



**REPORT OF FINDINGS FROM
A SERIOUS CASE REVIEW**

ISLE OF WIGHT SAFEGUARDING CHILDREN BOARD

**Independent Reviewer
Moira Murray
August 2013**

Prepared for publication by Alan Bedford, November 2013

Local Safeguarding Board (LSCB) Chair's Foreword

The national guidance 'Working Together to Safeguard Children 2013' requires LSCBs... 'when compiling and preparing to publish reports (to) consider carefully how best to manage the impact of publication on children, family members and others affected by the case. Following advice from medical sources, independent safeguarding experts, I have decided that it can only be appropriate to publish the findings of a Serious Case Review (SCR) in this form- which looks at lessons learned and no detail from the case that was studied.

The LSCB fully supports the national guidance that every effort should be made to publish full SCRs but also recognises that it has a duty of care to mitigate risks that may identify vulnerable children.

It has been necessary to provide limited information about the purpose of the review and terms of reference to ensure that the case cannot be recognised.

A safeguarding consultant, Alan Bedford, was commissioned to anonymise the findings from the SCR, and prepare this report which can be published. I am satisfied that this Report, which is supported by the SCR independent reviewer, is true to the findings approved by the LSCB.

A number of the findings echo those made by Ofsted in their 'Inspection of local authority arrangements for the protection of children: Isle of Wight' (January 2013) <http://www.ofsted.gov.uk/local-authorities/isle-of-wight> This also assisted the decision that a findings only report could be published as there was no need for case detail to establish some of the key conclusions.

Child protection arrangements on the Island are currently overseen by an independent Improvement Board, overseen by the Government and the IOWLSCB is committed to ensuring that close scrutiny is given to ensuring necessary improvements are put in place in line with the findings of this SCR and the Ofsted judgement. New management arrangements commenced in July 2013 between Hampshire County Council and the Isle of Wight in the running of Children's Services on the Island. I was appointed as the new Independent Chair of the LSCB in October 2013.

**Maggie Blyth, Independent Chair, Isle of Wight Safeguarding Children Board
November 2013.**

1. INTRODUCTION

1.1. **Background to the Review:** The Isle of Wight Local Safeguarding Children Board (LSCB) concluded that the circumstances of the case concerned met the statutory requirements for a Serious Case Review. It commissioned an independent reviewer Moira Murray (an independent social work consultant) to prepare the report from agency reports, under the oversight of a Panel which was independently chaired by Phil Green (who works with the training and development agency Reconstruct). The process followed the guidance then in force, Working Together to Safeguard Children (2010). As can be seen from the Foreword, it was not possible following extensive advice to publish a traditional SCR, and so this Report focusses on the Findings.

1.2 **Terms of Reference:** The purpose of a serious case review as set out Working Together (2010) is to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- Improve intra- and inter-agency working and better safeguard and promote the welfare of children.

1.3 In addition to the standard questions that were listed in Working Together there were case specific terms of reference which focussed on the quality of assessment of risk, the response to the risks concerned, and the degree to which there was evidence of professional challenge and robust questioning of other agencies assessments of family capacity.

1.4 **Review Process:** The Panel had an independent chair, and members from the involved agencies, and the designated nurse for safeguarding who produced an overview of all the health contributions. Individual Management Review (IMR) reports were received from the involved health and social care agencies: The Isle of Wight Council (children's social care), the Isle of Wight NHS Trust (comprehensive community and secondary health care) , and the Isle of Wight CCG (for primary care/GP) and the Children's Society (children's centres) . They were written by staff who had not been involved in the case.

1.5 There were a number of delays in the production of IMRs, and some lack of consistency in Panel attendance from Children's Social Care, but enough information was collated to understand the issues and identify learning. The SCR Panel considered how early learning could be shared with relevant agencies and staff. The recommendations and action plans will be shared with staff and implemented immediately where possible, under LSCB monitoring.

1.6 **Anonymity:** For the reasons described in the Foreword, this report does not talk about the specific case.

2. FINDINGS

2.1 The SCR findings, of necessity, cannot go into specific detail, but are generalised to maintain the focus on findings rather than family. A few findings (of which agencies are aware) cannot be described as that would reveal identifying detail.

