Suffolk Safeguarding Children Board

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LSCB SCR Response

1. Introduction

1.1 The case was referred formally to the Suffolk Local Safeguarding Children Board (LSCB) 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'

1.2 Working Together 2013 allows LSCB's to use any learning model consistent with the principles in the guidance, including systems based methodology. After 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 LSCB's. This model involves each agency appointing a lead person to gather information and prepare a chronology of involvement. Two learning events were held attended by practitioners and their line managers involved in the case to help understand who did what and the reasons why; they also identified ways in which local practice should be improved. Issues arising during the review process were acted upon by individual agencies as the learning unfolded.

1.3 Suffolk LSCB appointed Bob Cook as the Independent Safeguarding Lead to manage the process, chair meetings of the Review Team and facilitate the professional's learning events. Bob has over 30 years social care experience including 20 years management experience (10 at strategic level) in statutory and voluntary sectors. These include 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. Bob has not previously worked in Suffolk.

1.4 Suffolk LSCB also appointed Mr Ron Lock, an Independent Consultant in Safeguarding Children as the Overview Report Author. His responsibility includes writing the final report and working closely with the Independent Safeguarding Lead to manage the learning event meetings with professionals. He has worked in child protection social work for 40 years in both operational and strategic roles. In 2001, Ron 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 in more than 70 Serious Case Reviews on behalf of 30 different Local Safeguarding Children

1.5 As the partnership learning model approach taken for this Serious Case Review is new, a full evaluation of the process will be undertaken to help inform local and national learning on the methodology for SCR's.

1.6 Suffolk LSCB met on the 12th December 2013 to consider the Serious Case Review report. It fully accepted the lessons learned outlined in paragraphs 14.1 to 14.3. It then went on to consider the actions already taken to date as a result of the learning, their impact and other actions required to address the learning.

Lessons Learned

2. Working with avoidant families – Learning 14.1

2.1 *Working with hard to reach and avoidant families is very challenging for professionals and has impact upon the parents in the anxiety it creates for them and for the loss of the benefit of receiving supportive services. Innovative multi-agency interventions and new initiatives are likely to be required to engage parents in a more constructive working alliance. There is considerable research and literature on this subject which can give direction to practitioners and managers on how to attempt different strategies and achieve effective outcomes*.

2.2 **LSCB View**

2.2.1 The LSCB considered carefully the challenges involved in working with hard to reach and avoidant families. It recognises that work should be undertaken on revising its current policy. The revised policy should reflect the findings and lessons of the review and take steps to improve the skills and knowledge of professionals and their managers in order to work more effectively with hard to reach and avoidant adults.

2.3 **LSCB Actions:**

2.3.1 The LSCB Planning, Policy and Engagement Group will review, revise and re-publish new practice guidance on working with hard to reach and avoidant families. This will involve a partnership approach including input from Norfolk and Suffolk Foundation NHS Trust to provide direction on how practitioners can utilise different strategies and achieve effective outcomes where there is no remit for statutory involvement of mental health services. The LSCB will co-ordinate an awareness raising campaign to re-launch the revised policy.

2.3.2 The LSCB will initiate a review of the current multi agency training programme including that of Child Protection Leads in schools to ensure it adequately covers good practice with hard to reach and avoidant families.

2.3.3 The LSCB will identify best practice and research on the impact of working with families where avoidance is a pattern of behaviour and enhance the above practice guidance to improve the skill of the workforce accordingly.

3. The Experience of the Child – Learning 14.2

3.1 *An effective way to identify whether emotional abuse or neglect exists within a family is to focus on the experiences of the children and identify what the impact of any emotional neglect might be. Practitioners need effective supervision and support to enable them to retain a child focus and assess their behaviours and development within families where the parents have high levels of need.*

3.2 **LSCB View:**

3.2.1 The LSCB recognises that when bureaucratic aspects of the work become too dominant the heart of the work can be lost. Some aspects of this case highlight this.

3.2.2 The LSCB recognises that effective supervision is key in ensuring that the experiences of children are central to assessment and practice.

