the concerns as sufficiently serious to use statutory interventions.

6.4 As a general rule, all contacts from anonymous sources or family members raising concerns about the welfare of a child should be treated automatically as referrals not contacts and the details of such referrals, discussed directly with the referrer.

When they work well, families and communities are a child's greatest safeguarding asset. The importance of listening to families is core learning from successive Domestic Homicide and Serious Case Reviews, yet contacts by families still result in lack of action because they are 'unsubstantiated' by professional observations. Family and friends tend to be closer than professionals to children's realities and will invariably see aspects of family life that are simply not visible to professionals. Professionals must triangulate all of the evidence and information and avoid assuming that unless empirically evidenced, allegations cannot be taken as truths.

6.5 When working with Domestic Abuse, practitioners must ensure that three strands of assessment and intervention are combined as: i) the impact on children at the centre of assessment, ii) the needs of the victim and their ability to safeguard, and iii) the requirement to hold perpetrators to account for their actions.

When professionals receive information that a child may be exposed to domestic violence, an approach is needed that takes account of all three components as indicated. Practitioners must remain sceptical about the likelihood of permanent separation of partners with collusive histories and remain alert to the risks to children and challenge assumptions by evidencing claims that changes have been made.

6.6 This case and others provide instructive case scenarios against which multi-agency professionals are assisted to develop tools and skill in the practice of 'respectful uncertainty' as a means to combatting disguised compliance, particularly in safeguarding children where parental substance misuse and or domestic abuse are key causes for concern.

Agencies and practitioners must give honest consideration to the conditions that make it easier rather than harder for service users to deceive professionals. This requires honest appraisal of professional practice, communication and how professionals can create checks and balances of our own judgements and subsequent actions. The review found that practitioners would welcome greater opportunity to consider the issues and reflect on practice in a multi-agency context.

6.7 Patterns of poor pre-school attendance should trigger a response from early intervention services

Successive case reviews show that patterns of chaotic parenting and disguised compliance begin in early childhood and have lasting consequences for children's life chances. Providing targeted support at early stages is the most effective way of addressing problems that prevent children from accessing nursery and subsequent school opportunities. There is a danger that because there is no legal enforcement for children to attend educational provision below statutory school age, that this creates an unhelpful rationale not to undertake lower level interventions.

6.8 Engaging the community in safeguarding children is an important step in identifying children that need protection and families that need support.

Professionals working with Child T had been unaware of the extent to which members of the community had observed that all was not well for Child H. The subsequent police investigation revealed that despite their concerns, there was a reluctance within the community to report their concerns, although the reasons remain unclear. It may either have been the fear of repercussions from MT's connections with the drug subculture or may simply have been a mistrust of formal agencies. Had the community alerted professionals to their concerns, it would may have prompted enquiries and the 'piecing together of information from a range of sources could have built a more accurate understanding of the issues facing Child T.

7. Agency contributions

7.1 This Review has been somewhat protracted due to the complexities of police and health investigations and the freedom to share information being restricted to appropriate points in the criminal proceedings. Agencies' reflections have developed incrementally in line with emerging information and so much of the learning from this review has been addressed along the way.
The review identified a number of missed opportunities to better protect Child T during the pre and post-birth period some seven years ago. The past seven years have seen significant changes in the delivery of multi-agency working, in particular following the Munro Review of Child Protection and the 2015 revisions of Working Together to Safeguard Children. In addition, there has been updated legislation and guidance to support local authorities and practitioners to achieve best practice standards. There have also been several high profile child death reviews highlighting the prevalence and impact of disguised compliance and a need for professionals to exercise 'respectful uncertainty' and professional curiosity.

7.2 Children's Social Care

7.2.1 CSC identified a range of issues pertinent to the management of this case, including the complexities and challenges of working with substance misusing parents who can be adept at disguising compliance. CSC identified the need to work collaboratively across adult and children services, sharing common goals across a different client base. The impact of operating with high caseloads during the pre and post-birth period of intervention with Child T was also recognised to have been a risk factor.

