Warrington Safeguarding Partnership

Serious Case Review

Child R Summary Report

Date published: 16/12/2019

About this report

This summary report will be published in line with statutory guidance. In order to preserve the anonymity and protect the family from further community targeting and potential abuse the full report has been summarised into the following areas:

- What went well?
- What were we worried about?
- What did we learn?
- Action Plan

Names have been changed:

Child = Jack
Sibling = Olivia
Mother = Amy
Mother's Partner = Christopher

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Background to review

In 2018, Warrington Safeguarding Children Board (WSCB) was notified that Jack, a young child, had died and that the police and the local authority were making enquiries into the circumstances. Information describing a serious childcare incident was also submitted to Ofsted, the government office for standards in education, children's services and skills. In accordance with national guidance[1], WSCB conducted a rapid review of the facts that were readily available to agencies and organisations in order to determine whether the criteria were met to undertake a serious case review. National guidance indicates the circumstances in which Local Safeguarding Children Boards (LSCB) should undertake a serious case review (SCR). Those circumstances include when a child has died and abuse or neglect is known or suspected.

The cause of Jack's death was confirmed at post-mortem examination as being positional asphyxia. The police investigation found Jack's death was 'non-suspicious caused by way of a tragic accident'. Information provided to the Serious Case Review Panel (SCRP) indicates that police found home conditions to be poor but they did not reach the threshold of criminal neglect. No evidence has been found by the review that professionals could have reasonably predicted or prevented Jack's death. At the time of writing; the inquest into the circumstances of Jack's death has not taken place.

The decision to undertake a SCR was taken by the Chair of WSCB based on the information that had been gathered by WSCB's Rapid Review Panel. WSCB convened a Serious Case Review Panel (SCRP) to oversee the conduct of the review. The SCRP included senior representatives of key agencies and organisations with involvement in the case. It comprised:

- Operational Director, Children's Social Care (CSC)/Deputy DCS, Warrington BC
- Head of Service Early Help, Warrington BC
- Service Manager, NSPCC
- Head of Service Children's Safeguarding & Quality Assurance, Warrington BC
- Deputy Manager WSCB, Chair
- Detective Constable Major Crime Review Team, Cheshire Constabulary
- Detective Superintendent, Cheshire Constabulary (Public Protection Directorate)
- Designated Nurse Safeguarding Children and Children in Care, Warrington CCG
- Head of Service, Children in Need, CSC, Warrington BC

The SCRP determined the time period the review should cover and indicated that the review should particularly consider whether there were local lessons in relation to working with neglect. WSCB appointed an independent reviewer, Isobel Colquhoun, to facilitate learning, support the development of recommendations and provide a final report to WSCB for its consideration. The report was completed in March 2019.

A learning event took place in February 2019. Participants included involved practitioners and managers from community, primary and secondary health settings; school; police; along with the local authority's early help services, adult social care and children's social care. Practitioners and

[1] Working Together to Safeguard Children; HM Government 2015 and 2018

managers were invited to construct an agreed timeline of professional involvement and to work together to consider the effectiveness of practice overall. Members of the SCRP also attended the event and led small multi-agency learning groups as part of the process. Learning from IMRs and the learning event informed the review.

The independent reviewer met with Jack's parents, in the company of the allocated social worker. Their views about the provision of services are included and also inform the learning and recommendations for action.

What went well?

Professionals were generally aware of mum's health needs and her management of these. Specialist practitioners working with mum knew her well. They provided consistent support to her over the years and tried to improve her compliance with treatment.

Midwifery services were generally sensitive to mum's circumstances and they took good account of her previous history when planning her ante-natal and maternity care. Her health and emotional vulnerabilities were recognised and appropriate action taken. Referrals were made for Psychological support

The risk of harm to the children was raised by the school who made an appropriate referral to CSC and a social worker came to school to see Olivia and to speak about an allegation of physical harm.

A few days after Jack's birth, Amy was discharged from hospital, with appropriate follow up from midwives and having been referred for psychological therapy due to her distress about the allegations. Within the social work assessment, information provided by professionals about Olivia was generally reassuring. The fact that Jack was a very pre-term baby was recognised.

