Serious Case Review

Child B and Child C

An Independent Review undertaken on behalf of

Stockport Safeguarding Children Board

Jane Booth

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Acknowledgements

The serious injury of young children is always distressing, both for the family and for professionals working with them. While the children survived the assault upon them, it is important to acknowledge that their injuries may have a long-term impact on their health and development and the repercussions affect all members of the family.

As a result of on-going investigations it has not been possible for the reviewer to meet with the family and therefore it has not been possible to reflect on their experience of services.

In undertaking this review and completing this report the author would like to acknowledge the contribution made by the professionals involved and by members of the review panel. The author is also grateful to the staff of the Stockport Safeguarding Children Board who provided administrative and professional support. The roles of the professionals interviewed and those who sat on the review panel can be found in the Framework in Appendix 1.

Contents page

1. Introduction

1.1. Twins B and C are the youngest of a large family of children. On 21.06.15 Child B was admitted to Manchester Children's hospital accident and emergency department having been brought by ambulance. The child was found to have two fractures of the skull. Subsequently the child's twin, Child C, was also found to have a fracture of the skull.

1.2. As a result, a child protection investigation was commenced and all the children had paediatric medical examinations. One of the other children had bruises on the thighs and two had minor burns – one said to have been caused by the iron and one by the fire – none of these injuries were deemed to be as a result of physical abuse.

1.3. The family had been an open case with children's social care for a number of years and previously subject of a multi-agency plan under the child in need[1] and team around the child[2] procedures. At the time of the incident the children living at home were subject of a child protection plan[3].

1.4. The Chair of Stockport Safeguarding Children Board took the decision to convene a Serious Case Review in July 2015. Working Together[4] states that:

"For the purposes of paragraph (1) (e) a serious case review is one where:

(a) Abuse and neglect of a child are 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."

The Board Chair agreed that this case met the criteria in (b) (ii) and an independent reviewer (the author of this report) was appointed. It was agreed the Board would seek to complete the report by March 2016 with a view to publication as soon as practicable thereafter. The timeframe to be considered in detail was from 01.06.13 to 21.06.15. This timeframe commences with the date of the latest formal referral to Children's Social Care and the date of the admission to hospital after the incidents.

1.5. Most Serious Case Reviews deal with difficult and distressing situations and this is no exception as it involves the serious injury of two very young babies. The purpose of this report is not to investigate what happened and allocate blame. Its purpose is to focus on the way in which agencies worked together and worked with the family and to identify any learning that can improve services for the future.

[1] See glossary re child in need
[2] See glossary re team around the child
[3] See glossary re child protection plan
[4] Working Together to Safeguard Children HM Govt. March 2015

1.6. During the course of this case there have been examples of good practice as well as missed opportunities:

- From mid 2014 multi-agency communication was good, meeting frequency was increased as concerns increased and the case was appropriately escalated into child protection procedures.
- The reviewing officer went out to visit the father and convey the outcome of the child protection conference when he had failed to attend.
- Services normally delivered at the children's centre were offered in the home in an attempt to get the mother to engage.
- The social worker and health visitor showed a commendable degree of persistence in seeking to address the family's needs.
- The GP, unable to attend core group meetings, convened a multi-agency discussion to ensure her concerns were understood.
- The midwife, having been unable to get the mother into the clinic at the right time, delivered the pre-op process at home to avoid the planned caesarean being delayed.
- The school nurse recognised the vulnerability of both the older girls and arranged for one to attend a group work programme to enhance her self-esteem and resilience in addition to pursuing their health care needs.
- Stockport Homes were proactive in responding to the family and treated the family as homeless, providing temporary accommodation despite them not meeting the criteria.

1.7. During the course of this review care proceedings have been concluded but a police investigation is on-going.

2. Predictability and preventability

2.1. In the course of this review, consideration has been given to whether the injuries to the twins were predictable and / or preventable.

2.2. The test used is that the injuries would have been predictable if there was evidence from the words, actions or behaviour of the parents at the time that could have alerted professionals that violence towards the twins was a significant and immediate risk, even if this evidence had been unnoticed or misunderstood at the time it occurred.

2.3. The test used in respect of preventability was whether there was evidence that professionals had the knowledge, the legal means and the opportunity to stop a violent incident from occurring but did not take the steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

2.4. In this case, although there had been long-standing concerns about neglect, there had been no clear substantiated concern of physical abuse to the children in recent years. Historically there had been an injury to one of the older children but many years had passed without any confirmed concerns about physical abuse. There was no evidence of threats, assaults or violent behaviour from either parent, which would have alerted professionals to the risk of violence. Therefore, although the risk of harm as result of on-going neglect was a factor, the risk of violent assault of the twins was not, in the view of the reviewer, predictable.

2.5. In the absence of predictability, the question of preventability is complex. Nothing in the circumstances of the case had suggested a current risk of a violent assault and as such, it is

unlikely that anything short of removal of the twins from the parents' care could have prevented the unforeseen injuries. While the shift in focus, which had moved management of the case into the child protection arena, might, in due course, have resulted in proceeding to remove the children from their parents' care, there were further steps required before this was likely to be a viable option and therefore, in the opinion of the reviewer, the assaults were not preventable.

3. **Scope and Framework for the Review**

3.1. Working Together (2015) does not require a specific methodology to be adopted in the conduct of Serious Case Reviews. It does however set out a set of principles that should underpin the work. Reviews must:

- Contribute to learning and improvement;
- Be proportionate in their methodology;
- Be undertaken by an independent reviewer;
- Fully involve professionals;
- Give families the opportunity to contribute;
- Be produced in such a way that they are suitable for publication;
- Ensure improvement is sustained so that findings make a real impact on improving outcomes for children and young people.

3.2. The Stockport Safeguarding Children Board established a framework for this review, which is attached as Appendix 2.

3.3. Specific issues to be explored were identified as follows:

- Use of prescribed medication and physical and mental health impacting on the parents' ability to care for their children;
- Long term neglect issues;
- Role of older children in household functioning;
- Engagement of father with services and processes; and
- Complexity of child protection planning in large families and level of support offered.

4. Background and family history

4.1. Children B and C are twins and the youngest children of a large family. The family are recorded as White British and English is their first and only language. There is no other recorded information about cultural or religious issues. The parents have lived together as a family since they formed a relationship as young teenagers and all of the children in the family are a product of this relationship.

4.2. Little is known about the parents' own childhoods. As an adult, the father has a relatively small number of convictions between 1998 and 2012. One conviction related to an assault on the third child of the family in 2002. The father received a community sentence in respect of the assault but failed to engage with this, which resulted in him serving a prison sentence. He has generally been in work, working long hours on manual labour. The level of income has never been clear to the agencies but it is clear that the family were often in debt. The paternal grandmother has been involved with the family from time to time and some professionals have looked to her when unable to engage effectively with the parents.

4.3. The mother has a long history of ill-health; she has been in receipt of prescribed drugs to control back pain and headaches for a number of years. She was arrested and charged on one occasion in 2014 for tampering with a prescription with the outcome still pending. She was said to have been on poor terms with her extended family following a difficult childhood.