7.2.2 As in many local authorities, a Multi-Agency Safeguarding Hub (MASH) has been established. All referrals to CSC now go direct to the MASH, enabling immediate multi-agency screening of referrals, fast access to case histories, sharing information in a dynamic way to support efficient identification of risk, quick decision making and most importantly - timely interventions at the relevant threshold.

The embedding of thresholds at a level consistent with need is illustrated from 2011 to date by an increased and moderated use of Child Protection Plans and accommodation as illustrated below.

	2011 – 2012	2012-2013	2013-2014	2014-2015	2015-2016
Children Looked After	155	200	265	265	304
Child Protection Plans	88	232	407	226	262

At the time of this review, North East Lincolnshire had 12% of Looked After Children placed under *formal arrangements* with a family or friends and subject to formal fostering assessments. To reflect landmark court judgements, NEL is mindful to restrict the use of Section 20 Children Act 1989 appropriately, seeking to issue proceedings where appropriate without delay.

7.2.3 The Local Authority has introduced a model of Creating Stronger Communities, supported by the DfE Social Care Innovation Fund. To embed this approach, NEL has created a Families First Access

Point (FFAP) to support professionals working with families in the Early Help arena to ensure that help, support, advice and guidance can be accessed by children and families at the right time to prevent escalation and to reduce the need for statutory interventions.

The introduction of a Signs of Safety Framework from January 2014 has provided social workers with a framework in which to work collaboratively with families and children to produce Children's Plans designed to increase safety and reduce risk by focusing on strengths, resources and networks available to the family.

Practitioners report that significant changes to assessment processes are improving areas such as robust pre-birth planning for children at risk of significant harm, avoiding drift and reducing confusion once a child is born. NEL has adopted a consistent approach to Connected Persons Assessments where relatives are asked to be responsible for the safety and welfare of a child, and introduced a Single Assessment process from September 2014.

7.2.4 In order to be assured that newly implemented structures and assessment models are working effectively, the Local Authority is undertaking case audits - the learning from which is shared across the children's management team to highlight strengths and areas for improvement at the earliest stages.

Caseloads remain under constant review and although now reduced, still serve as a salutary reminder that social workers must be given sufficient time and the support structures needed to undertake high quality of assessments of risk and need.

7.2.5 Management oversight is now enhanced via a panel approach to monitoring progression and decision making for Child in Need, Child Protection, Looked After Children, Resource Allocation and Step Down to case closure or Early Help Support. The panels provide senior management oversight and a forum for quality assurance.

7.2.6 The LSCB has commissioned and delivered training on Disguised Compliance and the risks of 'over-optimism' across the workforce, that has been positively welcomed by practitioners. In addition CSC has commissioned additional training for social workers in assessment and risk analysis and they are confident that a culture of respectful challenge and respectful uncertainty is now more apparent.

7.2.7 The Children's Safeguarding and Reviewing Services (CSRS) manager in conjunction with the operational Safeguarding Services has jointly reviewed the Child Protection Plan format to complement the Signs of Safety and Single Assessment models. From January 2016, the CSRS has introduced an Independent Reviewing Officer (IRO) peer audit and management oversight process to monitor the quality of Child Protection plans, promote consistency in quality and oversee relevance and timeliness.

Themed workshops have been held within CSRS on Child Protection planning and 'What a Good Plan Looks Like.' IROs alert to their requirements and expectations and can benchmark the quality of plans. CSRS is developing post-conference evaluations of parents on the relevance of the plan and the inclusivity of conference process with a questionnaire designed to elicit the service user experience.

7.2.8 The CSRS is also auditing long-term and complex Child Protection cases to track progress on cases ensuring the right child is on the right plan at the right time. Other bespoke audits are ongoing on the impact of substitute professional's attendance at Child Protection Conference and conference decision-making. Relevant agencies will also be alerted when professional attendance or non-attendance at conference impacts adversely on outcomes for children. The

CSRS also issues a Quality Assurance Notification to practice seniors so that deficits are appropriately escalated.