3.3 **Context / Actions Taken:**

3.3.1 Strategically, and over recent years Suffolk County Council Children and Young Peoples Services (SCC CYPS) has redesigned services to increase early intervention and improve capacity for reflective practice in response to Professor Munro's Review of Child Protection published in May 2011. In order to strengthen and embed the changes in front line practice, CYPS have invested in a 3 year programme of practice development introducing the Signs of Safety and Wellbeing model. This will ensure that practice improves in clarity and precision with regard to the risk to children, and the strength of

families to protect them, including particular emphasis on the experience of the child in the household.

3.3.2 The current implementation of the Suffolk Signs of Safety and Wellbeing programme will include all partners. This will ensure there is a common and consistently applied focus on the child.

3.3.3 The LSCB has led the development of a new Assessment Framework within which the Suffolk Signs of Safety and Wellbeing approach will be delivered.

3.3.4 Children's views and experiences are measured by SCC CYPS under current arrangements.

3.3.5 In July 2013 SCC CYPS strengthened the monitoring arrangements for checking the frequency of supervision for all frontline staff and a report on this is received monthly by a Service Director.

3.4 **Impact**

3.4.1 The impact of the re-design work over recent years has:

- stabilised the number of Looked After Children;
- reduced the numbers of Children in Need;
- increased the numbers of families supported early;
- managed the workforce across the county to ensure that in most areas the capacity meets demand; and
- created more stability in the system to allow for reflective child centred practice

3.4.2. Since the new supervision monitoring arrangements were introduced 98%* of staff in Lowestoft has consistently received monthly supervision. (One member of staff on sick leave accounts for the 2% shortfall).

3.4.3 In respect of Suffolk Signs of Safety and Wellbeing, a full training programme for SCC staff starts in February 2014. The plans expect 300 staff to be trained by April 2014 and a further 800 by October 2014. There is an ongoing programme for engaging partner agencies and to date over 100 strategic and operational managers have been briefed.

3.5 LSCB Actions:

3.5.1 Reports presented to future LSCB meetings on the progress of the implementation of the Suffolk Signs of Safety and Wellbeing programme will include information and evidence on how this has improved practice in relation to practitioners focussing on the child's view and experience.

3.5.2 The LSCB will continue to lead on the implementation of the Statutory Assessment Framework and during the planned formal review in July 2014 will require evidence of how well the 'child's experience' element of the framework is being implemented.

3.5.3 On a quarterly basis over the next twelve months, SCC CYPS will provide a report to the LSCB Learning and Improvement Group evidencing the continued consistency of supervision across the County.

4. Eliminating drift in the Child Protection Process - Learning 14.3 14.4, 14.9 and 14.13

4.1 *To allow Child Protection Plans to continue unaddressed throughout a number of Child Protection Conferences means that the children will continue to be subject to significant harm whilst still within the child protection process.*

The role of the Child Protection Conference Chair is a pivotal one in challenging the management of a case that is not achieving Child Protection Plans and by inference, it is maintaining children in at-risk scenarios

When cases are not progressing in terms of the protection of children, and the multi agency process has become entrenched, if there is no separate process utilised to objectively review why the case has become problematic, then the children would continue to be at risk of significant harm, and the multi-agency interventions become further entrenched.

To fail to record important discussions and agreements reached between Child Protection Conference Chairs and managers outside of the Child Protection process, will mean that any actions agreed to ensure that a case is properly progressed, cannot be effectively reviewed or monitored and could enable management drift to occur.

4.2 LSCB View

4.2.1 The LSCB accepts this learning and acknowledges the vital role that Child Protection Conference Chairs and agency partners play in ensuring that Child Protection Plans have clarity and pace to effectively protect children and that drift is swiftly addressed.

4.3 **Context / Actions Taken:**

4.3.1 The SCC CYPS escalation process for case concerns arising from the Safeguarding Service was revised in April 2013. A written record of any concern is made, the list monitored at a monthly meeting of safeguarding and service managers and action taken on any matters that are yet unresolved.