4.4. Stockport Children's Social Care first became involved in 2003, at a time when there were three children and the youngest had been the subject of an assault by the father. This resulted in the children being made subject of a child protection plan between January 2003 and April 2005 under the category of physical abuse. A variety of agencies have been involved to a greater or lesser extent for the following 12 years, with concerns being predominantly around neglect. Assessments were carried out in 2012 and 2013 and intervention via Section 17 of the Children Act 1989 resulted in a "team around the child" approach being adopted. The referral, which prompted the 2012 assessment, was from a neighbour who was alleging that the father hit the children and that there was no food in the house.

4.5. Concerns recorded include:

- Poor financial management leading to multiple evictions and move of home;
- Poor school attendance and punctuality;
- Older children inappropriately caring for younger children and missing out on their own education;
- Poor health and missed health appointments for both the mother and children;
- Poor take up of ante-natal care and lack of preparation for the birth of the twins;
- Poor dental hygiene in respect of the children;
- Lack of supervision of children with the children left alone or with an older child caring for the younger ones;
- Mother's poor physical and mental health and her dependence on prescribed medication;
- Dependency on professionals to assist with day to day family tasks; and
- Lack of compliance by both parents and lack of engagement from father.

4.6. The family are referred to in records as “a close and loving family” and agencies put in a high level of support in seeking to keep the family together and ensure a good enough level of care for the children. Subsequent to the incidents with the twins, other evidence suggests the children have indeed experienced some good attachments. Professionals comment about the mother: “you want to help her” and “her reason for not doing things always seemed justifiable at the time”.

4.7. Managing the behaviour of the boys in the family and in school had become a difficulty as the boys got older, and truancy had been a very big concern. With the oldest boy, these difficulties escalated in adolescence and he became accommodated[5] by the local authority. School attendance, particularly for the girls seems to have been undermined by the mother’s need for support at home. On numerous occasions, the older girls remained at home to care for younger siblings. Consideration was given to the extent to which the absence from school should be seen as a “young carer’s[6]” issue but this approach was not adopted. Indeed, the opposite approach was adopted and formal court action has been taken in relation to school attendance. As the older girls have reached teenage years, there have also been issues about behaviour outside the home. The mother’s response to this was perceived as positive.

4.8. The prospect of the birth of twins in 2015 raised significant concern and prompted a re-assessment. Following the assessment, an initial child protection conference was convened and on 21st April 2015, the children, with the exception of a child who was being accommodated, by the local authority, were made subject of a child protection plan under the category of neglect.

4.9. Although the time period for this review is from 01.06.13 to 21.06.15 there are some events in previous years which may be of significance in understanding the family. Despite the original reason for agency intervention being a physical assault upon a child the focus very quickly moved to concerns about neglect. Some events which were not related to neglect did, however, occur and were dealt with at the time.

4.10 In 2001 and 2002, there were two events involving the then youngest child: a broken arm with an explanation that attracted some suspicion, and then an assault by the father causing extensive bruising to the child’s face and buttocks (the assault that resulted in criminal prosecution).

4.11 In 2011 and 2012, there were two occasions when the oldest boy alleged assault by professionals (teacher and taxi driver). These were followed up appropriately.

4.12 In 2012 one of the children alleged to a teacher that the father hit all the children and the mother, but not the particular child. A section 47[7] child protection investigation took place, but the mother and other children largely denied the allegations. One of the children said that the father was always either working or sleeping, but also said that he shouted and sends them to bed, and on one occasion tried to stab them with a butcher’s knife. The child was described as making this allegation with “a smirk on his face”. All the children were otherwise consistent in saying that their parents exercised reasonable punishment for misbehaviour. The investigation was closed with no further action.

[5] See glossary re Accommodated
[6] See glossary re Young Carer
[7] See glossary

5. Chronology of significant events

5.1. During the period under review, there were numerous missed appointments with all services. Two of the children had significant health problems requiring specialist support but frequently did not attend clinical appointments. The youngest child did not attend for routine developmental assessments and immunisations. School attendance continued to be poor. The oldest boy moved in and out of care. The mother frequently attended the G.P surgery and the hospital requesting emergency medication. Two such reasons given were that the prescription had been lost or destroyed, or the mother was planning a holiday. She did not attend appointments for re-assessment at the pain clinic.

5.2. The period under detailed review commences in June 2013 at the point where a referral was made by a family support worker to Children's Social Care resulting in an assessment being completed and a "team around the child" (TAC) process established. An overview of health visiting engagement shows that in the previous year there had been nine 'no access' visits; 15 appointments had been offered in seeking to do a developmental assessment on the youngest child.

5.3. Numerous concerns were recorded during 2013, including the refusal of access to the house, management of aggressive behaviour from the oldest boy (including two calls to the police following threats of sibling violence in the home), eviction processes as a result of rent arrears and attempts by the mother to obtain additional medication. This latter resulted in the GP initiating a review of mother's medication and advising the mother to withdraw from morphine based medication.

5.4. During 2014, similar concerns continued to be recorded with the mother's requests for increased or additional medication escalating and on at least one occasion resulting in an attempt to obtain medication by false pretences. There was an emergency appointment with the GP who recorded the mother's low mood and panic attacks and the mother also had one admission to the psychiatric ward. She was reporting anxiety, headaches, low mood, paranoia, and the records state that she was responding to unseen stimuli on admission. She was described as "unkempt and distressed". During this admission, there is the only recorded evidence of the mother openly discussing her childhood and adverse childhood experiences. She also described a one-year history of self-harm, cutting, and an overdose 12 months earlier. Whilst she was an in-patient, the pharmacist reviewed her medication and reduced the level of opiates during her period in hospital. She was offered follow-up and outpatient support when discharged one week later but never took this up.

5.5. It was during 2014 that there was a change of social worker. One worker was allocated the case of the oldest boy and another, a newly qualified worker, the rest of the family. The family social worker had a protected caseload and describes the support from her manager and team as very supportive. She describes working closely with her co-worker and reflects that she was given the time to gain a full understanding of the family history and to get to know all the children as individuals. Other professionals describe this time as reflecting a shift in approach. Communication was good, meetings were more focused and the need to promote change rather than monitor and support was given more priority.

5.6. There had also been a change of GP, which resulted in strict controls being adopted across the GP practice to try to control more effectively what was now being clearly seen as the mother's dependency on her medication and her attempts to abuse the system in order to obtain more. When the pregnancy was confirmed, the mother discussed her options with the GP. The GP was clear that she needed to reduce her usage of opiates based medication. Unable to attend the team around the child meetings, the GP convened a multi-agency meeting at the surgery to discuss this. The mother continued to try to get more medication, and was referred back to the pain clinic for review. She did not attend however and her dosage did not reduce. Criminal charges for altering a prescription during this period remain outstanding.