At the point at which casework responsibility was reallocated in CSC. The change of social worker brought a fresh perspective and impetus to case-planning for Jack. The social worker quickly negotiated a delay in Jack's discharge and worked with parents and hospital staff to enable an in-hospital, 48-hour training and assessment period to take place. With help, Christopher and Amy were able to demonstrate that they could provide for Jack's basic care needs. Effective communication between the hospital and CSC increased when casework responsibility for the children was reallocated and the extent of the concerns about parents' abilities to provide immediate safe care for Jack were recognised.

The local authority provided intensive practical parenting support when Jack was discharged.This considerably increased the likelihood that parents would be able to keep Jack safe and well. With support, parents were able to develop and sustain good routines with both children. Professionals helped parents manage their limited finances and arranged for further specialist support. The family support team also instigated a referral to the CAMHS Baby Incredible Years programme for support for Christopher in handling and caring for Jack. Amy had initially declined support but, after she had met the staff involved; she agreed to take part.

When Jack came home, Amy and Christopher were helped to meet Jack's early physical and emotional developmental needs by the provision of family support complemented by Baby Incredible Years programme.
The Incredible Years programme is open to any parents in Warrington who have a baby within the target age group but the workers' assessments of Christopher and Amy's needs and vulnerabilities informed their specific interventions within the group. They also took action to support parents' attendance. This was a timely intervention which focused on Jack's emotional and intellectual development and which complemented the practical help being given to parents at home by the local authority. This is an example of good practice.

The health visitor who had worked with Amy and Olivia had been a regular visitor to the family home. Amy appreciated her help and advice. A different health visitor, however, was allocated to Jack. Although Amy chose not to have ante-natal care from her, the health visitor was able to maintain good contact with hospital services and took part in child in need planning. The health visitor also arranged for a nursery nurse to work with Amy when she said that she was finding Olivia's behaviours difficult to manage.

In general, there was good communication between hospitals caring for Jack and arrangements for his care appear to have been smoothly transferred. There was also evidence of contact between the neonatal services and health visitor and CSC. Hospital staff brought to the attention of CSC, their concerns about parents' lack of contact with Jack and their unavailability on occasions.

Throughout the period of the review, Olivia's pre-school and school have been important in her life. The school made appropriate referral to CSC when Olivia alleged that Christopher had hurt her. The school has always contributed to child in need meetings, provided details of Olivia's progress and shared observations about family relationships. The school has consistently had Olivia in their sight. The school has kept a chronology which has been used to monitor family's progress, to prompt support and to refer to other agencies. The evidence from the learning event is that partner agencies valued the contribution that school made to joint-working.

What were we worried about?

The learning event revealed that non-medical and some non-specialist practitioners were generally unaware of the impact of Amy's health needs & treatment had on her everyday life. Amy's health needs were mainly managed solely by the GP. The relevant health Independent Management Review (IMR) suggests that the treatment for mum's medical and mental health needs would have benefitted from a more integrated approach with other involved professionals.

Despite their familiarity with Amy's struggles, GPs did not consider how they might impact on her capacity to care for children. This was a gap. The GP practice was unaware that children's social care had had involvement with the family. The IMR author identified missed opportunities for the GP to communicate with the health visitor about Amy's mental health problems and to establish whether, as a parent, further support was needed. The IMR refers to 'underlying negative perceptions with the practice about the role of health visitors' as a potential contributory factor to poor communication in this instance.

Some agency records suggested that Amy had learning difficulties but there was no evidence that this is the case. It is known that mum experienced significant childhood trauma, was bullied at school and was socially isolated. She was said to have been very affected by grief & loss. She has had difficult relationships with people in the community and is vulnerable to exploitation. Every professional working with Amy understood some aspects of her circumstances but no single agency had developed a comprehensive assessment of her vulnerabilities.

