Suffolk Safeguarding Children Board

LSCB Response - SERIOUS CASE REVIEW - BABY 'E'

January 2017

Introduction

This report concerns the life of Baby E, who died in January 2016 at the age of 17 months. He is believed to have died from Sudden Unexpected Death in Epilepsy. The inquest has not yet taken place.

As there were other parallel processes underway at the time of the review, this SCR does not explore either the cause of his death or whether any individual bears some culpability for his death.

Whilst Baby E was not considered to be at high risk of harm, there were a range of concerns about neglectful care and the impact of difficulties in the family on his life. A range of services had contact (and at times direct involvement) with Baby E, his brother and his family so it is particularly important to reflect on how they worked together to support Baby E and his family and improve his life. This report will help professionals collectively learn from what happened in Baby E's life and improve how families receiving early help are properly supported.

There is much that was done well during Baby E's life. However, when the professionals involved met to consider, reflect on and debate what happened they identified many things that could be improved on, and some key practice episodes that if managed differently could have had a more positive influence on the quality of Baby E's life and how he was cared for. The learning from the Review is already being applied by agencies to their current practice.

These matters were brought to the attention of the Suffolk Local Safeguarding Children Board (LSCB). The Chair of that Board, Ms Sue Hadley, decided that the circumstances of the child's death required that a Serious Case Review (SCR) should be conducted, in line with the government's guidance as laid out in HM Government *Working Together to Safeguard Children 2015*.

An SCR must be carried out when a child dies and there are concerns that the child may have been abused or neglected.

A formal referral was made to the Suffolk LSCB on the 22nd January 2016. The Case Review Panel met on the 15th February to consider the case. After careful consideration the LSCB commissioned a Concise Child Practice Review, based on the framework set out for concise reviews in the LSCB (Wales) Regulations 2006 as amended 2012.

The Review was undertaken by an Independent Lead Reviewer, Jane Held, who has substantial experiences of Children's Services, and has led a number of SCRs. She was supported by a multi-agency Review Panel, chaired independently by Alan Caton, a very experienced LSCB Chair.

The core questions posed by the Review are 'what did professionals do well to support Baby E, what could have been done better and what can we do differently in the future as a result?

Baby E's Mother and Father both contributed to the review supported by Independent Advocates. E's Father also gave permission for access to his medical records. The circumstances of this case meant that agencies were asked to review their involvement with the family from August 2014.

The conclusion of the Review is that for Early Help to work most effectively for this and many other families the local partnership should develop two key cultural expectations of all practitioners and managers:

- Professionals should recognise that outside child protection processes children can still be harmed within the context of both risk and vulnerability. Professional responses as part of early help and family support can provide opportunities to both prevent and protect children from harm; and

- Staff should foster an authoritative professional approach to vulnerable children and their families which combines authority, empathy, and a degree of self-awareness.

Two issues were identified where system change would result in improved frontline practice:

- The need for a system which recognises early help as an opportunity for prevention and protection; and

- The importance of a workforce that recognises professional challenge and a positive practice cycle.

The report consists of

- A factual context and brief narrative chronology.
- Commentary on the family situation and their input to the SCR.
- Key practice events during Baby E's life.
- Analysis of practice, learning review points and messages from the Review.
- Conclusions and key learning and messages from the Review for the LSCB.

The LSCB held an extraordinary Board meeting on the 10th November 2016 to consider the Serious Case Review report. It fully accepted the key learning points and recommendations outlined below. Board partners then went on to consider the actions already taken to date as a result of the learning, their impact, and any further actions required to address the key learning points.

Considerable work is already underway within partner agencies and the LSCB will continue to ensure that individual agency action plans are implemented and reported to the Learning and Improvement Group. The LSCB has also developed a Multi-Agency Action Plan and will receive regular updates as to progress and impact.

Again, implementation of actions is already underway, however endorsement of the Action Plan by the Board will take place at a full LSCB meeting in January 2017.

Key Learning Points noted and endorsed by the LSCB.

KLP 1*: Early Help systems, processes, and tools.*

KLP 3: *Threshold conversations, professional respect, repeat referrals, and assertive escalation*

KLP 5*: Working with a case that is not progressing*

KLP 6: *Leadership, management, and supervision*

The behaviour of the adult family members was not properly recognised and analysed, and action to address it properly did not happen. The confusion about who the Lead Professional was added to this absence of leadership and assertive Early Help. In effect no one “was in charge” of the multi-agency Early Help plan and process. Agencies worked within their own agency systems rather than together through a coherent TAC plan. The “see, plan, do, review” cycle was not rigorously applied. Plans were practical input focussed not outcome focussed.