5.7. Concerns continued and increased during the pregnancy. There is evidence of both social workers succeeding in engaging with the father, albeit infrequently. The father gave up work to support the care of the mother and children but the areas of neglect remained a concern. The health visitor and social worker were persistent in making contacts with the mother and seeing the children. The social worker completed a pre-birth assessment and challenged around unacceptable responses and failure to comply with plans and appropriately recognised risks. The midwife was pro-active in ensuring the mother received ante-natal care. All this culminated in the decision to call a child protection conference in April 2015, and the children being made the subject of a child protection plan. When little or no progress resulted from the child protection plan, consideration was given to initiating legal proceedings and the social worker was advised that the evidence of harm was weak and proceedings would be unlikely to succeed at that point in time.

6. Involvement of professionals and multi-agency working

6.1. A multitude of professionals have been involved with this family since 2002. For some agencies, specifically the schools, their involvement has been long-standing. For others their interventions have been of varying lengths and intermittent. All agencies were able to evidence that appropriate safeguarding supervision or consultation arrangements were in place. The period considered in detail by this review covers the most recent episode when the case was open to children's social care. Professionals talk about "going the extra-mile" to support the family and only towards the very end of the period under review was serious consideration given to formal intervention via care proceedings.

6.2. This review reflects on multi-agency practice but a number of agencies have identified single agency learning and developed action plans in response.

6.3. **Two schools, a nursery** and **a children's centre** were involved. The nursery had little engagement as efforts to persuade the mother to take the youngest child to nursery were largely unsuccessful. The parents were invited to engage with parenting support activities at the children' centre but did not do so. Subsequently, they were offered parenting support input in the home but engagement was limited.

6.3.1. The primary school was heavily involved and had known all the children as they reached school age. The head teacher had an active relationship with the mother but rarely saw the father and if he did collect the children from school, he waited for them at a distance and did not engage with staff. Attendance and the behaviour of the boys was a constant problem, as was a persistent failure to pick the children up from school on time. The school worked hard to support the children and experienced considerable frustration at their inability to get the parents to address the issues. Contacting the parents was a huge issue for them and the parents are described as having frequent changes of phone number. The school did have a phone number for the paternal grandmother and sometimes used this if all else failed. They perceived her to be a strong-minded woman who could and would find the parents if school could not. The school describe the girls of the family as having a degree of resilience and doing well in terms of achievement despite the chaotic circumstance of the home and the neglect of their basic needs. The boys' response to their circumstances appears to have been different and they became more prone to engage in difficult behaviours, both in school and the community.

6.3.2. The secondary school's involvement was more focussed on attendance issues though the school nurse did engage actively with the two oldest girls and provided additional support to enable them to develop resilience and recognise risks and manage their behaviour outside school.

6.3.3. Both schools engaged pro-actively in multi-agency approaches and were members of the core group when the "team around the child" approach was in place and later under the child protection plan. They describe years of frustration as agencies struggled to make a positive difference to the quality of the children's lives. They recount numerous agreements being made with the parents but never complied with and without consequences, plans made and never followed through and multi-agency meetings reaching agreement about next steps but with no identifiable beneficial outcomes. Both schools identify a shift in approach to the family in 2014/15 coincident with a change in social worker. The shift in professional thinking is

evident in the pre-birth assessment completed before the twins were born. The schools were supportive of the move to managing the case under a child protection plan, and describe communication and information sharing as having improved significantly.

6.3.4. The schools did not identify any single agency actions as they felt they had done all they could to support the family. The multi-agency learning points cited below will include the schools.

6.4. **Numerous health professionals** were involved with the family offering both universal and specialist services.

6.4.1. **Health visiting services** struggled to get the mother to attend appointments and developmental reviews were often completed late. Relevant advice was given and assurances received from the mother, but this did not result in sustained improvements. The children's dental care was also neglected.

6.4.2. **Midwifery Services** provided care during the pregnancy and following the birth. They experienced the same difficulties as other agencies in getting the mother to attend appointments. The named midwife went to considerable efforts to ensure the planned birth by Caesarean went ahead on the due date. She understood the possible impact of the use of opiates on the unborn twins and ensured colleagues involved following the birth were alert to any concerns. Continuity of care was an issue and a number of midwifery staff were involved in the post-birth period.

6.4.3. Two of the children had specific medical needs and were under review by specialist services. Their care was constantly hampered by failed appointments. Professionals intervened to ensure the children were not discharged from specialist care when appointments were missed.

6.4.4. Stockport NHS Foundation Trust have included the following in their Action plan:

- The dependence on pain killers and the possible impact on parenting capacity
- The significance of failed appointments and the impact of 'forced compliance' by professionals
- The importance of continuity of carer is crucial when daily visiting plans are put in place, with key professionals being made very clear of their role and threshold for escalating any concerns to children's social care
- The understanding of risk and vulnerability where parental mental health is poor and there is evidence of substance misuse.
- Assessment being shared/managed appropriately with multiagency colleagues
- The role of supervision when reviewing complex neglect cases

6.4.5. The mother had frequent contact with her **GP** and changed GP during the period under review. She is described as having chronic problems with back pain and headaches. She had been referred for specialist support at the pain clinic. The majority of her contacts with the GP were in relation to pain and the need for medication. Her medication was addictive in nature and she appears to have had a significant dependency upon it. She made numerous GP contacts seeking to increase her medication or to obtain additional prescriptions giving a variety of reasons for needing to do so. Many of the reasons given are clearly untrue – several planned holidays and the death of her mother in-law clearly being examples of this. Tampering with a prescription resulted in criminal proceedings. The change of GP appears to have been as a result of being challenged about her drug usage. The second GP was similarly pro-active

about seeking to control her usage. The GP addressed the issue directly with the mother and, as she continued to try to abuse the system, put in place increasing number of controls to try to ensure no additional prescriptions were issued.

6.4.6. When the mother was in the early stages of pregnancy she discussed her options with the GP. The GP responded appropriately.

6.4.7. During the pregnancy with the twins, the GP called a meeting with the health visitor and midwife and was in telephone communication with the Social worker. She did not attend the multi-agency "team around the child" meetings or child protection core groups and told the review this was rarely possible for GPs, given clinic commitments. She made referrals for medication reviews with the pain clinic but the mother did not attend. She was very clear with the mother that the use of her pain-killers had potentially dangerous consequences for the unborn twins but her efforts to engage the mother in a reduction were not successful.

6.4.8. The GP did not identify any single agency actions. The multi-agency learning points cited below will include the GP services.

6.4.9. There is very little information recorded about mother's mental health during the relevant period but she is often described as "low". She was admitted to the psychiatric ward in September 2014 and notes refer to an earlier admission and to self-harm. She was offered outreach follow-up from the hospital and referred for counselling but did not take these services up.

6.4.10. Pennine Care Foundation Trust included the following in their action plan:

- The use of prescribed opiate prescription drugs must be considered in relation to the assessment of parenting capacity.

6.5. **Family support workers** offered support at various times over the years and as a result of the child protection had very recently re-engaged with the family. In addition, a referral had also been made to **Homestart** (a charity working with families) around the time of the birth of the twins. For both the family support workers and Homestart the very recent involvement had not had time to make an impact before the injuries to the twins occurred.