4.3.2 A full review of the Child Protection Conference system, including observations of the practice of Conference Chairs, was undertaken by an independent consultant together with the SCC CYPS Head of Safeguarding between July and November 2013. Conference Chairs were observed and graded against a clear set of best practice standards. A rolling programme of observations has been introduced to check performance against these standards to maintain a high standard of chairing.

4.3.3 From July 2013 all cases where a Child Protection Plan has been in place for 15 months are reviewed at the monthly meeting held between the operational service managers and safeguarding managers. This meeting ensures that, if required there is a clear plan that:

- outlines immediate action required;
- considers innovate approaches for implementation at the 18 month Child Protection Review Conference for those cases where insufficient impact has been achieved.

4.4 Impact

4.4.1 Progress to date indicates that since actions were taken there has been:

- A 17% reduction across Suffolk in outstanding concerns in the first quarter of the use of the revised escalation process. In Lowestoft there has been a 36% reduction;
- A 33.8% reduction in the length of time children are subject to Child Protection Plans over 18 months;
- 83% of Chairs of Child Protection Conferences have been independently assessed as good or outstanding.

4.5 LSCB Actions:

4.5.1 The LSCB Learning and Improvement Group will receive a progress report on improving the effectiveness of the Child Protection Conference system in January 2014 and this will go to the LSCB in March 2014 with recommendations for further actions.

4.5.2 The LSCB require the SCC CYPS Head of Safeguarding to present a report at the July 2014 meeting to demonstrate the level of multi agency compliance with the policy on engagement, attendance and contribution to the Child Protection Conference system.

4.5.3 On a quarterly basis over the next twelve months SCC CYPS will provide a report to the LSCB Learning and Improvement Group outlining:

- Management oversight on plans that have been in existence over 18 months
- The number of and resolution of concerns raised by Child Protection Conference Chairs.
- The number of cases reviewed at monthly Safeguarding and Operational Manager meetings

4.5.4. The LSCB will establish a task and finish group to consider the introduction of a 'stop and review' process that can be called for by any professional at any time during the course of a Child Protection Plan.

5. Effective Challenge - Learning 14.5 and 14.6

5.1 *For Child Protection Conferences to only include those professionals directly working with the family will deprive the Child Protection Conference of objective input by managers and specialists to help progress the case and reduce safeguarding risks of the children.*

All professionals have the responsibility to challenge inappropriate or ineffectual practice, which has become intransigent and is not protecting children. This does not solely apply to Child Protection Conferences and should include the need to escalate concerns to senior managers when necessary.

5.2 **LSCB View:**

5.2.1 The LSCB discussed how to improve the objectivity of Child Protection Conferences through managers and other specialist attending conferences and concluded that the attendance by senior managers, as a matter of course, at a child protection conference, is not best use of their time and could impede consistent and regular supervision of cases.

5.2.2 The LSCB considers challenge throughout the partnership to be a key factor in safeguarding and promoting the welfare of children. However, this is not being consistently used to best effect. The LSCB acknowledges that there is a need to embed consistency among partners to promote professional challenge and develop further mechanisms to resolve inter-agency differences.

5.3 Context/ Actions Taken:

5.3.1 There are currently three Local Area Safeguarding Groups who meet on a quarterly basis to discuss local safeguarding practice and issues.

5.3.2 The LSCB have an escalation policy entitled 'Working together to resolve professional disputes'.

5.3.3 It is acknowledged in this particular case neither had an impact.

5.3.4. No remedial action has been taken to date.

5.4 LSCB Actions

5.4.1 The LSCB Planning Policy and Engagement Group will review, revise and re-publish new practice guidance on resolving professional disputes. This will include consideration of a method of mediation and will include a mechanism for senior managers to attend Child Protection Conferences when appropriate. The LSCB will co-ordinate an awareness raising campaign about the revised policy on re-launch.

5.4.2 The LSCB will include a section in the annual Section 11 Children Act self assessment that requests agencies to report on their use and impact of the LSCB escalation policy.

5.4.3 The LSCB will lead a review of the role and function of Area Safeguarding Groups. This will ensure they are 'fit for purpose' and in particular have mechanisms to support and enhance multi agency challenge.