Effective multi-agency Early Help services are invariably best provided when there is one named and clearly identified professional who facilitates and drives the assessment of need and risk, the coordination of action, the evaluation of plans, and the use of multi-agency challenge within the multi-agency team.

Managers lacked a clear understanding of what was expected in terms of practice supervision, as well as what the best case management processes were. The integration of different professional groups into an Early Help service required new skills of frontline managers and new relationships between different professional managers.

It is essential to ensure that staff in all partner agencies have access to a coherent framework to support them to work effectively with families without recourse to Child Protection systems, with helpful tools, systems, and processes and which gives the same weight to the importance of Early Help as it does to Child Protection systems. Without the use of shared and standardised tools to assess risk, professional judgement and decision-making is more likely to be flawed and this can leave children vulnerable.

It is crucial that professionals understand and use the processes available when they disagree professionally and the difference of view cannot be resolved. The use of the Suffolk Local Protocol for multi-agency thresholds guidance, repeat referrals, and the failure to use assertive escalation in situations of professional disagreement are all factors in this case.

KLP 2: *Working with neglect and the management of risk: understanding parenting*

KLP 4: *Epilepsy and its impact*

KLP 8: *Assertive confident practice with challenging parents*

In the management of neglect cases the rationale for professional judgements should be clear, based on research and evidence based practice, and through the use of evidence based assessment and intervention tools and frameworks. In Baby E's case it is noticeable there is almost total absence of the use of any screening or risk assessment tools including those which would provide a far stronger evidence base of both parent's capacity to care safely and well for Baby E and to put his needs first.

Research tells us that authoritative Early Help and Child Protection practice require models of practice and professional cultures that mitigate the complexity and ambiguity of working with families such as Baby E's; that provide effective supervision and support and that is provided by staff with empathy, authority and a degree of humility It is also not clear how much the impact of and stress caused by caring for a baby with a chronic medical condition was taken into account in weighing up concerns and issues.

KLP 7: *Working with adults with additional needs*

Key learning from this review is that when working with parents with additional needs it is important to involve the professionals working to support that parent in their own right in work with their child and family. Effective practice requires a "whole family" as well as a child focussed approach. Doing this also provides valuable insights into whether there is a potential for change or not, which provides a clear indicator of whether a case therefore needs escalated. It also informs the intervention approach and likely duration of any intervention.

It is worth reflecting on the fact that had the family been subject to child protection processes or care proceedings formal assessments of each parent's abilities and needs would form part of the understanding if how best to work with them and safeguard their children.

The LSCB Actions are as follows:

- *The LSCB will consider how best to ensure every agency and every practitioner uses the question "what is life like for this baby/child?" as the core practice question and assure itself it is at the forefront of everyone's practice.*
- *The LSCB will support the development of a multi-agency coherent framework, with shared use of helpful tools, systems and processes to support practitioners to confidently assess risk, parenting and family capacity, professional judgement and decision making which gives the same weight to the importance of Early Help as it does to Child Protection Systems and assists in effective work with families.*
- *The LSCB will refresh, relaunch and promote the Neglect strategy and consider whether there is a further need to specifically address the understanding across the multi-agency workforce of how neglect and poor care can be identified.*
- *The LSCB will assure itself that the framework for case management in Early Help is clear, with the same rigour in terms of the processes required as in Child in Need/Child Protection addressed, and additional ways to use Signs of Safety to best effect.*

- *The Board will consider how to build on and develop the current review of the ACCORD protocol to develop and disseminate a whole family approach, with clear cross service pathways, protocols, and practice standards.*
- *The Board will assure itself that each partner agency understands the value of escalation as an act of advocacy on behalf of the child, takes action to embed and promote the policy and encourages its front line staff to escalate concerns.*
- *The Board will receive information that evaluates what the curriculum for multi agency as well as single agency training should contain to give frontline staff and managers the skills they should support and equip front line staff, leaders, managers, and supervisors across a range of agencies to:*
    - *Take a whole family approach,*
    - *to work systemically and*
    - *decide what support is required for lead professionals to act to best effect.*
    - *Utilise the threshold guidance available, including how and when to utilise the Escalation policy.*
    - *Work with challenging adults.*
    - *Understand the impact of chronic illness on family functioning, give proper weight to all family member views and take the impact into account when assessing and working with vulnerable children and families.*
- *The LSCB will receive assurance that the standards (in terms of knowledge, skills and capacity) required of first line managers when supervising staff who are working on cases which are not progressing are reviewed and refreshed.*
- *The LSCB will give consideration to reviewing its standards and protocols for working with challenging adults, jointly as necessary with the Adult Safeguarding Board.*
- *The LSCB will assure itself that each partner agency has complaints procedures that are robust, respectful and focussed on the needs of children and adults and develop a protocol for when to share information about complaints made by challenging parents within the family support network.*