6.6. **The police** had had intermittent involvement with the family in response to offences by the older boy and the father and occasional allegations in the past but had no current involvement at the time of the twins' injuries. There were fourteen incidents requiring police involvement in the two years under review.

6.6.1. The Police included the following in their action plan:

- Front line officers need to recognise when criminal activity may have an impact on the safeguarding of children and refer to children's service appropriately

6.7. **Stockport Homes** also had intermittent contact with the family. As a result of their rent arrears, they had been evicted and had moved house on several occasions. The last house move was within days of the twins discharge from hospital and was a result of the Housing Service agreeing to treat them as unintentionally homeless and offering accommodation.

6.7.1 Stockport Homes included the following in their action plan:

- Refusal of entry to a home in order to do routine checks and there have been access or non-compliance issues and where there are children this needs to be reported to Children's services.

6.8. **Youth offending services** - the oldest boy in the family had been subject to a statutory order supervised by the youth offending services. Their involvement produced the same response from the parents with little or no follow through by them on commitments given, and numerous missed appointments. There was a recognition that a fundamental improvement of the parents' skills to manage their children was required and considerable efforts made to enable the mother to engage in parenting support programmes but with little success even when the course was brought to her in her own home.

6.9. **Children's social care's** most recent continuous involvement was in coordinating the support via the team around the child arrangements and later the child protection plan. The oldest boy was given a separate social worker as it became increasingly clear that his needs were going to be best met outside the home. There was also a recognition that the case was too big for a single worker to manage.

6.9.1. Non-engagement with the father is a feature of all agency involvement. He is largely invisible in the earlier years and an inconsistent presence later, even after he had given up work with the intention of helping with care of the family.

6.9.2. Although agencies had worked together for many years, the pregnancy resulted in a new phase of work being commenced in order to complete a pre-birth assessment. The service being provided to the family by children's social care was on the basis of Section 17, as the children were considered to be children in need. The decision to complete the assessment coincided with a change of social worker.

6.9.3. The social worker allocated to the case was a newly qualified social worker, and as such, she reports that she was given time to read through the files and undertake the work. She was on a restricted case-load and was a member of a supportive team. Other professionals comment very positively about her involvement and report that she got to know all the children and communicated well across agencies both via meetings and email updates. Her visits to the family were numerous and she was persistent, sometimes visiting several times in a day until she gained access or waiting until the family came home.

6.9.4. The pre-birth assessment was completed on 21.04.15 and concluded that the children's needs were largely unmet, and that a child protection conference was required. A child protection conference was initiated and the children made subject of a child protection plan. There was agreement that care proceedings would be considered if no progress was made. This is the first real evidence of there being likely consequences for the parents if they did not comply with the plan. When the status of the case moved from child in need to child protection, it would usually be considered more appropriate for a more experienced social worker to carry the case. Although this did not happen in this case, the social worker managed the case well and reflects that she had access to good supervision and colleague support. The fact that she retained a limited caseload may well have been a factor in her continued pro-active and thoughtful response.

6.9.5. As the case progressed, it became clear that the agreements made with the parents, as part of the child protection plan, were not being adhered to and the social worker, with the support of her manager, sought legal advice about the possibility of initiating care proceedings. She was advised that the threshold for such action was not met. The advice given has been reviewed and confirmed as appropriate at the time. The essence of the discussion appears to have been that, although the parents may indeed have been neglectful, inter-agency support had enabled the children to receive "good enough" care and that there was, as a result, insufficient evidence of significant harm. This was not the outcome the social worker had hoped for and she was faced with continuing to work with the family under a plan she was concerned was not viable. She was encouraged to have the case reconsidered when more evidence was available.

6.9.6. Stockport children's social care included the following in their action plan:

- Social work assessments: to ensure all adults have real engagement with assessment and plans and that professionals understand each parents' history, role and functioning within a family including nature and impact of mental health, prescribed medication use, illicit drug use, domestic abuse.
- Ensure all siblings are included in a holistic social work assessment and plans.
- Evidence of parenting capacity described and analysed in social work assessments in order to demonstrate legal thresholds.
- Each member of any multi-agency group takes responsibility to clearly and explicitly understand their role and responsibility as part of the plan.

6.10. All core agencies were involved in the discharge plan after the twins' birth. Daily visiting was agreed, but in reality, the family often received multiple visits each day as agencies covered both their commitment to the discharge plan but also their statutory requirements. There appears to have been telephone communication between professionals but it is difficult to identify who had an overview of this fairly chaotic period. For example, despite daily visiting it seemed to come as a surprise when at the weekend the family actually moved house.

6.10.1. All agencies were concerned for the children. Their focus was around the impact of neglect and the risk of physical abuse by a parent was not reflected in their plans.

6.10.2. The safeguarding children unit identified the following in their plan:

- Support the improved understanding of long term neglect cases and support better outcomes for children
- Offer a multi-agency reflective learning circle to help develop analysis inconsistencies and complexities to support deeper analysis and more informed assessment.

7. Analysis and Learning

7.1. This review has not considered in any detail the circumstances when the family first came to the attention of agencies (in 2002 when the youngest child was assaulted). It is clear, however, that even from that earliest time the focus of work has been on reducing the impact of neglect. The family do not appear to have ever engaged appropriately with the plans developed. They are described as being difficult to contact, frequently out or not opening the door, actively denying access to the house and children at times, hostile but then warm and apologetic.

7.2. Research findings highlight that neglect is a complex phenomenon and rarely has a single cause. As such, it is rare for a single approach to be successful in promoting change[8]. The risks of the very significant adverse impact of chronic neglect either being masked by the level of support from services or under-estimated are also evident[9]. No specific tools, for example the Graded Care Profile, were used to inform the judgement about the level of neglect and its impact. This would have been good practice and an opportunity to draw on the skills of all involved agencies.

7.3. Most of the contact has been with the mother and children.

7.4. Until the December 2014, the father was in full-time employment and little was seen of him. In the most recent episode of social care involvement he proved difficult to engage, would often be said to be out, when in, would often ignore professionals, walking past them without acknowledgment and going upstairs.

7.5. Both parents did however, have the capacity to persuade professionals that they were on the point of a breakthrough. An encounter would take place and the professional leave feeling there had been a really useful discussion with signs of a commitment from one or other of the parents to move forward only to find this evaporated before the next engagement. The mother's presentation is described by professionals as being one that evoked sympathy. The number of children, the apparent poverty, the mother's poor health, the children's poor health etc. all led professionals to feel she had too much on her plate and her failure to attend appointments, or to remember what had been agreed, did not seem unreasonable.