7.2.9 All Child Protection Conference procedures have been reviewed so that split decision making or dispute between chairs and other members is escalated appropriately. Child Protection Conference tracking processes have also been revised to ensure delay or lack of progress is identified swiftly and addressed between conferences.

7.3 Children's Health Provision

7.3.1 Health agencies identified deficits in recording hampered their understanding of what was occurring and the potential consequences of non-engagement, particularly where a challenge to the absence of a multi-agency plan should have occurred. Children's Health provided health visiting services for Child T and report that at this time the prevalent view in Health was that decisions relating to child protection were CSC's responsibility and so cases tended to remain within Child in Need processes whilst partner agencies did not provide challenge or act in a '*critical friend*' role.

7.3.2 It is significant to note that the health visitors that contributed to the Review considered that this culture is now different. Health staff are aware of the Threshold of Need document and associated guidance and that this it is designed to promote challenge and escalate concerns through a dispute resolution policy.

7.3.3 The agency reports indicate that there was an absence of thinking about disguised compliance and an absence of rationale for ending the Child in Need Plans, other than an absence of further incidents. Since 2013, child health have attended LSCB training on Working with Resistant Families and have an expectation that all children's health practitioners are active parties in children's meetings and plans.

7.3.4 Changes to the delivery of Health Visiting Services mean that a decision to change the Health Visitor simply due to a child's change of address is no longer the norm. This allows for greater continuity of caseload management and consistency for service users. Health Visitor numbers have increased since 2014, with a revised caseload management system. Children's Health has used this case as a salutary reminder for staff of the need for professional curiosity and professional responsibilities to challenge and support to maintain safe systems and safe decision making around the child.

7.3.5 During this Review period, progress has been made in the communication pathways between Children's Health Provision and Adult Mental Health Services with a distinct pathway being developed by the Named Nurse, Safeguarding Children and the Service Development Manager Corporate Affairs in NAViGO to address information sharing between services, specifically in relation to matters of concern about the impact of adult behaviors on children.

7.4 Substance Misuse Services

7.4.1 During the timeframe of this Review, the Rotherham Doncaster and South Humber (RDASH) NHS Foundation Trust was responsible for The Junction Drug and Alcohol Services. This is now provided by Foundations and all Foundation practitioners have undertaken safeguarding training within their induction. The Trust examined the agency practice in the case, and practitioners participated in review events.

Whilst safeguarding children assessments were completed, the Trust found that meeting minutes and an analysis of the impact of parental substance misuse should be better documented and evidenced in recording. The report reflected on the interventions and support provided to MT following the domestic abuse incident, in particular on their mistaken belief that

being in a refuge provided extra protection and reduced risk when research shows risk usually increases after the separation.

7.4.2 The service has been developing communication pathways between Children's and Adult Mental Health Provision with a dedicated pathway being developed by the Named Nurse, Safeguarding Children and maternity services to address information sharing between services, particularly on matters of concern about the impact on children of adult behaviours and disguised compliance. Staff have also benefitted from training to support professional curiosity and the responsibility to challenge and support to maintain a safe systems and decision making around child protection.

7.4.3 Addaction provided a helpful reflection on what they as an agency had learnt as follows: - to ask the right questions at the right time, follow through on questioning situations that don't seem quite right, and ensuring they triangulate information by working in partnership with other agencies.

7.4.3 The approach taken by the Junction demonstrated a sound understanding of the safeguarding responsibilities of adult focussed services when faced with a parents who are skilled at deception.

7.5 Education

7.5.1 Child T was admitted to Nursey/Foundation unit at a Primary School aged 3 years 3 months for 5 mornings a week. Within one month, attendance was irregular, averaging only 2 - 3 sessions per week, which was noted as not unusual amongst peer children. The agency report notes that attendance is not compulsory for pre-school children and relies entirely on parental co-operation.

7.5.2 The development of FFAP is significant to identifying families who need help to develop routines and promote educational opportunities, the service incorporates pre-school establishments and promotes the value of early targeted support.