Christopher was considerably less well known to services. Some professionals had small amounts of information about Christopher's family but it was clear from the learning event that this knowledge was not generally shared. There is a record that Christopher had mental health issues but details were not known. A CSC assessment contained little information about Christopher. A separate risk assessment which had been proposed was not completed. It has subsequently been identified that Christopher has difficulties reading.

No child protection strategy discussion took place following the first allegation reported by nursery which meant that police and health partners had no opportunity to consider the allegation that Olivia had made and were not able either to contribute to decisions about what should happen next. Oliva made another allegation the following day which the local authority concluded as 'unsubstantiated'. No rationale was given for this conclusion. It is not clear whether parents were informed that the allegations of harm had been found to be unsubstantiated. In reality, however, despite this recorded decision; the local authority's actual position was that the risk posed by Christopher had not yet been evaluated. Arrangements were put in place to prevent Christopher having care of Olivia and would, subsequently, prevent him from having unsupervised contact with his son.

Over the course of two months following the original alleged incident; the local authority undertook a family assessment. The trigger event for that assessment was clearly identified as the allegation made by Olivia against Christopher. The assessment, however, did not address that matter. The document contained little information about Christopher's characteristics or circumstances: his history, his strengths and vulnerabilities are not explored. Reference is made to a continuing intention to complete a separate 'risk assessment' when the outcome of the police investigations was known. At the same time, however, the assessment implies that the risk assessment is essentially a formality and that Christopher would be able to return home at that point. The assessment considers Amy's vulnerabilities and suggests that these are likely to compromise her parenting capacity, but the link between Amy's vulnerabilities and the specific implications for the children is not, however, clearly made. The assessment does not consider the couple as a parenting partnership. There is insufficient explicit consideration of how parents, either separately or apart, would be to keep him safe and well at home. Neglect in his parents' care, was not specifically identified as a future risk.

Parents did not regularly visit Jack in hospital. The reasons why parents were not doing this were not wholly understood and planned support was ineffective. The potential impact on Jack's development of not having parents caring for him in hospital did not sufficiently inform the local authority's assessment and the multi-agency child in need plan. The learning event revealed that different professionals had different views of the roles that both parents played at home and, specifically, in respect of meeting Jack's care needs. The use of the Graded Care Profile could have

helped professionals and parents develop shared focus on everyday care and routines. Such an approach might have led to a clearer picture of the children's lives at home.

When Jack was discharged from hospital; health visiting services became more disjointed as the allocated health visitor was absent due to long term sickness. A gap in service provision developed. Four months later, another health visitor was allocated but she was unable to attend the Child in Need meeting which had been planned for that month.

Communication and working arrangements between professionals were variable. The learning event revealed that there were clear gaps in practitioners' understanding of the roles and responsibilities each had in relation to the individuals and the family with whom they were coming into professional contact. The biggest gaps in mutual understanding were between those whose responsibilities were primarily for individual adults and those who were providing services for children and their families. In particular, there appears to be very limited awareness by children's practitioners of the nature and structure of adult mental health services and how help can be accessed.

When it came time to end the child in need planning the multi-agency group recognised that the family were 'losing all their support at once'. Family Outreach (an Early Help service) was, therefore, recommended to provide continuing input in respect of debt management and specific issues. The corresponding referral, however, focused on parents' request for continuing parenting support.

The health visitor was unaware that the child in need plan was to end, and only found this out when she visited the family home two days later. At that point, Amy and Christopher talked positively about support that had been offered but said that they had declined an offer of further support. The health visitor support was reduced to a Universal offer. The relevant IMR acknowledges that this decision 'failed to recognise the family's vulnerabilities and ongoing support needs'.

When the request for support was received in Early Help; a complicated process of allocation followed. Guided only by the information which was contained in the referral form; it was not immediately clear what level of support would be required. This led to a delay in an offer being made. In the event, parents were not available when home visits were made to discuss future support. The Early Help IMR suggests that had the service made greater efforts to establish the history of professional involvement with the family; staff might have been more tenacious in trying to establish contact. The Early Help service formally closed the referral three months later, without having met the family.