2.2 In January 2013 Ofsted published a report, following an inspection in November/December 2012, into Local Authority arrangements for protection children. It reached the following conclusions which were largely found in this case- which is not surprising since the case was essentially in the period studied by the Review. Ofsted found the overall child protection services inadequate ('a service that does not meet minimum standards') and summarised a number of key areas for improvement

- Not all children and young people get the right help from social workers when they need it to help them be safe.
- Sometimes social workers are slow to sort problems out for children and they are not always good at understanding all the things that need to change before a child will be protected.
- Some of the managers have not been able to understand or put right things when there are delays or when the social worker doesn't understand the problem properly.
- When social workers look at the problems in a family they sometimes give too much attention to what the adults say and do not think hard enough about what might be best for the child. Sometimes this means the plans they make won't work and things don't get better.
- Social workers do not always get the chance to talk to their managers about the children there are working with and how well they are doing as a social worker.
- Managers don't always have the right information about all the work that is being done with children. This means that they find it hard to sort out problems and make improvements to all the work that they are in charge of.

2.3 Most of these characteristics were seen in this case. In the full Ofsted report the following more specific points were made that were also seen in this case:

- Significant weaknesses and systemic failures in core child protection business
- Services being delivered by Children's Services First Response Unit ...were found to providing inadequate responses to children in need of protection, with some decisions which exposed children and young people to the risk of harm
- The 'clear and relevant' threshold document (for when referrals should be accepted) was not consistently being applied, with a variable response to referrals
- Professionals from other agencies reported experiencing delays and a lack of responsiveness from First Response when raising concerns about children

- Too many cases were kept at the 'contact' stage that should be escalated to ... initial assessment, and cases which met the threshold for child protection enquiry were not escalated
- Some cases were closed or 'stepped down' inappropriately, relying on other agencies to carry undue risk
- A number of assessments seen by inspectors had overly optimistic conclusions that did not sufficiently reflect risk or the child's journey in terms of the use of historical information and prognosis for positive change. Too many risk assessments do not consider patterns of behaviour, family history or previous events and as a result risk is assessed based on one specific incident rather than a comprehensive overview.
- The majority of assessments seen are of poor quality, lacking sufficient analysis of risk and indicating a lack of understanding of risk factors.

The LSCB was also said to be underdeveloped

- 2.4 By listing these findings from Ofsted, it prevents this report from illustrating its own findings too much, and thus put anonymity at risk. The list of findings above and the findings from this SCR relate to 2012 and before
- 2.5 **Appraisal:** The SCR concluded that there was good practice on the part of certain agencies, notably health visiting, mental health services, the named midwifery safeguarding advice, and the children's centre. (Children's centres were also praised by Ofsted). The health visitor was exemplary in monitoring the baby's development and acted appropriately in getting the right medical intervention when this was of concern. In overall terms, these agencies were aware of risks to the children involved and shared them with Children's Social Care.
- 2.6 However, in face of very poor responses from Children's Social Care, the SCR found that other agencies should have been more challenging and escalate their concerns about inaction, or for example ensuring a thorough assessment during pregnancy. It was also concluded that all agencies could have given more thought 'to what it was like to be a child in that family' (given the range of social and health risk factors).
- 2.7 Children's Social Care is criticised by the SCR for the following reasons, some of which echo the Ofsted findings above
- A reluctance to accept the implications of the risk factors regularly presented by the mother, either for her or future children
 - The full range of risks in the extended family, and from the history, were either not considered or given sufficient credence. Children's Social Care is best placed to bring together the whole picture
 - Deciding that the case needed dealing with at the CAF level, rather than responding to the seriousness of the concerns as a 'child protection' case
 - The CAF assessment was, as a result, led by another agency worker who would not have been trained to assess the level of risk involved

- When Children's Social Care did agree to do an assessment it was not done in time to impact on some key decisions around the baby concerned
- Nor was it properly multiagency as required
- The Review concluded that there was a reluctance in Children's Social Care to engage with mental health professionals
- An assessment of mother to be and family's capacity with a new child was resisted until too near birth
- When an initial child protection conference was eventually thought necessary on by a social work manager on the baby who was failing to thrive, there was no Strategy Meeting with Police or any other agency first as is good practice, and the Conference was arranged for over three weeks' time. By that time it was too late to have any impact on protecting the baby
- There was a very serious failure by managers in Children's Social Care to review and account for decisions in the First Response Unit, and subsequently in the short term unit.