7.6 Police

7.6.1 Protecting Vulnerable People Units (PVPU's) are located within the Specialist Command of Humberside Police under the direction and leadership of a Chief Superintendent. Since the commencement of this Review, there has been an increase in PVPU staffing levels that also now respond with a wider remit around Public Protection in accordance with the key areas as identified by the College of Policing, this includes Domestic Abuse, Child Protection, Serious Sexual Offences and the Management of Sexual and Violent Offenders. Workloads within the PVPU's are monitored on a weekly basis with a robust performance regime in place.

7.6.2 Humberside Police outlined significant changes to the processes around sharing safeguarding concerns with CSC following consultation with the four Local Authorities covered by the Force. All safeguarding concerns identified by officers are now processed through one nominated SPOC box for each Local Authority area and all cases are triaged and risk assessed by an Officer of the rank of Sergeant. Maximum timescales are in place for dealing with incidents which are linked to particular levels of risk and the workloads and compliance to timescales is audited on a weekly basis.

In addition, from June 2015 a new policy was put in place across all four unitary authorities in relation to sharing information on domestic abuse. Any incident that requires consultation with CSC following a secondary risk assessment within the Domestic Violence Unit in relation to Section 17 and Section 47 of Children Act 1989 is now managed by a Detective Sergeant working within a co-located team based in the Local Authority. Within North East Lincolnshire this Officer

is located within the MASH (Multi Agency Safeguarding Hub). The Policy also details how the Police will share Domestic Abuse incidents with early help services.

7.7 Mental Health Services

7.7.1 Navigo is a 'not for profit' social enterprise that is responsible for all mental health services in North East Lincolnshire. The service provided care to MP2, who was often seen accompanied by his mother, via a Consultant Psychiatrist throughout the period of this Review. Although they had no knowledge of MP2's association with Child T, the agency has taken an active part in the Review and have affirmed their intention to use this experience to be alert to new possibilities for mental health services to work in collaboration with child led services.

8. Review Recommendations: Learning and Action Taken

The findings and recommendations from the Child T Serious Case Review were considered and fully accepted by the NELSCB in November 2016. 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 Serious Case review Sub Group.

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.

It is recommended that the NEL Safeguarding Children Board satisfies itself that:

8.1 **Decisions relating to threshold application, particularly 'step down' arrangements are underpinned by updated assessment, evidence of change and sustainability and take account of how multi-agency partners understand the ongoing needs for the child**

CIN closure panels are in place weekly & all cases must go through panel, process for step downs:

- Child in Need step down **following** panel meeting:
- CIN step down meetings to be held each Friday.
- Integrated Family Services/Family hub rep to attend CIN step down meetings.

When "stepped down" to;

- Universal - Be accompanied by a letter which formally identifies universal services that are supporting the family, i.e. HV, school CP co-ordinator, children's etc.) by the social worker

- Early Help/universal plus, include an overview of the reason for involvement, i.e. the original danger statement, safety goal, bottom line (clear identification should family disengage at this level, what needs to happen), family plan, genogram, Ensure agencies that are to be involved are informed. Review date identified.

Be accompanied by the CIN plan, the step down meeting minutes and the family safety plan.

8.2 **All children identified as Child in Need within CSC have a multi-agency plan with a level of management oversight equal to children subject to Child Protection Plans**

All children subject to Child in Need (CIN) have a CIN Plan which is multi agency. The timeliness and Quality of CIN Plans are tracked through the Performance Monitoring and Accountability Framework and through the Children's Assessment and Safeguarding Service (CASS) Quality Assurance framework through audits.

There are key points of management oversight throughout the Single Assessment and via CIN Panels to ensure that cases are progressing. The introduction of a Single Assessment process in September 2015 ensures that every child open to Children's Social Care now has a Single Assessment which leads to a plan for the child within a 10 day timescale. The Single Assessment process builds in defined management checkpoints with the purpose of ensuring that there is a timely and robust plan with the benefit of clear management direction. In addition all CIN cases are subject to monthly case supervision and management oversight.