7.6. Historically, there had been a brief focus on the father following abuse of the oldest boy, but thereafter he appears to have been a largely absent figure until shortly before the birth of the twins. The social worker was able to involve the father to a limited extent in the pre-birth assessment and there was discussion about the need for more support for the mother. The parents seem to have believed that he was asked by children's social care to give up work but the social worker is less clear about this. It is clear however, that it was discussed and he did give up work. This was in the context of mother needing more help and his ability to provide it and cope with the reality of being at home and caring for his children was not tested. No-one knows much about his life, work, and finances. One professional describes poor literacy levels but if this is so, then it has not generally been recognised as such. There was no comprehensive assessment or understanding of the father's parenting capacity was completed.

[8] Turner and Taylor Interventions in Chronic Neglect: What works?

[9] Horvath and Tarr May 2014 Child Visibility and Chronic Neglect.

7.7. Violence / control was not seen as an issue in the recent period nor had this been a focus in the past although there had been one allegation of domestic abuse and some evidence of controlling behaviour. Case conference minutes from 2002 refer to controlling behaviour and the children not being allowed to play downstairs.

7.8. Historically the assault against the oldest boy had been described in terms of a response to the pressures of parenting three very young children. The father is quoted as having said things had "got on top of him". During the pre-birth assessment, he told the social worker that he had not wanted more children. He said it had taken him some time to get used to the youngest child and he supposed he would get used to the twins.

7.9. The mother's own health problems and the impact on her parenting capacity was not sufficiently well understood by professionals. She was using a high level of painkillers to which she would have developed a degree of tolerance. The drugs, and her need for them, were likely to have led to a level of preoccupation and significantly reduced energy resulting in a reduction in her availability to her children much of the time. Prior to the completion of the Pre-birth Assessment, the quality of assessment and planning was inconsistent. Plans were not successfully implemented and the problems experienced by the children continued over many years.

7.10. With the possible exception of the decision not to initiate legal proceedings at the point originally requested, no specific practice episodes stand out but what is clear is that the range and frequency of issues presented by this family resulted in very significant agency activity but with little impact on improving of family outcomes. Over the two years considered in detail by this review there are however some points in time where agencies were particularly challenged in responding effectively:

- From January to July 2014 the mother made repeated requests for increased medication, replacement for lost prescriptions, advance prescriptions for specific events e.g. a holidays and trips abroad to visit relatives or attend a funeral, allegations of the chemist dispensing the wrong amount etc. On a number of occasions, there have been attempts to falsify prescriptions by altering dates or adding items. This suggests a heavy dependency on her medication – including the strong painkillers – which would have reduced her ability to focus on and respond to her children. The GP, in the later period took a strong line in an effort to reduce the opportunities for abuse of the system, but professionals do not appear to have been sufficiently sighted on the impact of her drug addiction on her parenting ability.

- In September 2014, the mother was admitted to an acute psychiatric unit and reported to be having blackouts, and responding to unseen stimuli. She gave an account of her own adverse childhood experiences and expressed an interest in follow up – she did not subsequently pursue this nor did it appear to influence the work being done with her by other professionals, although the health visitor did try to pick up some issues in a follow up visit.

- During the pregnancy, there was growing professional concern about the impact of opiate usage on the development of the twins during pregnancy and possible post-delivery issues. The GP initiated an additional multi-agency meeting in order to discuss her pregnancy. Whilst this was good practice, it did not result in the development of a specific plan to reduce the mother's medication.

- September to December 2014, there was a further period of attempts to get increased medication with the mother being arrested for falsifying a prescription in the December.

- From January to June 2015, the threat of eviction developed to the point where the family ended up going into temporary accommodation the weekend the twins came out of hospital.

- A change of social worker was used as an opportunity to reflect and re-assess, and multi-agency practice from that point is characterised by generally very good communication and information sharing. Core group frequency was increased and professionals met to discuss the family outside these meetings. The quality of assessment had improved, but was clearly focused on the children's needs and the quality of care, and did not identify underlying problems or blockages to progress that might need to be dealt with before the parents could make the changes required of them.

- Both the social worker and health visitor developed a commendable degree of persistence in seeking to meet with the family and there was an appropriate escalation into child protection procedures as concerns increased. There were also however, many occasions when the family denied professionals access to the home and there was little if any improvement in attendance at planned appointments and meetings.

- In June 2015, in response to a lack of progress, and in accordance with the child protection plan the social worker sought legal advice re the possible initiation of care proceedings and received advice that the threshold was not met. This was linked to the very considerable level of agency support being provided and reducing the impact of poor parenting. Despite the clear concerns about the adequacy of parenting, the adverse impact on the children's development was difficult to measure and it was judged that the "significant harm" threshold was not met. However, advice was given with a view to possible action in the future.

- The mother's engagement with ante-natal services was poor. All agencies went beyond the norm in trying to engage with the family to the point where, for example, the midwife under-took the pre-op process at home to avoid the planned delivery being delayed.

- The day before the twins were born an older sibling alleged in a review meeting that the mother was subject to domestic violence and the records note "similar disclosures have been made by other siblings". The only formal allegation of domestic abuse was in August 2012, when a neighbour phoned the police. The mother was described as having "had a fall" and was checked over at A&E. Neither party wished to cooperate with a domestic abuse risk assessment; they alleged they had only been shouting. The question of violence within the family has been in the shadows. There was the incident of assault on oldest boy in 2002. He had suffered a broken arm prior to that which was said to have been caused by a sibling handling him inappropriately though the paediatrician was concerned by this explanation. In 2012, one of the children alleged her father hit all the other children but the investigation found no supporting evidence.

- There were two episodes in early June, where one twin is reported to have “stopped breathing” – the first was discussed with the midwife who gave advice but did not seek a medical examination of the child. Review of this incident has generated considerable discussion. An alternative approach would have been to have requested paediatric medical review after the incident and this would have reflected good practice, particularly as the twins had been delivered slightly prematurely. The paediatrician has confirmed, however, that the likely outcome of this would have been that the midwife’s observations would have been confirmed and no more detailed medical intervention considered necessary. It is very unlikely that, even presuming the skull fracture was present at that point, that X-rays or scans would have been considered to be appropriate. The second incident was dealt with at hospital, the parents having followed the health visitor’s advice and taken the child to A&E. The child was examined and found to be well and no further tests considered necessary.

8. Conclusions

8.1 While this report identifies a number of areas for consideration in section 7, during the course of this review there have also been examples of good practice, which are referred to on page 5.

8.2 Agencies have reflected on their own practice and identified a number of single agency learning points. A summary of single agency actions is included in section 6.

8.3 The headings below reflect the areas set out in the review framework for specific consideration in respect of multi-agency working:

8.3.1 **Drug use and physical and mental health impacting on the parents' ability to care for their children**:

8.3.1.1 The specific nature of mother's physical health problems was not entirely clear to professionals. She reported back pain and headaches. At one point, she told professionals she feared she had a brain tumour though there is no medical evidence for this and the condition is described in medical records as being inter-cranial pressure. She was prescribed strong painkillers, including opiates, to ease her pain.

8.3.1.2 The GP understood and was appropriately concerned about the mother's drug use, particularly the possible adverse impact on the unborn twins, but professionals were not sufficiently sighted on the likely impact overall on the mother's availability to parent her children and her likely pro-occupation with her own needs. As a result, the extent of the level of care being provided to siblings by the older children was not considered as a potential young carer's issue.