It was around this time that the GP and health visitor received notification from the hospital about Jack having been presented with 'hypothermia'. It has been established that the ED diagnosis was, in fact, not at all related to Jack's presentation but was an 'administrative coding error'. Nevertheless, this was an unusual diagnosis which should have led the GP to explore family and home circumstances and to consider a possible safeguarding response. This was a missed opportunity. Similarly, when the health visitor received the hospital notification, she phoned the family home to find out if Jack was feeling better but she did not ask specifically about his having been diagnosed with hypothermia. She did not follow up, either, with a home visit when she could

have assessed the home conditions. Again, this was a gap.

The changes of health visitor and periods when there was no active health visitor input meant that the service was not as involved as would have been anticipated in terms of multi-agency planning and interventions. The IMR describes 'a depleted workforce, annual leave and sickness absence … a lack of ownership'' as being contributory factors in these gaps. There was a missed opportunity for the health visitor to initiate a formal early help plan. It is notable that Amy placed value on the health visiting service and regretted not having easy access to health visitor advice and support.

There was minimal communication between CSC and Early Help Services at the point that casework responsibility was being stepped across. A delay in allocation, as previously outlined, was associated with parents not being at home when an initial meeting was proposed. The social worker's view about any implications of closing the referral was not sought. No evidence was found on file that the referrer was notified when the service formally closed the case.

Lessons learned

In terms of multi-agency learning points outlined below; it is notable that a number reflect common findings of serious case reviews nationally. In the main, they also confirm concerns that are already being addressed by the local authority and safeguarding partners.

Learning Point 1: The importance of holistic assessments focused on impact as a basis for productive plans and multi-agency working.

Shortcomings in the combined assessment included:

- Not addressing the risk of harm that an adult might pose to the children when an allegation has been made of physical harm;
- Not providing a comprehensive analysis of the impact that parental characteristics, needs and stressful life experiences could have on capacity to meet the needs of children;
- Not identifying both adults as part of the parenting partnership;
- Not identifying child's specific vulnerabilities as a very pre-term baby; and,
- Not taking account of the roles of other people who were involved in caring for the children.

In particular, the assessment did not recognise the crucial role that a father plays in a child's life and there was no significant consideration of adult needs as a first-time father to a very pre-term baby. As the dynamics of the relationship between parents were not explored, the ways in which one may compensate for, or compound, any weaknesses in the other's care were unknown.

An overly narrow assessment led to an unsatisfactory child in need plan. For example, the assessment and the multi-agency plan both emphasised the need for the parent to engage with services to improve their well-being. Many years of being unable to make effective use of the treatments and support that had been offered over many suggests, therefore, that there was very little prospect that fundamental changes to usual ways of being would emerge.

Helping improve a parent's physical and emotional wellbeing are important aims but, in terms of

making sense of family life; a more effective approach to the child-focussed task would have been for the multi-agency group to work together with parents to clarify the impact of circumstances on the children's everyday lives and on their developing needs. Such an approach could have helped practitioners focus on identifying the actions that were most likely to promote the children's development and to reduce any risks of harm to them.

By working closely with the family and making use of professional knowledge and expertise to help build a picture of family life, including daily routines; planned interventions could be more focused and more likely to bring about sustainable change from the children's perspectives. Safeguarding partner agencies recognise this as fundamental to bringing about timely change for children and families in Warrington. Significant actions have already been made or are planned. A Local Assessment Protocol was published in September 2018. The aim of this protocol is to support a consistent for approach to assessment that 'defines roles and responsibilities and contributes to the protection and wellbeing of all children within Warrington'. It provides guidance to practitioners on 'What makes a good assessment' covering most of the issues raised about the quality of assessment in this case.

Reference has also been made to changes in CSC to include a systemic approach to social work; restructure of service to reduce 'handovers'; the development of practice learning hubs; and, training to increase awareness of the child's perspective, including the use of virtual reality.

