Suffolk Safeguarding Children Board
www.suffolkscb.org.uk

Partnership Review SCR: Family 'A' 2013/14
Process Evaluation

Introduction

The case of the Anderson Family was referred formally to the Suffolk Local Safeguarding Children Board on 16th April and their Serious Case Review Panel met on Monday, 13th May, 2013 to consider the case under Regulation 5 of the Local Safeguarding Children Board Regulations 2006. The Panel found that this case met the criteria for a Serious Case Review and agreed the commissioning arrangements in order to meet the requirements of such reviews as laid out in HM Government 'Working Together to Safeguard Children 2013'.

Working Together 2013 allows LSCB's to use any learning model consistent with the principles in the guidance, including systems based methodology. After careful consideration of the options it was decided that this review would be conducted using a systems based partnership learning model designed by Mr Ron Lock for Bournemouth and Poole LSCB and Dorset LSCB dated April 2013.

The Terms of Reference for this review outline the methodology as follows:

> *'Use of this style of review does not require the SCR Panel to develop key issues for the review to consider during the early scoping process as in line with qualitative learning principles, reviewers endeavour to start with an open mind in order that the focus is led by what they actually discover through the review process. Key themes are therefore developed by the Review Team once they have access to the full information contained in the agency chronologies.*
>
> *Ideally practitioners involved in the case and their line managers will be encouraged to engage with this process through the Key Learning Event. However, it is acknowledged that there may be particular circumstances that prevent this.*
>
> *If this occurs, partner organisations should make provision for the Independent Safeguarding Lead and/or the Overview Author to interview those members of staff in order to maximise learning opportunities.'*

To ensure that relevant areas were explored and enable the key themes for learning to be identified the time period for the review was set between 1st January 2009 and 15th April 2013. This encompassed a short period prior to the birth of the first child, through to the deaths of Fiona and her children.

The timescale for the review was from 21st June to 31st October 2014.

The Coroner was informed at an early stage of the decision to conduct an SCR, communication continued throughout the process and copies of the completed report were supplied in draft form ahead of publication.

Contact was also made with the family via the family's Police Liaison Officer and initially, by the Lead Investigating Officer.

Process

Decisions and Scoping

The initial decisions, scoping and proposals for review team membership were made by the SCR Panel. The final decisions as to who should sit on the Review Team were allocated to the Independent Overview Writer and Chair. Concerns were raised by the Designated Doctor that they, or an equivalent representative from Health, had not been included. This concern was taken to the Independent Overview Writer who was of the opinion that if a particular professional opinion was required at any point in the process then individuals would/could be invited to attend or join the reference group.

This concern was also raised with the Independent Chair of the LSCB who noted that the Designated Nurse for Safeguarding Children in Suffolk was part of the Review Team, as was the Director of Quality and Safety for HealthEast Clinical Commissioning Group for the Waveney area.

Organisations who contributed to the review were:

a) Suffolk County Council Children and Young People Services
b) Suffolk County Council Legal Services
c) Suffolk Constabulary
d) Fen Park Primary School, Lowestoft
e) Meadow Primary School, Lowestoft
f) Waveney District Council
g) Access Community Trust (formerly St John's Housing Trust)
h) CAFCASS
i) East of England Ambulance Service NHS Trust
j) HealthEast, NHS Great Yarmouth and Waveney CCG
k) James Paget University Hospitals NHS Foundation Trust
l) East Coast Community Healthcare CIC
m) Norfolk & Suffolk NHS Foundation Trust

The Review Team who were responsible for assisting the Independent Safeguarding Lead in facilitating the Learning Event, and in providing local context and challenge as the analysis of professional practice and learning developed were:

- Bob Cook, Independent Safeguarding Lead
- Ron Lock, Overview Author
- Ali Spalding, Suffolk LSCB
- Tina Wilson, Suffolk County Council CYPS Safeguarding
- Nigel Innis, Suffolk Legal
- David Cutler, Suffolk Constabulary
- Abigail Scully, Designated Nurse Suffolk CCGs
- Cath Gorman, Health East, Great Yarmouth and Waveney CCG

Understanding of Process

The LSCB Independent Chair sent letters sent to CEOs early in the commissioning of the review (May 2013) outlining the process of the SCR and asking CEOs to nominate leads for the Review Team. Copies of the letter, along with copies of the Terms of Reference and IAR templates were sent at the same time to identified Safeguarding Leads, Board Partners and to those IAR writers who had already been nominated by their agencies.

