Suffolk Safeguarding Children Board

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Press Release

Strictly Embargoed until **Wednesday 22 January 2014 00.01**

Suffolk Local Safeguarding Children Board (LSCB) publishes Serious Case Review following the death of Fiona Anderson and her 3 children

Suffolk Local Safeguarding Children Board (LSCB) has today (Wednesday 22nd January 2014) published its Serious Case Review into how public agencies worked with the Anderson family prior to the death of Fiona Anderson and her three children, Levina, Addy and Kyden on 15 April 2013 in Lowestoft.

The LSCB commissioned two experts, Ron Lock and Bob Cook who between them had been involved in over 100 Serious Case Reviews across the country but who had never before worked in Suffolk. They were asked to explore who did what and why, and to identify ways in which local practice could and should be improved in the future.

"The loss of Fiona Anderson and her children was a tragedy and deeply impacted on the local and the wider community" said Peter Worobec, Independent Chair of the Suffolk Local Safeguarding Children Board. **"Throughout this review, the Board has kept the lives of the family and in particular the children, central - so that any future lessons can be learned".**

"All cases where children die and abuse or neglect is thought to be a factor in those deaths are reviewed. As professionals from a number of agencies had been working with this family at the time of these tragic events, it was particularly important for this review to be rigorous and independently led."

The report identifies that Suffolk County Council Children and Young People Services (CYPS) first started working with Fiona and her partner prior to the birth of Levina, some 3 years ago, due to concerns about their parenting abilities.

Court proceedings to remove Levina were commenced but these were withdrawn following challenge and in recognition that there was insufficient evidence to justify that course of action.

The report acknowledges that this action resulted in the relationship between the family and children's social care becoming strained from the outset.

It goes on to identify that by June 2010, when Levina was 12 months old, the concerns had diminished sufficiently for formal involvement to cease. Following further concerns intervention recommenced in August 2011 and Levina and Addy were made subject of Child Protection Plans under the category of 'neglect'.

When Kyden was born in May 2012 he was included in the Plan.

Describing professional intervention during this period Ron Lock, author of the report said **"Despite interventions by a number of practitioners, there was no success in effectively engaging the family in interventions by professionals. This meant that overall the implementation of the child protection plans was significantly compromised. "**

The report acknowledges that the child protection process was implemented in line with recognised procedures. However, it makes clear that it was inappropriate for the Child Protection Plans to continue largely unchanged for a period of eighteen months from August 2011 without some form of review and formal revision of the way forward with the family. The lack of progress was not challenged by managers or other professionals.

Whilst there was a system of senior management overview in place, it did not impact on this case.

"There had been no known history of either the mother or the father intentionally causing physical harm to the children, or of any self-harming episodes by the parents themselves. " Ron Lock, the author of the report continued. **"In this respect, the deaths of the children and their mother were completely unexpected. It was not predictable or thought in any way likely."**

The report, which identifies 13 learning points, was discussed in great detail at an extraordinary meeting of the LSCB last month (December 2013) following which a formal LSCB Response was produced.

"The Board fully accepts the important lessons from this review and I would want to stress that things have and will continue to change as a direct result of this tragedy." Peter Worobec from LSCB said. **"In our Response to this review the action already taken to eliminate drift in such cases and ensure all child protection cases are subject to robust management oversight, particularly in Lowestoft, is laid out."**

"In addition we have identified a further 21 actions that will be taken to ensure that practice is improved, it has the desired impact and is embedded across the county and in all agencies".

"At this very sad time, I would like to give my sincere thanks to Fiona's parents and her partner who have worked with us during this review." Ron Lock, the author of the report continued. **"This remains a difficult time for them all and we appreciate their co-operation"**

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For interviews with Peter Worobec or Ron Lock please telephone Ashley Riley on 07835 309718 on or email SuffolkSafeguardingCB@live.co.uk

A copy of the full report and the LSCB response is available to download at www.suffolksafeguardingchildrenboard.onesuffolk.net

Frequently Asked Questions (FAQ's) on the work of the LSCB and more information on Serious Case Reviews are listed below:

What are LSCBs?

Local Safeguarding Children Boards (LSCB's) were established as part of the Children Act 2004. As a body they are not responsible for running child protection services but play an important role in challenging safeguarding practice and assessing the effectiveness of safeguarding services in their area.

Each local authority is required to set up an LSCB to bring together key agencies such as police, probation, health, education, youth justice and social care. The Chair of the LSCB is an experienced professional who is independent of the local agencies. In addition to coordinating and ensuring effectiveness of what is done by each agency to safeguard and promote the welfare of children, LSCB's also have a number of key things they must do which are set out in legislation.

These include agreeing local safeguarding policies and procedures for how different agencies work together, contributing to local plans, communicating and raising awareness of safeguarding to local organisations and the community, ensuring safeguarding training is provided and monitoring what the LSCB members do and how effective local safeguarding is. LSCB's are also required to;

- Undertake serious Case Reviews (SCR's)
- Review the deaths of all children who are normally resident in the area; and
- Produce and publish and annual report on the effectiveness of safeguarding in the local area.