The expected impact of the proposed changes was discussed by the SCRP. The panel's view was that improvements in respect of professional interventions would improve the lived experiences of children and families in the borough. An overall plan (working title: Warrington for Families) is being devised to reflect this. Local agencies will be required to demonstrate to the new Warrington Safeguarding Partnership (WSP) (which replaced WSCB in April 2019) that they are improving practice in this regard. This will be covered in the Quality Assurance Framework supporting the WSP.

In addition to 'consultation with existing service-user forums'; this framework will also include taking evidence directly from parents and children as to their experience of multi-agency working within child protection processes.

It is reported that the framework will include measures to assure the quality of assessments and multi-agency plans for children within the borough. Plans have already been made for a multi-agency audit day focusing on multi-agency assessment.

A commitment on behalf of the Safeguarding Partnership has been given to rolling out training based on the learning from this SCR.

Given the changes already initiated or planned, therefore, no specific recommendation is proposed in respect of this learning point.

Learning Point 2: The importance of balancing risks and rights when responding to allegations that a child has been harmed.

Agencies became involved with this family following a credible allegation made by a pre-school

child that an adult had hit her on the head. Family circumstances were unusual as mother was in hospital at the time therefore, not in a position to be able to immediately to look after the child and there was no other person known to have parental responsibility for her.

The local authority was not in a position to insist that the adult leave the family home or to make arrangements for the child to be cared for by a family member. From mother's account to the independent reviewer, however, there appears to have been some consultation with her while she was in hospital about how to keep the child safe in the short term.

The local authority's position in respect of the risk of harm quickly became confused. Unfortunately, in the absence of a recorded rationale, it is difficult to make sense of the relevant practitioner and manager's decision-making at the time. They were temporary members of staff and are no longer employed in the authority and so, they were not available to provide their perspectives directly to the review.

It was known that parents wanted to live together when mother returned home. Nevertheless, possibly for the reasons suggested above, effective restrictions on their living arrangements continued and family time restrictions were also put in place by the Local Authority. The fact that the local authority made no attempt, then, either as part of its family assessment or separately, to assess the risk meant that a proportionate multi-agency risk management strategy was not developed.

The CSC IMR states that 'on balance… a child protection conference ought to have been convened' and suggests that 'a child protection plan would have been warranted' Such a course of action might have resulted in a more overt process of risk analysis and management than was achieved through the child in need process, although this on its own would not be a reason to initiate child protection planning.

There is no evidence that parents were advised how to make a complaint or that they could seek legal advice in respect of what they understood to be enforceable restrictions. There is no evidence that the local authority has definitively drawn conclusions about the risks posed.

This learning point is linked to the need to ensure good quality assessments and plans for children. The legal responsibility of parents towards their children is a fundamental aspect of child care law in the UK. In this case, the review acknowledges that there were practical difficulties in putting in place immediate safeguarding measures for Olivia while the risk posed by Christopher was evaluated. These measures should, however, have been reconsidered when Amy came home and local authority child protection enquiries concluded. The consequences in terms of assessment of need and children's plans have been described above. In addition, Christopher and Amy were disempowered from exercising their parenting responsibilities to make decisions in important aspects of Jack's life and, for Amy, also in Olivia's.

Learning Point 3: The importance of recognising the risk factors that are associated with the likelihood of actual or future harm in very young children.

The main child protection concern that was identified in this case was the possibility that an adult had harmed a child and that, as a result, he might pose of risk of physical harm to both children.

There was no overt consideration, however, of whether there was a risk of neglect, despite the known vulnerabilities.

The NSPCC briefing, Infants: Learning from case reviews (2017) , acknowledges that ‘professionals can find it difficult to find a balance between supporting parents and recognising and addressing any risks posed to babies’. It also highlights the added difficulties where parents are facing multiple challenges; considers the particular vulnerability to abuse and neglect of premature babies; and, raises the question of whether professionals have sufficient understanding of how a child’s experience during their first few months of life can affect their future development.

In this case, a clearer acknowledgement of the risks and potential impact of neglect might have produced a more specific plan to improve levels of family time; together with increased clarity in terms of expectations of parents.