8.3.1.3 Had the mother's drug dependence not been of prescribed drugs, then it is likely a very different approach would have been taken.

Learning point 1: Drug addiction, whether to prescribed or illegally obtained drugs, is likely to have an adverse impact on the parent's ability to focus on the needs of children. In this case, the impact of the mother's concern about her own health and her increasing dependence on strong painkillers was not understood as a child protection concern.

8.3.1.4 The mother's mood was often described a "low". When admitted to the psychiatric unit in September 2014, there was a reference to an earlier suicide attempt and she told staff that she had been self-harming, cutting herself, over the last year. She recounted adverse childhood experiences, including her own abuse, and expressed relief at having brought this into the open. She was offered follow up but did not take this up.

8.3.1.5 The information was passed on and the health visitor did try to follow this up with the mother. The mother changed the subject and seemed not to want to discuss the matter. There is no record of any further discussion with the mother or between professionals and although the hospital admission is referred to in the pre-birth assessment, the issues potentially underlying the mother's difficulties were not examined.

Learning Point 2: Understanding the factors behind a history of neglectful or abusive parenting must underpin future assessments of risk.

8.3.2 Role of older children in household functioning:

8.3.2.1 The impact of the mother's inability to cope was probably most visible in the effect on school attendance. Getting the children to school and picking them up was a clear area of difficulty. The older children often took responsibility for getting the younger ones there, making themselves late for school as a consequence.

8.3.2.2 Overall attendance was poor, and children would often be at home when agencies visited, said to either be ill themselves or caring for younger children because the mother was unwell. Older children were observed to be taking care of the twins even as new-borns and taking on feeding responsibilities.

8.3.2.3 There were a number of occasions where the children were found to be at home with no parent present and other occasions when there was no food in the house. The chaotic nature of the household and unplanned moves due to eviction and rent arrears must have had an impact but the children, when in school, were described as showing a degree of resilience, particularly the girls. They were appropriately dressed and enjoyed the school environment.

8.3.2.4 The boys' presentation in school is described differently with behaviour problems increasing with age. The oldest boy displayed significant levels of aggression.

8.3.2.5 The school nurse in the secondary school did raise the question as to whether one of the older girls should be assessed as a young carer. This was not deemed appropriate at the time although there can be little doubt that she was taking on a significant parenting role. This again begs the question as to whether the response would have been the same if the mother's addiction had been to illegally obtained drugs.

8.3.2.6 The specific specialist health needs of two of the children, and the general health and dental care of all the children was significantly neglected. Routine assessments were delayed and many specialist appointments missed.

8.3.2.7 There is little evidence that, prior to the completion of the pre-birth assessment, there had been any real understanding of what it might be like to be a child in this family.

Learning Point 3: Challenging review and the opportunity of reflective supervision are particularly important in long-standing cases where little progress seems to be in evidence. This should provide the opportunity to ensure the impact on children is well understood and fully considered. The use formal tools to benchmark the degree or likely impact of neglect should be considered.

8.3.3 Engagement of father with services and processes:

8.3.3.1 The majority of agencies were engaged only with the mother and children. The father had been briefly observed with the children but his capacity to cope with more prolonged care had not been assessed. The decision for him to give up work and spend more time caring for the children was seen as a protective factor. This was not based on informed assessment.

8.3.3.2 The father appears to have controlled the nature of his engagement with professionals, even down to whether he would acknowledge their presence in the home or ignore them entirely. At times, he was aggressive and hostile and denied professionals' access to the house and children. At times, he was apparently willing to engage and even agree a plan. Perhaps significantly, when told there was to be a child protection conference, he told the social worker that if there were such concern about his children the authorities should take them all into care and leave him alone. He did not attend the conference.

8.3.3.3 Following the child protection conference, the reviewing officer who had chaired the conference and the social worker visited the father at home to talk to him about the outcome. He implied that he had not previously understood why there was such concern. Lack of engagement with fathers is a common theme in Serious Case Reviews and is seen to result in potential risk being hidden from view.

Learning Point 4: Understanding of the father's[10] role in the family and of family dynamics is a critical factor in assessment of risk and developing an effective child protection plan.

8.3.4 Complexity of child protection planning in this large family and level of support offered.

8.3.4.1 The extent to which professionals related to the mother in this case and were sympathetic to what they saw as her problems has been emphasised during staff the review process.

8.3.4.2 The size of the family and the health problems of the mother, the number of the children, and range of difficulties the family experienced were challenging. The mother appeared to be overwhelmed much of the time and professionals responded to crisis after crisis. Practical support was always forthcoming with normal procedures sometimes subverted in order to offer more – for example provision of uniforms and sports kit by the school, free access to the breakfast club, services brought in to the home when parents failed to attend – e.g. parenting skills training. Plans to support the family were fully documented, but mostly consisted of a list of things the parents should do, all of them being things the parents had previously failed to do. The nature of support was largely characterised by agencies stepping in to deal with an urgent need, rather than working with the parents to identify those things that were preventing them from being effective parents and promoting change. There was nothing in any of the plans which sought to identify or address any underlying problems, and no forward planning as to consequent action, should there be no improvement until the latter part of 2014.

8.3.4.3 Although the first referral had originally been due to physical abuse, there had been no significant confirmed concern about physical abuse in the intervening twelve years. Nothing in the circumstances of the case prompted professionals to consider an immediate risk of physical abuse of the twins. Prior to the incidents with the twins, the level of concern about neglect had increased and child protection plans were in place. None-the-less, given the long history of concerns and the ever increasing pressures on the family, it is hard to understand how professionals thought change would be achieved.

[10] Brandon et al, 2008 and 2009; Farmer and Lutman, 2010; Turney et al, 2011.

Learning Point 5: The degree and complexity of the practical problems presented by a family can (and in this case did) drive the professional agenda resulting in any risk of physical harm being overlooked.

Learning Point 6: An expressed willingness, on the part of parents, to engage with services and implement agreements has to be set against the reality – this was not a case of disguised compliance, the extent of refused access and DNAs was considerable.

Appendix 1

Roles of professionals interviewed	**Agency**
Headteacher	Primary school, Stockport Metropolitan Borough Council
Designated Safeguarding Lead	Secondary school (non- maintained)
Midwife x 2	Stockport NHS Foundation Trust
Social Workers x 2 - Children Social Care	Stockport Metropolitan Borough Council
Family support worker x 2	Stockport Metropolitan Borough Council
Independent Reviewing Officer	Stockport Metropolitan Borough Council
Service Manager	Pennine care NHS foundation Trust
Health Visitor x 2	Stockport NHS Foundation Trust
School Nurse	Stockport NHS Foundation Trust
General Practitioner	General Practice, Stockport
Service Coordinator	Homestart
Senior Lawyer – Social Care (Legal) Team Manager	Stockport Metropolitan Borough Council

Appendix 2

Framework of Review in respect of SCR Child B&C

The Framework below is for the serious case review (SCR) commissioned by Stockport Safeguarding Children Board (SSCB) in August 2015. It is a document to act as a guide to the Review. It may be subject to a change in the light of new information subject to agreement by the Serious Case Review Panel.