A briefing for IAR writers took place on the 28th May. Most nominated Review Team members also met individually with the LSCB Manager and were briefed as to their role. This included the expectation that they would ensure that their own agency, and any associated/commissioned agency would be kept briefed as to the progress of the SCR.

Attendance at the Review Team meetings was patchy. Not all Review Team members were able to attend every meeting and no nominated deputies were agreed at the beginning. Assurances had been sought from members of the Reference Team at the start of the process that they would make all meetings a priority. An exception to this was agreed with one Health Representative who advised the LSCB Manager of a clash in dates for one meeting at a very early stage and the Head of Safeguarding, who arranged for another senior CYPS manager to attend on her behalf.

As a considerable amount of work was undertaken in the review meetings in analysing and agreeing key facts, details and hypotheses in the case, any absence inevitably meant a gap in knowledge for the professional involved.

A misunderstanding/lack of understanding as to the communication responsibilities of Review Team members led to one agency who contributed to the SCR not fully aware of the progression of the review and a concern was raised at the extraordinary meeting of the LSCB Team that no doctor had reviewed the draft report prior to it being shared with the LSCB.

However when the report was shared immediately after the Board meeting, it was documented that the providers and designated team concerned felt that the report

was well written and measured in its response to the analysis of this tragic event. Important issues were raised and their impact on the management of this case and the ability of professionals to bring about change to these children's experiences analysed.

All agencies had been advised at the beginning of the SCR process that they should address any issues raised for their individual agencies as soon as they became apparent from the completion of IAR reports. Again, there appeared to be a lack of clarity or understanding as to the actions they should be taking as an individual agency to learn from their IARs and the expectation that individual agencies would ensure that they formulated action plans and executed those plans from the earliest opportunity.

The LSCB did not formally pick up on any process for feedback on any changes/lessons learned by individual partner agencies until an update to the Response document went to the Board in summer 2015. Somewhat belatedly, it came to light that there had not been a consistent approach to learning across the partnership.

Learning Events

All agencies were asked, as part of their IAR completion, to provide a list of all practitioners who should be invited to the Learning events with confirmation that they were still contactable through the organisation and contact addresses wherever possible. Invites were sent out by the LSCB support team on the basis of the information provided. Again, belatedly, the LSCB support team was made aware that a member of staff who had quite a high profile in the case had not indeed left the employ of the Local Authority and was still working for the Local Authority.

Both Learning Events were well attended by staff involved with the family and their Managers.

Learning Event Evaluations from 1st Learning Event: 9th September 2014

16 evaluations received. Overall, practitioners and their managers told us the event was:

4 Excellent
10 Good
2 Adequate
0 Poor

Factual Information	GOOD
Learning Themes	GOOD
Key Themes for Analysis	EXCELLENT
Consideration of the Children's Lived Experience	EXCELLENT

Overall event evaluation:

- Everyone had a chance to check out the work already completed and contribute.
- Well-structured and organised day that kept focussed and achieved objectives.
- Good overview and emphasis on 'what' and not 'why'.
- Felt supportive rather than blaming.
- Worth attending.
- Learning came from understanding the different perspectives of professionals working with the family.
- Thinking of things from the child's perspective really helped in understanding the emotional and psychological elements of the case.
- Some of the discussions were generalised and speculative – particularly when discussing the child's experience.
- Had expectations of something more challenging.

Learning from 1st Learning Event as commented by attendees:

- A Summary of the full chronology should be received by attendees before the event.
- Each attendee should have been familiar with their own agency chronology and been given the opportunity to look at this in detail.
- Smaller discussion groups would have been useful – maybe staff directly involved with the case should have had their own smaller meeting beforehand?
- Ensure that each organisation allocates time for staff to talk and spend time with their manager to prepare for the event and be provided with any resources/support where necessary.
- Change the name of the learning event to ensure attendees are aware that they are part of the development of the review and for their contribution. Some attendees felt they were coming to be 'told the story' of the SCR.
- Staff attending the event should be aware of who they can approach before and after the event for support. Contact details for each organisation should have been in the packs.