2.8 There were also general lessons, such as one seen in numerous SCRs about undue professional optimism despite considerable non-compliance with advice, and which is often unabated by subsequent events which would challenge such optimism. There was optimism (which stems from a natural desire to help families be successful) despite physical and emotional home conditions which might suggest a different conclusion and for example about a young parent's ability to take on new responsibilities given past social and health concerns.

2.9 A variation of this was that, probably out of a commitment to self - determination and respecting client wishes, a young mother's self-assessment of capacity and service need was followed by social care, to the detriment and exclusion of the views of other professionals who had been involved with the family.

2.10 A specific aspect of learning from the Review was the need for reflective supervision which encourages professional curiosity when faced with non-engagement/disguised compliance from families. Such reflective supervision should ensure that managers recognise the need to escalate child protection concerns that are not acted upon by statutory agencies. Whilst certain aspects of reflective supervision were evident in the practice of some agencies, it was not in others. There was, however, no escalation of child protection concerns by agency managers to their counterparts in Children's Social Care, when safeguarding referrals were rejected by the First Response Team. In the case of Children's Social Care there was no indication that any form of reflective supervision took place, as supervision was team focussed.

2.11 The Review looked at whether there were organisational difficulties which would put these findings in context. It describes approaches to the organisation of children's care on the Island that appears to have had an adverse effect on the ability to protect children. This is covered in the Ofsted inspection report. There appears to be no other capacity or organisational concerns highlighted in this SCR, except that the programme of recruitment to build capacity in health visiting numbers in line with national policy.

3 CONCLUSION

- 3.1 It is apparent that there were opportunities for early intervention by Children's Social Care. It is also apparent that the need for such intervention was recognised by some of the agencies involved in the review. However, the requests for early intervention were not acted upon until very late in the review process. Agencies need to follow up requests with a poor response more vigorously.
- 3.2 The Serious Case Review has recognised that there was good practice on the part of certain agencies, most notably mental health, midwifery safeguarding advice, the health visiting and the Children's Centre. These professionals recognised the safeguarding concerns presented by the family. They were also persistent in bringing such concerns to the attention of Children's Social Care.
- 3.3 If Children's Social Care had recognised the need for early intervention, in the form of targeted support for the family, within the framework of child protection, then the outcome may have been different.
- 3.4 Most of the findings of the SCR were issues found by Ofsted in their 2012 inspection. Strong action was recommended by Ofsted.

4 SCR RECOMMENDATIONS

These are the recommendations from the SCR. (The recommendations from the agency IMRs are reproduced in Appendix 1). It is acknowledged that some of these recommendations have been implemented since the completion of the Serious Case Review. The recommendations are for the Board to pursue

4.1 Isle of Wight Local Safeguarding Children Board

- 4.2 That the LSCB develops and publishes an agreed Threshold document for referrals to Children's Social Care, which accords with the requirements of Working Together to Safeguard Children (DfE 2013)
- 4.3 That the LSCB must be satisfied that each partner agency has an agreed escalation procedure in place that clearly indicates what action should be taken when safeguarding children referrals are deemed not to meet the threshold for intervention by Children's Social Care. Such procedures are to comply with the 4LSCB Escalation Policy.
- 4.4 That the LSCB considers undertaking a 'deep dive' audit (which includes the participation of multi-agency partners) of the Duty and Assessment team, which has replaced the First Response Team to ascertain:
 - The timeliness and quality of information provided in pre-birth assessments/child in need/section 47 assessments and in the case of teenage mothers whether an assessment has been completed in respect of the mother and the unborn child
 - Whether child protection concerns are adequately assessed at the time of referral;
 - Where a decision to 'step down' a child in need case to the status of a CAF is appropriate.
- 4.5 That the LSCB recommends that multi-agency meetings should always be held in cases where there are concerns from professionals of non-organic failure to thrive, which result in hospitalisation and there are subsequent admissions for the same reason. To be monitored by audit.
- 4.6 That the learning from this review is disseminated to multi-agency partners in a timely and meaningful way, so as to promote reflective learning and encourage best practice.