1.	**Purpose of the Review** SSCB is committed to a culture of continuous learning and improvement across the partner organisations that make up SSCB. The review into the Learning from Child B&C was commissioned by Stockport Safeguarding Children Board on 14 August 2015.The purpose of the review is to learn all we can from the experience of the children. The SSCB will seek to ensure that the SCR will be conducted in a way which: 1. Recognises the complex circumstances in which professionals work together to safeguard children 2. Seeks to understand how practitioners interacted with the children and parents and with each other and the interplay of the difficulties and problems presented by the family and the practitioner expertise and resources. It will seek to identify the underlying reasons that led individuals and organisations to act as they did; identifying the contributory factors that influenced key events and decision making. 3. Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than relying on hindsight analysis. 4. Is transparent about the way data is collected and analysed and makes use of relevant research and case evidence to inform the findings. (Working Together 2015, p74) The SCR aspects of the review will be conducted using a hybrid approach, which combines elements of a systems based approach but retains some of the traditional methods of an investigative approach to ensure that key events or decisions are identified. It will consider the practice that took place during the time period under review in the light of general practice, procedure requirements and expectation at the time. SSCB has commissioned an Independent Reviewer, Jane Booth (JB) to carry out the review. Jane Booth will be supported in this task by the Review Manager, SSCB Performance and Development manager, who is independent of all agencies involved in the review. The review manager will chair any meetings that are required as a result of this review.
2	**Scope of the Review** **Time period under review -** The timescale *(*chronology time period) of the SCR is review is from 01/06/2013 to 21/06/2015 which represents a period of 2 years before the injuries sustained by the twins. The extent to which the older children of the family are considered will be discussed at this meeting.
3.	**Issues to be explored for the SCR (Key Lines of Enquiry)** • Drug use and physical and mental health issues impacting on the parenting ability of the mother • Long term neglect issues • Role of older children in household functioning • Engagement of father with services and processes • Complexity of child protection planning in this large family and level of support offered.

4.	**Methodology to be used and the reasons** The method chosen for this review is a hybrid methodology - i.e. a review using elements of a systems review alongside features of an investigative review such as gathering of chronologies. Individual Management Reports are not required unless the decision of the SCR Panel is that they are required for specified reasons. All agencies are asked to commit to the SCR methodology and to enable practitioner's to have time to take part in conversations. It is not possible to be certain what time commitment will be required or where the key lines of inquiry will lead to. It is anticipated that the review will include the following: • Collation of chronologies to inform the Reviewer • Meetings with the SCR Panel of senior managers as appropriate • Meetings with practitioners either in a group or through individual conversations where appropriate • Efforts will be made to meet with the family to seek their views and support them to provide information • Contribution from any other significant person/people who knew Child B and C **SCR Panel Meetings** Initial Set Up meeting with the SCR Panel. This first meeting will seek to plan the review in a collaborative manner to make the most of the opportunity to learn. The set up meeting will also agree how many Meetings of the SCR panel need to be held and the frequency. This panel will be made up of senior representatives of agencies who were involved in the care planning for the children. The Review Panel will consist of the following : • Head of Service - Children's Social Care • Service Manager - Children's Social Care • Designated Nurse - Stockport Clinical Commissioning Group • Named Nurse - Stockport NHS Foundation Trust • Head of Midwifery - Stockport NHS Foundation Trust • Senior Advisor for Safeguarding in Education • Detective Chief Inspector - Greater Manchester Police • Head of Neighbourhoods - Stockport Homes • Stockport Family Locality Lead Officer (Health) • Stockport Family Locality Lead - MOSAIC – Heidi Shaw • Safeguarding Lead - Pennine NHS Trust Care - Mental Health • Service Manager, Safeguarding Children Unit • Performance Development Manager SSCB (Review Manager) • Head of Safeguarding & Learning This Panel will agree meeting frequency in order to: • Monitor the progress of the review and identify key themes or issues to emerge • Consider the learning that has been gained throughout the review. The minutes of these meetings will be kept by the administrator and shared with all members within 10 working days. The Independent Author will prepare a draft report for the third meeting and the outcome of the meeting will aim to be agreement over the final content and approval of the findings. Where there is disagreement there will be as many meetings held as required to reach an agreed final draft of overview report.

	Practitioner Interviews The independent reviewer will conduct individual conversations with practitioners who held a key role in the care of child B and C. Members from the Review Panel will be encouraged to complete the conversations with the independent reviewer in order to ensure that panel members are helping to facilitate the review and contribute to analysis and identifying themes. The purpose of the practitioner conversations is to support a narrative of events which can be identified through the chronologies and to allow the practitioners to tell their story, identify significant events, interactions or issues, and help to identify the contributory factors that are enhancing professional practice and identify any barriers or shortfalls that may be an impediment or require improvement. The conversations are intended to highlight practice that worked well, in addition to challenges, or barriers to good practice. Staff will be asked for permission to record these interviews. We intend to record these conversations with a digital recorder and they will be transcribed if necessary for the Independent Reviewer. The SSCB performance and development manager will save the recordings as files on Stockport ICT system and delete them as soon as the review is complete. Where staff do not wish to be recorded a co–interviewer will write notes from the meeting to make a record of what was discussed. The themes arising from these interviews will be shared with the SCR Panel on completion of the interviews and will be used to generate learning for individual agencies and the multi-agency network. The SCR Panel will agree how the findings should be represented in the review and how individual agency learning will be incorporated. Support available for family and staff The family will receive written notification of the SCR via the social worker and will be contacted as soon as legal proceedings allow, in order to gain their perspective on the multi-agency working. If this is not possible before as the review timescales are drawing to a close, a decision will need to be made by the SCR panel about the inclusion of their views and whether completion should be delayed. Staff should be supported by senior and line managers during the review process. They will be invited to attend a practitioner briefing, and can seek clarification from SSCB performance and development manager as required. Practitioners identified to be interviewed for this review are listed in Appendix 1 Every effort will be made to meet with family members of Child B &C when parallel proceedings are completed. Practitioner group meetings • Practitioners will be required to attend either individual interviews or small group meetings to address themes that have arisen in individual conversations and to develop key themes from their point of view. • It is expected that there will be an initial practitioner meeting to outline the review, and a follow up meeting to share the draft report.