Learning Event Evaluations from 2nd Learning Event: 24th October 2014

22 evaluations received. Overall, practitioners and their managers told us the event was:

Content	*Organisation*	*Findings Presentation*
2 Excellent	5 Excellent	3 Excellent
19 Good	15 Good	17 Good
1 Adequate	2 Adequate	1 Adequate
2 Poor	0 Poor	0 Poor

Comments: 'Hard work but good Agenda'
'Thanks for the superb organisation and communication'

Participant views of the day and the most valuable aspects of the day:

- A useful multi-agency forum with representatives such as legal and CAFCASS who are not normally present at other multi agency for a.
- Useful sharing of multi-disciplinary practice/knowledge.
- Change to organised programme made it confusing.
- More constructive - lots of learning outcomes achieved. Became a little muddled in the afternoon.
- Was well run and was better staying in the same groups.
- This was an open and wide ranging discussion forum. I am less certain that the primary focus of the day was clear to all.
- Well organised, focused – a good working day.
- More challenge which is productive and helped to unpick further clarity regarding the case but also facilitate discussion.
- Intense but created good strong open and honest discussion. Feel exhausted!
- Well-structured and worthwhile. A good working day.
- Good to see draft overview report and look at themes and to try to identify innovative practice that can be looked in to and start to progress this locally, rather than waiting until the report is produced.
- Good to have been in multi-disciplinary groups but would have been more enriching to have changed groups.
- Good discussions - very helpful - aiding understanding of the "bigger picture".

- Ideas for service development in terms of case management and scrutiny [multi-agency].
- Hearing from practitioners directly involved and how the jigsaw pieces were so fragmented.
- Multi-agency discussions - hearing views from other professionals.
- Being able to discuss with colleagues and pull out information and compare perspectives.
- Looking forward to what can change to improve communication between agencies.
- Useful input about some options that could have been available e.g. child assessment. This could have been a practical way of addressing the drift issue. Legal input is so clear and focussed - most helpful.
- Understanding the view point of other professionals involved in the case. Identifying things that could have been done by holding multi-agency meeting.
- Networking and looking at it from other professionals' views.
- Highlights how we have moved on and responded not only to this incident but also to our awareness of the number.

Views on those aspects of the day which could be improved:

- Better understanding of expectations from professionals attending.
- Scoping - needs to include history if relevant.
- Concentrate more about how professionals could approach parents differently to achieve positive outcomes and deeply.
- Analyse why we couldn't engage fully.
- Need to ensure that practitioners who were involved in the case and not present today are given feedback – managers of the agency should be responsible for this.
- Provision of the conference process/minutes would have been helpful if included so that constructive critique could be fed in if they were available.
- It was fine and better than not sharing.
- The whole approach was too speculative in my opinion. I do accept that there is some merit in speculation but children died and I thought the general approach to be wrong. The author and chair led the days well (I

accept that they have the experience of running these/drafting reports and I don't) but the direction of travel if you like, was I think, flawed.

- Second session probably needs revisiting. Concerns raised as to process. E.g. hindsight and 'speculation'.

Presentation and LSCB Response

The report was presented to the LSCB at an extraordinary Board meeting on the 12th December 2013 by the Overview Writer.

Following the presentation, the Board went through each recommendation, formally accepted each recommendation and agreed any action. The agreed actions contributed to a formal LSCB Response to the SCR document. This document outlined the actions already taken and the methodology for meeting any outstanding actions/lessons to be learned.

This response document accompanied the Overview Report to the DfE and OFSTED and appears to have been well received in that there were no adverse comments from either organisation or the National Panel of Experts. Anecdotal evidence from LSCB Chairs and representatives of other local authorities would suggest that the report content, formal and, in particular, the response document were seen as a model of good practice.

The Overview writer was also asked to write an Executive Summary. This document proved very useful as a training resource and for the Coroner's office.

An action plan was generated from the LSCB response document.

I have already commented on what appears to have been a misunderstanding between Review Team representatives, designated health professionals and health colleagues that led to concerns being raised at the Extraordinary LSCB meeting held on the 12th January that certain health providers had not had access to the draft report. This was addressed immediately and confirmation was received that they were satisfied with the report and recommendations therein.

Press Release and Publication

The case attracted a high media profile both locally and nationally and the media were informed that the case has been referred to Suffolk LSCB early on.