6. Robust Management Oversight - Learning 14.7 and part of 14.2

6.1 *In demanding child protection cases, robust management oversight of the progress of the case is essential and should be shown to have a direct role and impact on the professional interventions*

6.2 LSCB View

The LSCB agrees that robust management oversight of cases is essential. It does though recognise that financial pressures have necessarily resulted in a reduction in resource. However, it has over the last three years, urged partners to ensure that despite this, adequate management, skill and

oversight remains within the system to mitigate increased risk during times of financially driven change.

6.3 Context / Actions Taken:

6.3.1 The senior management in Lowestoft was changed and strengthened in October 2012. As part of the ongoing SCC CYPS audit programme a 'Health Check' was undertaken between December 2012 and 2013. This health check evidenced a clear need for improvements in practice mainly due to management and staff instability resulting in poor management oversight. An action plan was put in place to address this which was reviewed and checked following the events subject of this Review. The progress of the action plan has been overseen at Senior Director level during 2013.

6.3.2 An Ofsted inspection of Child protection arrangements took place in June 2013 in which Lowestoft cases and management were included in their scrutiny. The overall judgement by Ofsted was that services were 'adequate'.

6.4 Impact:

6.4.1 As a result of the action taken in Lowestoft:

- The staff vacancy rate has been reduced to 6% (3 staff);
- 97% of children subject to Child Protection Plans are currently visited every 15 days in line with practice standards.
- The Public Law Outline tracking sheets in Lowestoft evidence that there has been no drift in Public Law Outline cases. A meeting with the judiciary in Lowestoft has confirmed cases are dealt with in a timely manner;
- In the last six months there has been a 61% reduction in the length of time children are subject to Child Protection Plans for over 18 months.
- There has been a reduction in caseloads overall and in particular for newly qualified social workers;
- From July 2013, managers in Lowestoft have audited 15 cases every month.
- A duty system has been put in place to ensure when there is staff sickness that statutory visits still take place within timescales.

6.5 LSCB Actions:

6.5.1 The LSCB requires a report in July 2014 from SCC CYPS evidencing that child protection practice conducted in the Lowestoft area continues to be consistently and appropriately subject to the appropriate levels of senior management oversight. The report will detail evidence to support such assurances including audits, caseload information, supervision compliance, staffing and consistency of management of cases

7. Mechanism for Professional Consultation - Learning 14.8

7.1 *To generate the appropriate response and relevant assessment of parents when there are concerns about possible adult mental health issues will prove to be very difficult when the parent does not see the need for any such assessment and is avoidant of any assessment activity focussed upon mental health. It nevertheless must remain on the agenda for multi-agency discussions in consideration of any changing family circumstances, and whether this might enable pertinent mental health assessments to be newly progressed and offered to the parent in question.*

7.2 LSCB View

7.2.1 The LSCB particularly recognised that in their knowledge and experience, the issue and potential impact of an adult's mental health and wellbeing on their children is a significant factor in ensuring their safety and wellbeing.

7.3 Context / Actions Taken:

7.3.1 The LSCB has current practice guidance entitled 'Working with Hostile, Non Co-operative Clients and those who use Superficial/Disguised Compliance within the Context of Safeguarding Children'. The LSCB acknowledges that this practice guidance should be the subject of review and revision.

7.4 LSCB Actions

7.4.1 The LSCB at paragraph 2.3.1. has already directed the review of its practice guidance on working with hard to reach and avoidant families. The review should also include the development of a mechanism for professional consultation when there are professional concerns as to mental and emotional wellbeing of a parent, but no clear diagnosis.

8. Chronologies and background information – Learning 14.10

8.1 *Background information of a parent's own childhood is essential to understanding their own parenting capacity, and if this information is not collected and shared among professionals, it will limit the accuracy of any parenting assessment.*

8.2 LSCB View:

8.2.1 The LSCB agree that background information is essential in order to make informed decisions. There is a shared multi agency commitment to ensure relevant information is available for inclusion in assessments and other child protection processes. In this case the learning events indicated that the failure to collect and/or record background information was specific to this case and not a reflection of a systemic problem. Nevertheless, the LSCB requires further assurance

8.3 Context/Actions Taken:

8.3.1 The LSCB has procedures in place that direct practitioners to ensure that assessments **must** include background information on the child/children's parents with an analysis of that information in relation to the risk it may present.