	The Independent Reviewer will: • Review agreed documentary evidence in relation to the case – i.e. particular records or reports that are requested in consultation with the panel. • Produce a review report for the panel. • Present this overview report to SSCB. • Contribute to a learning and development event for practitioners and managers if required to do so. SSCB: • The SSCB performance and development manager will act as the SCR Review Manager and chair the SCR panel meetings and practitioner panels. • The SSCB performance and development manager will request agency chronologies. • SSCB administrator will compile combined chronology. • SSCB administrator will prepare minutes of SCR Panel meetings. • The SSCB performance and development manager will record conversations in the manner agreed by the SCR Panel. • The SSCB performance and development manager will liaise with legal representatives and any other person identified. • The overview report will be published on completion of the review. • Both multi-agency and single agency action plans will be reported and monitored by SSCB Quality Assurance and Performance Sub, with oversight by SSCB main Board.
5.	**Good Practice** This review will seek to identify good practice which is identified through the process of conversations, documentation reviews and group work as applicable. Good practice that has taken place will be acknowledged and highlighted in the Review and practitioners and managers will be given the opportunity to identify systems and practices which work well.
6.	**Reference to disclosure, criminal proceedings or any other matters causing delay** If there are any delays to the progress of the review for whatever reason, the review panel should be notified as soon as possible. This information will also be conveyed to SSCB.
7.	**Confidentiality and anonymity arrangements** All parties to the review will be asked to sign a confidentiality agreement: papers or details of this review will not be shared with any person who does not need to have the information i.e. senior line managers. If required, advice on this matter should be sought from the Independent Reviewer or the Review manger if for any reason this review needs to be discussed. Where there is a conflict of interest in relation to confidentiality the individual organisations will seek to resolve this as early as possible. Outside the confines of this review, all efforts will be made to maintain the anonymity of the witnesses and their families and workers involved in the case at all times.
8.	**Ethos of the Review including commitment to family and wider social group involvement and adherence to the Equality Act 2010** SSCB seeks to promote an open culture of learning. The priority is to ensure that organisations are engaged in a way that will ensure that important factors in a case can be identified and appropriate action taken to make improvements. All professionals from agencies contributing to this review will participate without fear of blame for actions they took in good faith at the time (p66 Working Together to Safeguard Children) in order to maximise this opportunity to improve our services.

	The review will be coordinated in such a way that all involved will have a voice in the review and where challenge, exploration and discussion are encouraged. The review: • will recognise the complex circumstances in which professionals work together; • will seek to understand who did what and why; • view practice from the viewpoint of individuals and organisations taking account of hindsight; • be transparent about the way information is collected and analysed; • use research to evidence and inform findings as far as possible. <u>Other considerations</u>: There are criminal proceedings running alongside this review, which will have a bearing on how the review is conducted. Advice will be sought from the Senior Investigating officer about the way to proceed. Individual agencies may have processes running in parallel to this multi-agency review, but they will remain separate to this review and the findings. The Review will seek to have the voice of the family. At all times, they will be offered the utmost respect and sensitivity. They will be free to bring any supporters to meetings as they choose. Meetings will be arranged to suit them and their needs. A second interviewer will accompany the Independent Reviewer to take written notes.
9.	**Arrangements for feedback on progress to the commissioners** The SSCB performance and development manager will keep SSCB informed about the progress of the review and any issues that arise.
10.	**Statement that report will be written with recommendations made if appropriate** • The Independent Reviewer will prepare a report of her findings and those will be shared with the SCR Panel in the first instance. The report will be written with the expectation that it will be published in full and without redaction. • The SCR Panel will work with the Independent reviewer to formulate recommendations, reflections or challenges based on evidence that that she has found in order to improve local services.
11.	**Publication and dissemination** • When the SCR Panel is satisfied that the review has been completed and agreed the draft report, it will be presented to the SSCB. • The Independent Reviewer will attend SSCB to share the Report findings. This will be the final opportunity to make comment before the Report is finally 'signed off'. • SSCB has an expectation that the report will be prepared in such a way that makes publication possible i.e. suitably anonymised. If any issues emerge which predicate against publication these will be discussed by the Panel. • A date and method for publication will be agreed on the SSCB website, and the learning disseminated through learning events. • Consideration will be given to media notification and publication date • On conclusion of the review, the final report will be shared with the family as appropriate. • The final report will be lodged in NSPCC repository for Serious Case Reviews.
12.	On completion of the Review, SSCB will include the findings in the Safeguarding Learning Events in order to disseminate the learning to front-line practitioners. SSCB will seek to maintain a programme of improvement around the issues identified and ensure that that improvement is sustained and embedded.

Appendix 3: Glossary

Accommodated	Section 20 of the Children Act 1989 states that every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of: (a) there being no person who has parental responsibility for him; (b) his being lost or having been abandoned; or (c) the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care. A local authority may provide accommodation for any child within their area (even though a person who has parental responsibility for him is able to provide him with accommodation) if they consider that to do so would safeguard or promote the child's welfare. This does not require a court order and accommodation is not infrequently provided at the request of parents and a child in such circumstances is described as "accommodated".
Child in need	Section 17 of the Children Act 1989 defines a child as being in need if: • He or she is unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the local authority, • His or her health or development is likely to be significantly impaired, or further impaired, without the provision of services from the local authority, • He or she has a disability. The definition includes any child or young person under the age of 18. The service can also be provided to the child's family or any member of his or her family, so long as the aim is to safeguard and promote the child's welfare. Support can include providing cash assistance to a family. Local Authorities are under a general duty to safeguard and promote the welfare of all children in need in their area. They must do whatever possible to ensure sufficient services and measures are in place to promote a child being raised within its own family, if it is safe to do so.
Child protection plan	Following section 47 enquiries, an initial child protection conference brings together family members (and the child where appropriate), with the supporters, advocates and professionals most involved with the child and family, to make decisions about the child's future safety, health and development. If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth. The purpose of a conference is to bring together and analyse, in an inter-agency setting, all relevant information and plan how best to safeguard and promote the welfare of the child. It is the responsibility of the conference to make recommendations on how agencies work together to safeguard the child in future. One of its functions is to agree whether a child protection plan is required to safeguard the child/ren and if so develop an outline child protection plan, with clear actions and timescales, including a clear sense of how much improvement is needed, by when, so that success can be judged clearly.
Pre-birth Assessment	If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth. In such cases an assessment of risk and need should be completed including the child/children's additional needs and deciding how these should be met. It

	promotes more effective, earlier identification of additional needs, particularly in universal services and aims to provide a simple process for a holistic assessment of children's needs and strengths; taking account of the roles of parents, carers and environmental factors on their development.
Section 47 Investigation	A child protection investigation is called a “Section 47” after the section of the Children Act 1989, which sets out the duty. Children’s Social Services have a legal duty to look into a child's situation if they have information that a child may be at risk of or has suffered significant harm. Investigations are carried out alongside jointly by Children’s Social Care and the Police.
Team around the child	This term describes a formal process for managing and coordinating multi-agency support to a family where there is a child in need. The agency with the primary involvement will usually initiate this process and provide a lead professional. The process involves regular meetings between professionals and the family and requires the family to consent.
Young Carer	A young carer is a person under 18 who provides or intends to provide care for another person of any age (unless when employed to do so or working as volunteer). If a local authority considers that a young carer may have support needs, they must carry out an assessment The local authority must also carry out such an assessment if a young carer, or the parent of a young carer, requests one. Such an assessment must consider whether it is appropriate or excessive for the young carer to provide care for the person in question, in light of the young carer’s needs and wishes.