It was agreed and noted in the Terms of Reference that on completion of the SCR Report, and before publication, the LSCB would determine an appropriate media strategy and that in the interim, no information concerning the review, or comment about this case attributed to the LSCB, should be shared with the media without the express authority of the LSCB Independent Chair, or in his absence the Vice Chair.

Considerable work went into the preparation for the press release. The LSCB had independent representation with regard to media communication. An embargoed press release was sent out to local and national media and members of the media were able to contact our media representative to book interview 'slots' for TV or radio with the Independent Chair and Overview Writer.

This worked particularly well and meant that the local and national press were fully aware of the details of the case and had been briefed fully as to the role and function of a SCR.

A copy of the press release also went out to OFSTED and the DfE. The report was published on the website from midnight of the day of publication, the same time as the press release embargo time.

Training and Dissemination of Lessons

Learning from this review was disseminated throughout partner organisations, via the website and through five multi-agency presentation events held by the LSCB support team and run across the county. In addition, a number of additional multi and single agency learning events and presentations have taken place to address the training needs identified. 73 professionals attended the multi-agency events, Feedback from agencies would indicate approximate numbers in excess of 400 have been briefed on the lessons learned from the SCR.

The impact thus far from the SCR includes:

- ✓ Revision of LSCB policies on Escalation and Working with Hostile and Evasive Families (including training events) and development of a fact sheet on the Public Law Outline.

- ✓ Development of a set of standards for Child Protection Conferences.

- ✓ A neglect strategy and guidance document has been endorsed by the LSCB PPE Group and is now on the LSCB website.

Evaluation Learning

Actions

The following actions were identified in order to enhance the process for future SCRs:

1. Working Together 2013 gives the LSCB flexibility to design and tailor a discreet methodology for every SCR to ensure a clear and proportionate response to individual cases. Development of this methodology will be the responsibility of… It is the responsibility of the review team to ensure that members of their organisation who participate in the review process have a clear understanding of the methodology agreed and its rationale.

2. Because of the rigidity of date-setting necessitated by the use of an Independent Reviewer, ensure that any initial briefing session for IAR / Chronology Writers and nominated Review Team representatives includes documentation that lays out expectations, dates of meetings, allocation of a named nominated deputy and briefing arrangements at the beginning of the process.

3. Ensure there is clarity at the start of the SCR process that agencies should be working to address any learning issues as soon as they become apparent from the completion of any Serious Incident or IAR reports; there will be an expectation from the LSCB that agency action plans are formulated and actioned at the earliest opportunity and that the Review Team will collate this learning and feed into the review process at the earliest opportunity.

4. In developing the methodology at the start of the SCR process, consider how practitioners viewpoints will be fed into the review; this will include agreement of whether individual interviews with key staff members will be required and at what point of the Review timeline this will take place. The Review Team will take responsibility for ensuring that the agreed process is implemented.

5. Review Team members will take responsibility for ensuring that their professional sector is represented in the broadest sense and with input from any relevant specialist disciplines or practice areas.

6. Change the name of the ‘Learning Event’ to ensure that attendees are aware that they are part of the review process and the expectation of their contribution. Some attendees at the Family A Learning Events thought that they were coming to be ‘told the story’ of the SCR, rather than participate in it.

7. Ensure that each organisation allocates time for staff to talk and spend time with their manager to prepare for the Learning Event and be provided with any resources/support where necessary.

8. Ensure that Staff attending the ‘Learning Event’ are aware of who they can approach before and after the event for support. Contact details for each organisation should be in the participant packs. Each attendee should be

given the opportunity to familiarise themselves with their own agency chronology and look at this in detail.

Reflection and Feedback

The following reflection and feedback should be considered in the development of process for future SCRs:

- Practitioners found it useful to understand the view point of other professionals involved in the case and identify things that could have been done by working on a more multi agency basis.

- An accompanying Response document to the SCR report is effective, as is an Executive Summary written by the overview writer.

- Not everyone was happy with the process of identifying themes through discussion and reading of the chronology. Some found the process too 'speculative' for their liking. This is addressed by Action 1, as above.

- Practitioners found it useful to see a draft overview report and look at themes and to try to identify innovative practice as a response to the recommendations that could be progressed locally, rather than waiting until the report is published.

- Use of this methodology and learning, where appropriate, on a future SCR would further support the development of a robust process for learning from SCRs. The embedded process would then provide participating agencies with a clear understanding of the identification of causal factors in relation to any identified failings in practice and the actions required.