8.3 **Current procedures relating to pre-birth assessment are effectively implemented and embedded into multi-agency professional practice**

On existing open cases, where it is known that there is another pregnancy, an assessment of the unborn child will begin immediately. There are robust procedures in place to ensure that there is no delay in undertaking pre-birth assessments and planning and these are currently being strengthened to include cases open at an Early Help level.

Conference chair procedures have been revised to ensure that the conference process fully considers pre-birth assessments if they have been completed prior to conference or recommends they are completed.

Conference chairs are also required to ensure that if they become aware that the parent or parents of a child/ren already subject to a CP plan, has had a pre-birth assessment or is pregnant, the unborn child is considered and also the impact on the family and child once the new baby arrives.

Conference chairs are also advised to ensure when holding a conference on another child and during conference agencies become aware that a parent is expecting another child, the unborn child is considered in its own right at conference and if necessary a further conference is convened relevant to the timescales of the expected birth.

8.4 **Systems in place proactively ensure that siblings of children subject to a Child Protection Plan, including those new born and unborn, are given specific consideration as to whether a Child Protection Conference or Plan is indicated**

Conference processes are such that regardless of the subject of the conference, chairs are required in all cases to consider any siblings, (including new-born babies) and expected babies as individuals in their own right and where necessary, recommend that the social worker arranges for a further Section 47 investigation to determine whether or not a further conference or CP plan is needed.

8.5 **Multi-agency professional meetings – including CP conferences, Core groups and CIN meetings, should ensure attendees have a full understanding of the status and range of kinship care arrangements and their implications for practitioners in order to be satisfied that sufficient oversight and challenge can be achieved where necessary fine**

Conference chairs are advised to ensure that any proposed arrangements for kinship care are considered fully at conference and that all attendees, including family, are aware of the implications for the Child Protection plan and their responsibilities within the plan if the care arrangements are being altered or will impact on the safeguarding responsibilities of parents, carers and professionals

The Local Authority have robust Kinship Care assessment arrangements in place and such cases are actively assessed and supported by CASS and the Fostering and Adoption service under Reg 24 and LAC procedures. Children in the care of their family make up a significant proportion of our LAC population currently.

Children who are LAC and are placed with connected people are subject to the full Reg 24 and LAC assessment, planning and review procedures which are multi agency.

8.6 **All referrals to CSC from family, relatives, the public and anonymous sources are, wherever possible, responded to by communicating directly with the referrer.**

Where possible, all people who refer into the MASH will be contacted directly by a social worker to discuss their concerns directly.

Humberside Police have based dedicated resources consisting of a Detective Sergeant and administrative support within the MASH at North East Lincolnshire. All referrals, whether received internally or externally are co-ordinated through a single route. Joint decision making is undertaken within the MASH through these dedicated resources which sees consistency of approach and response to referrals. Research is undertaken on all Police systems prior to decision making taking place.

It is recommended that NEL LSCB promotes:

8.7 **Opportunities for practitioners to develop increased skills in analytical thinking to apply at points of assessment and decision making**

The Local Authority have a Creating stronger Communities approach that is used by all of the children's workforce within North East Lincolnshire. The approach consists of Signs of Safety, Restorative Practice, Outcome Based Accountability and Family Group Conferencing.

In January 2014, the Authority began an implementation of the 'Signs of Safety' Framework, this provides social workers with an underpinning ideology from which to work collaboratively with families and children to produce Children's Plans designed to increase safety and reduce risk by focusing on strengths, resources and networks available to the family. There are many recent research studies which have identified substantial benefits of this model which does direct practitioners to identify specific aspects of risk.

8.8 **Awareness raising within the community about safeguarding and making referrals with a view to promoting a better partnership approach to protecting children**

The LSCB have well established relationships with the voluntary sector and community groups. The LSCB website provides clear guidance on who to contact if worried about the welfare and safety of a child and on safeguarding procedures. The LSCB publish a quarterly newsletter which highlights both local and national safeguarding development, activity, audits and learning from Serious Case Reviews.

Targeted campaigns about Neglect awareness have taken place in key wards in North East Lincolnshire since November 2013, this has included comprehensive training of the children's workforce, marketing and media and parent workshops.