What is a Serious Case Review?

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of the LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in where:

(a) abuse or neglect of a child is known or suspected; and
(b) either:
(i) the child has died: or
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

In addition, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Health Act 2005. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide.

It is important to remember that the review is not a public enquiry, a disciplinary process or grievance hearing. The focus of the review has to be on how agencies worked together on the case to identify ways in which local practice might be improved in future.

When does it start?

A Decision to start an SCR is usually made within 1 month of the death or incident.

How long do they take?

It depends on many factors such as the scale and complexity of the case as well as other issues such as whether there are ongoing police investigations or criminal proceedings as invariably these have to be completed before SCR's can be finalised.

The target is to complete them within 6 months. Even if the review process has not been completed lessons to improve practice are usually identified at an early stage action commenced. It is important that any lessons that are learnt are implemented and shared at the earliest opportunity.

Who writes the review? Is it just 1 person?

There is usually an Independent Safeguarding Lead appointed to manage the process, chair meetings of the Review Team and facilitate the professional's learning events.

In addition an Overview Report Author is appointed with responsibility to write the final report and work closely with the Independent Safeguarding Lead to manage and lead the learning event meetings with professionals.

How are they chosen?

In order to provide a totally independent view it is important that both are not from the local area and have no current relationship with either the LSCB or at local level any of the agencies involved in the case.

The Overview Report Author is usually someone with substantial experience as a practitioner and manager from one of the disciplines involved in child protection. There are no formal registers of individuals qualified to undertake this work so they tend to be chosen on reputation and through recommendation from other LSCB's who have been impressed with the quality of their work.

In practice, an Overview Report Writer is usually chosen because of their relevant experience, their availability to work within the timescale and their professional reputation.

The same is true of Independent Safeguarding Leads.

Who was appointed in this case?

Mr Bob Cook was appointed as the Independent Safeguarding Lead. He has over 30 years social care experience including 20 years management experience (10 at strategic level) in statutory and voluntary sectors including a major voluntary/private sector partnership programme. He specialises in safeguarding, complaints management, historic abuse, child care law, recording/information sharing, policy and standards, risk management and multi-agency governance.

Mr Ron Lock was appointed as the Overview Author. He has been in child protection social work for 40 years in both operational and strategic roles. In 2001, he became an independent safeguarding consultant and since that time has specialised in Serious Case Reviews (SCRs). He has been commissioned as either the Independent Chair or Independent Report Author of more than 70 Serious Case Reviews on behalf of 30 different Local Safeguarding Children Boards.

What approach is used to conduct reviews and what was used in this case?

Government Guidance entitled Working Together 2013 allows LSCB's to use any learning model consistent with the principles in the guidance, including systems based methodology. After carefully considering the options it was decided to use a systems based partnership learning model designed by Mr Ron Lock for Bournemouth and Poole LSCB and Dorset LSCB and currently being used by two other LSCBs.

This model involved setting up a Review Team made up of senior managers from health, police and social care. Each agency that had involvement in the case appointed a lead person to gather information and prepare a chronology of their involvement. Two learning events were then held attended by practitioners involved in the case and their line managers to help understand who did what and why, and to identify ways in which local practice should be improved. The Review Team met with the Independent Safeguarding Lead and Overview Author on 3 occasions to answer questions, initiate further enquiries and help shape the final report. Issues arising were acted upon by them and individual agencies as the learning unfolded.

What are the potential outcomes of SCR's?

The SCR will identify a series of lessons that should be learned aimed at improving practice across and within agencies that work in Suffolk. The LSCB will then decide what actions need to be taken to address the learning and decrease the likelihood of the same mistakes being made again in order to prevent other children being killed or harmed in the future.

Are they legally binding?

Neither the learning nor the actions arising are legally binding. They have the status of professional advice based on the experience of the case and analysis of the facts. It is for the constituent agencies of the LSCB to respond to this advice and review or amend where appropriate their operational policies, procedures and practice.

However, the actions are taken very seriously by the LSCB and many in this case are designed specifically to ensure that changes have been made to single agency practice and that those changes are having the desired impact.

In addition the LSCB is itself subject to external scrutiny and is held accountable by government through Ofsted.

Could SCR's lead to disciplinary action, dismissal or further legal proceedings?

SCR's do not in themselves lead to disciplinary action, dismissal or further legal proceedings. An SCR does not recommend action against an individual; it seeks to look at how the whole system can be improved to protect children from harm.

However, the findings of the SCR may be used in subsequent actions by individual agencies after it becomes a public document.

Once an SCR is published what happens?

The LSCB will have responded to the SCR by agreeing a range of actions that should be taken to address the learning. This is transferred into an Action Plan, the progress against which the Suffolk LSCB Learning and Improvement Group will monitor until they are all in place.

This process is not always a quick fix and can sometimes take anything up to 2 years depending on the nature of the actions. Progress is regularly reported to the LSCB and if there are difficulties in achieving particular actions then the Board has a responsibility to challenge those partners to ensure agreed actions have been taken and changes implemented.