8.3.2. In SCC CYPS management oversight is required before assessments can be 'signed off' which provides a checking mechanism to ensure assessments include full background information.

8.3.3 Current CYPS monitoring includes compliance of social workers providing full and accurate chronologies to Child Protection Conferences.

8.4 LSCB Actions:

8.4.1 The LSCB will satisfy itself that the Statutory Assessment Framework and supporting Information Technology systems include a checking prompt to ensure that background information is included as part of any assessment analysis.

8.4.2. The LSCB will disseminate information from this case and ensure that the sharing of learning outcomes include particular emphasis on the importance of background information in assessments.

8.4.3. The report from SCC CYPS Head of Safeguarding referred to in paragraph 4.5.2 will include information on compliance with the provision of full and accurate chronologies for Child Protection Conferences

9. Effective Working Relationships – Learning 14.11 and 14.12

9.1 *Drift of the Public Law Outline process must be avoided by strong management oversight and via an effective working relationship between CYPS and legal services. This can only be achieved if there is a shared*

understanding and clarity about the separate roles, responsibilities and accountability for decision making.

If there is a shared understanding by non CYPS agencies of legal processes instigated for children, then they are more able to contribute and challenge the process when appropriate, as part of partnership working

9.2 LSCB View:

9.2.1 The LSCB agrees with the learning points.

9.3 Context / Actions Taken:

9.3.1 SCC Legal Services report that from spring 2013, monthly meetings between CYPS Senior Management and Senior Legal Management have taken place. This is in order to bring the services closer in addressing together challenges they both face in child protection and the revised Public Law Outline (PLO). This includes cases highlighted through the PLO case tracking system and the recently strengthened escalation process to Heads of Service of cases causing concern within the legal process.

9.3.2 In January 2014 SCC introduced quarterly meetings between the Heads of Corporate Parenting, Legal Services, Safeguarding and the Lead Lawyer to maintain a strategic overview of current practice and future developments.

9.3.3. The Head of Legal Services is the Chair for the local Family Justice Board. The Family Justice Board addresses issues which affect the workings of the Public Law Outline and the public law matters.

9.3.4. The Local Authority attends the Family Court Justice Board. This ensures closer working relationships with Judges, the Justices, CAFCASS and local lawyers.

9.3.5. There has been a formal review of the PLO process and as a result outcomes from the legal process are shared with partner agencies through the Child Protection Conference and ongoing Core Groups.

9.4 Impact:

9.4.1. In Lowestoft the Public Law Outline tracking sheets evidence that there has been no drift in Public Law Outline cases. A meeting with the judiciary in Lowestoft has confirmed cases are being dealt with in a timely manner.

9.5 LSCB Actions:

9.5.1 In July 2014 SCC Legal Services are required to provide a report to the LSCB evidencing progress made on eliminating drift through the regular meetings and introduction of the PLO case tracking system.

9.5.2 The LSCB requires SCC Workforce Development to review Levels 2 & 3 multi agency training provision to ensure it provides an understanding of formal legal processes associated with Child Protection, in particular PLO. The result of this should be reported by July 2014 to the LSCB Planning, Policy and Engagement Group.

10. **Additional LSCB Action**

10.1 The LSCB will disseminate information from this case through a series of seminar events in spring 2014. It will work with SCC Workforce Development Team to ensure the lessons are incorporated into Level 2/3 LSCB endorsed safeguarding training and training for newly qualified social workers.

10.2 The above actions will be presented to the LSCB meeting on the 8th March in the form of an action plan for final approval. The action plan will be monitored by the LSCB Learning and Improvement Group with exception reporting to each Board meeting.

Suffolk LSCB 13th January 2014.