NELC is also part of the CSE National Working Group and over the past two years have introduced a new approach to awareness raising about the signs of CSE. We have trained hotels, B&Bs, taxi drivers and children's workforce staff.

As part of the council's 0-19 project, a new approach to education and awareness is being undertaken. This will include a social marketing approach to understanding community behaviour and barriers to change, in the first instance with parents of 0-2s to enable us to develop innovative solutions to ensure our prevention and early intervention solutions truly meet user need.

8.9 **Domestic Abuse is addressed rigorously by addressing the position of the child, victim and perpetrator.**

Strategically Domestic Abuse reports to the Children's Partnership Board (Local Children's Trust) and is Humberside Police's main priority as well as one of the four key priorities of the LSCB.

A review of partnership resources has resulted in additional funding being provided for a Domestic Abuse Co-ordinator and two additional Independent Domestic Violence Advocates (IDVA's).

Two partnership groups have now merged and chaired by the Director of Social Care they are ensuring there is a clear focus and progress on the whole Domestic Abuse agenda.

Conference Chairs are advised that any Child Protection Conference dealing with Domestic Abuse must specifically consider the individual roles and positions of children, victims and perpetrators, refer to this in summing up and decision-making and make reference to the child, the victim and the perpetrator in CP Plans.

Where a child involved with Domestic Abuse is made subject to a CP plan under one of the four categories (Physical, Emotional, Sexual Harm or Neglect – conference chairs must make specific reference in conference to Domestic Abuse as a 'secondary category' and this should be recorded in the child's conference record on CCM.

At Early Help needs are identified through the development of a Single Assessment which should incorporate the views of & impact on all the family members. The Families First Action Point will advise practitioners if the needs can be addressed through direct referrals to services or if appropriate the SA will be discussed at the multi- agency Family Hub Cluster SA meeting to develop a team around the family, the SA uses the signs of safety approach & includes a family plan.

Within Family Hubs & Help Family Support teams currently a range of support can be offered. It has been recognised by the 0-19 Commissioning Programme research that DA needs to be a priority driver. Existing pathways for Domestic Abuse are being further developed for Domestic Abuse along with a comprehensive workforce development plan which is aligned to the Children's Workforce Professional Capability Framework.

All cases of Domestic Abuse are assessed by the Police within the Police DA Unit. Additional training has been given to all front line Officers and the F913 has been amended in relation to children, particularly around recording and seeing the children that are present. Additional checks are now undertaken with the Call Handling Centre to inform the current risk based on previous reported DA incidents. Information Sharing Policies are in place with Local Authorities to ensure that appropriately and timely information sharing is undertaken with partner agencies where children are present or living in households where DA incidents have occurred. MARAC processes are well embedded within the Local Authority area to work in partnership on those cases deemed to be at high risk.

Level 1 – Domestic Abuse Awareness and Level 2 - Domestic Abuse and the Impact on the Child and Family training is delivered by Women's Aid and LSCB trainers to all relevant staff. During 2015-16 107 staff trained at Level 1 and 71 in level 2. During 2016/17 so far 32 staff have been trained at level 1, 13 at level 2 and 44 staff attended the Martin Calder pilot sessions.

Level 1 covers signs symptoms, raises awareness and what to do if Domestic abuse is suspected or known and how to support the victim. Level 2 covers the impact on the child their development and emotional resilience at different stages. It covers how to support the victim and understand the barriers to change for them and perpetrator behaviours and characteristics (also about dealing with concerns about perpetrators attending child protection conferences in terms of influencing the victim speaking freely). It also introduces the DASH Risk Assessment.