Appendix 1 Recommendations from Agency Individual Management Reviews (IMRs)

These are reproduced from the agency IMRs submitted to the Review, with adjustment for this Report where necessary to ensure anonymity of family detail. The agencies and the LSCB are clear on the full wording of the actions concerned. The recommendations are listed by IMRs

1. Isle of Wight Council Children's Social Care

- 1.1 Storage of information related to service users to be simplified so that electronic recording is easily accessed.
- 1.2 Adoption of a consistent approach to how cases are allocated to Consultant Social Workers.
- 1.3 Initial child protection conferences to be allocated in a timely fashion to meet legislative standards.
- 1.4 Ensure the voice of all relevant children in cases is heard, recorded and acted upon.
- 1.5 Ensure the CAF process is suitably quality assured
- 1.6 Ensure that thresholds are agreed, understood and applied consistently
- 1.7 (The Council is working on this recommendation)

2. Education

- 2.1 All schools to have a standard recording policy Records should include a bullet point chronology of significant events, record actions and outcomes with clear timelines for review.
- 2.2 When pupils are absent from school in excess of 15 days for illness a referral is made to the Local Authority so that a clear plan can be made to ensure a child is provided with an effective education in line with their health needs
- 2.3 Schools to have identified Pastoral Support processes for children with additional needs with senior leadership ownership and oversight.

3 The Children's Society

- 3.1 All Conversations/actions that take place must be recorded in case files as per policy (Case Recording & Records Management policy-July 2010).
- 3.2 The Children's Society staff should challenge other agencies including Children's Services where appropriate.
- 3.3 A review of criteria for distribution of 'well done certificates'
- 3.4 A process to be embedded in order for incomplete actions to be addressed.
- 3.5 Completed Risk Assessments to be fully evidenced in files prior to any home visits/outings/lone working

4 Primary Care (GP) IMR (recommendations for the NHS)

- 4.1 To undertake a training needs analysis to benchmark progress with delivery of safeguarding children training and updates to GP practices and their staff.
- 4.2 To ensure that GP practices and their staff have access to updated safeguarding children policies, guidance and research (including READ code information).

- 4.3 To promote an understanding of the need for GPs, Nurse Practitioners and Practice Nurses to consider the impact of parental/carer difficulties (on children in the household and make referrals accordingly).
- 4.4 To require registration details to include information of who is living in a household, in relationship to cooperating with Serious Case Review investigations. Where members of a household are registered at a different practices, to seek consent for information sharing in line with legislation and guidance.

5. Isle of Wight NHS Trust

- 5.1 Quarterly meeting set up with (specified) Safeguarding Children Leads in mental health to promote/review/challenge multi agency risk assessments.
- 5.2 Clinical Review in CCAMHS Education Forum of National Clinical Practice Guideline Number 78 National Institute for Health & Clinical Excellence, 2009, Chapter 9.
- 5.3 Need for Health Staff to have further training in faltering growth.
- 5.4 Need for Staff to have further training in (a specific issue) from this case
- 5.5 Ambulance - All minors attending hospital by ambulance should be accompanied by their care giver.
- 5.6 A&E - Accident and Emergency Unit needs to ensure that if they see a pregnant mother who has abdominal pain and bleeding that they liaise urgently with Maternity Staff (Accident & Emergency)
- 5.7 Maternity – (specified medication) levels should be promptly measured so that preventative treatment can be given in a timely manner.
- 5.8 Safeguarding - The IOW Trust policy of Safeguarding is out of date and needs updating.
- 5.9 Health - TAF minutes should be available to Health Staff and action plans monitored.
- 5.10 Health Visiting - There is a need to improve the offer of universal ante natal health visiting contacts. This has also been raised in a previous partnership review action plan.

6 The Health Overview Report

- 6.1 That the newly appointed Named GP for the IOW undertakes a safeguarding children audit of all IOW GP practices as a baseline for future learning and development. The audit tool should be derived from the RCGP & NSPCC Toolkit. Support in this activity should be provided by the Wessex Area Team/CCG Safeguarding Leads
- 6.2 That the NHS England Wessex Area Team reviews the specification for health visiting services to ensure this includes an antenatal contact by the Health visiting service as per the Healthy Child Programme (Department of Health, 2011);
- 6.3 That the NHS England Wessex Area Team work with local partners and the Department of Health to commission the Family Nurse Partnership programme for the IOW;
- 6.4 This recommendation is being pursued by the NHS

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