Also of relevance to learning from this SCR is the Department for Education research report, Missed opportunities: indicators of neglect (2014). This refers to the cumulative impact on families of poverty, social isolation and poor living conditions and highlights the association between the risk factors for accidents and a number which are also linked to neglect. More recently, Public Health England: Reducing unintentional injuries in and around the home among children under five years (2018) identifies accidents to young children as a major health inequality citing ‘a persistent social gradient for unintentional injuries‘.

Warrington Safeguarding Children Board published a Neglect Strategy following its decision in 2014 to make tackling neglect a priority. The Neglect Strategy in place at the time of the review acknowledges the particular risks for children under 3 years old. It emphasises the advantages of partnership working and high quality training. The strategy endorses the use of methodologies that assess key areas of risk in relation to neglect so as to enable practitioners apply structure and systematic analysis to very complex situations.

In 2016, WSCB undertook a multi-agency audit of practice in respect of children with different levels of need where neglect was a feature of their lives. The use of the Graded Care Profile as an assessment tool was also evaluated and it was found that there was a ‘variable picture in terms of awareness and usage’. A second audit was undertaken in 2017, focusing on neglect of children between 5 and 17 years old. On that occasion, among other findings, it was noted that while there was ‘an increased awareness of the Graded Care Profile … its use was variable, with practitioners selecting only certain aspects (mainly home conditions) for assessment’. The inconsistent use of historical family information and shortcomings in ‘taking a holistic view of family dynamics where they impact on the child’ were highlighted as areas for further work. These findings are congruent with learning in this case. It is understood that renewed focus on the neglect strategy is anticipated shortly to coincide with the adoption of Graded Care Profile 2.

It is acknowledged that this learning point is made in the context of the Safeguarding Partnership plans to launch its revised neglect strategy and associated training. In their discussions, the SCRP recognised the particular vulnerabilities of very young children and how compromised parenting capacity can lead to the unintentional risk of neglect. The SCRP extended their thinking on this to include unborn children and babies who might be in hospital for reasons other than being premature or pre-term.

Learning Point 4: The importance of ensuring that, before stepping across to Early Help, unresolved areas of concern are explicitly identified in the referral for services along with circumstances which might warrant re-referral to CSC.

The assessment of parenting capacity was not re-visited at a time of change and so there was an absence of any basis to direct interventions or mark progress. This meant that, when it was agreed that the plan would end; there was no consideration of the likelihood that problems would re-emerge. This was reflected in the brief information given to Family Outreach/Early Help which contributed to the unsatisfactory response by the service.

The purpose of a recommendation in relation to this learning point would be to ensure that:

- Unresolved areas of concern, or issues liable to recur, should be clearly articulated and recorded at the point that Child in Need plans end; and,
- Subsequent referrals for Early Help services should contain that information along with circumstances which might warrant re-referral to CSC

Summary of recommendations

Recommendation 1

Warrington Safeguarding Partnership should require that immediate safeguarding measures taken to protect a child are lawful, proportionate, and endure only as long as strictly necessary by:

i. Ensuring that the local authority has taken steps to:
   - Improve the recording of the rationale for management decisions which result in restrictions being placed on the exercise of parents' parental responsibility;
   - Routinely confirm by letter to parents the details of, and rationale, for any agreements or proposals respect of restrictions on the exercise of their parental responsibility, using a template which has been agreed with the local authority's legal services.

ii. Reflecting key elements of these requirements in the Safeguarding Partnerships multi-agency procedures.

Recommendation 2

The Safeguarding Partnership should ensure that relevant elements of its Neglect Strategy:

i. Are informed by research in respect of vulnerabilities of infants, particularly those with significant health needs; and,

ii. Emphasise that, where parents are likely to struggle to meet their unborn or children's needs; practitioners should consider, and address, the possibility of future neglect.

Recommendation 3

The Safeguarding Partnership should ask the local authority to provide assurances that measure have been made to:

i. Improve records of closing summaries agreed in Child in Need meetings by specifically identifying any areas of continuing concern; and,

ii. Reduce the likelihood that families do not 'fall through a gap' between ending Child in Need plans and establishing an Early Help approach.