Pilot training has just been undertaken delivered by Martin Calder to cover the following Learning outcomes to;

- To introduce some options for staff when challenged with engaging perpetrators of domestic violence and their partners within the home
- To introduce some assessment frameworks to support this approach
- To examine the challenges and options of engaging children and young people in work to equip how they deal with, and recover from, domestic violence in the home
- To affirm existing knowledge & build on this to enhance staff confidence & skills in undertaking work in this area

In 2016 the Domestic Abuse training was reviewed in order to incorporate the learning from serous case reviews, the referral process and contacts have been reinforced. A group exercise has been added on the effects of domestic abuse on children and young people which includes all age groups. This also highlights the significant risk to the unborn baby and the significantly heightened risk to the mother during this time. Slides have been added about lessons from local serious case reviews, highlighting the significant risk of a new pregnancy in the home where there has been domestic abuse. It also highlights checking whether there are any children within the family and checking whether they are safe. Trainer input also reinforces this throughout delivery and within discussions.

The training pathway is currently being reviewed as part of re commissioning. A skills survey is being undertaken across the workforce which includes domestic abuse, practitioners have been asked about their knowledge and skills in supporting families with domestic abuse needs. The survey also asks about staff persistence and assertiveness where families do not engage.

The Children's Workforce Professional Capabilities framework has been launched and provides the outline of the Skills, knowledge and behaviour required by the workforce (including in relation to DA) and will enable individuals and leaders to identify any gaps and learning requirements. This information will inform the on-going development plan for the workforce going forward in terms of meeting any gaps in their knowledge, skills and behaviour.

Evaluation feedback from Domestic Abuse courses held this year;

Level 1 Domestic Abuse Awareness (2 courses held in period)

- Will audit front line staff confidence/experience in completion of the DASH assessment tool
- Helped to understand the reasons why victims behave in certain ways
- Will be able to read signs and put what I've learnt into practice

- Will be more mindful of the difficulties facing women/children if the woman is still in the relationship
- Ensure greater promotion of information sharing – develop a greater understanding of why victims stay in abusive relationships, from their voice and the impact on the child
- Great to have the awareness and info on how to refer + who to as well as empathy/understanding.
- Hope to identify and support people more efficiently
- More understanding of DA which will help me to support clients
- More understanding of danger situations, i.e. when perpetrator present

Average progression rate/ distance travelled : knowledge and confidence:-
Course 1: Knowledge - 3/confidence – 3
Course 2: Knowledge – 2/confidence – 2
92% found the training excellent and 8% good

Level 2 Domestic Abuse and the Impact on the Child

- Will emphasise the importance of capturing the child's voice, safety planning and use of best questions
- Now more aware of questions to ask, seek the voice of the child/ think outside the box when needed
- More confident in working with/approaching families on the subject
- Will now be able to identify and recognise DA, support and signpost
- Will hopefully now be able to help the child come to terms with the impact
- Will be more proactive and alert in respect of DA
- More confident in addressing and investigating DA
- Making sure staff are aware of contact details of services to support victims locally
- Increased confidence when talking and supporting staff and making decisions on referral pathway
- Better understanding of MARAC
- Ensuring parents understand the impact on children
- Able to raise awareness about domestic abuse

Average progression rate/ distance travelled: knowledge and confidence:-
Knowledge - 2/confidence – 262% found the training excellent, 31% good and 7% average

DV – Pathways to Successful Engagement and Outcomes (Martin Calder training)

- Making Improvement in my ability to assess.
- Be able to use identified tools to use within assessment of risk.
- Apply knowledge/skills to my families.
- It will now make me think of the other underlying issues. I will also be aware of diversion tactics.
- Being able to attempt to unpick the issues related to the situation and see the different aspects.
- Will help me to recognise DA and what to do next.
- Understanding of how to keep the child at focus.
- Informed me how to begin to approach families with DA issues, as before the session had very limited knowledge.
- I will consider the multiple applications to assessment in all cases.

- More holistic understanding can affect approach to include perpetrators to help effect engagement and change (positive).
- I will feel more confident of I am in this situation involving DA, to challenge the perpetrator – also to look at it from all angles of the family.

Average progression rate/ direction travelled: knowledge and confidence:-
Course 1 Knowledge – 2.5/confidence – 1.5
Course 2 Knowledge – 1/confidence – 1
Course 1 - 62.5% found the training excellent, 31.25% good and 6.25% (1person) did not respond.
Course 2 60% found the training excellent, 33% good and 7% (1person) did not respond.