Serious Case Review

Baby 'E'

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Contents

1. Introduction

This is the report of a Serious Case Review into the life of Baby E, who died on 21st January 2016 aged 17 months. He is believed to have died from Sudden Unexpected Death in Epilepsy, and at present there are no known toxicological causal factors and no other indicators as to the cause of his death. The inquest has not yet taken place.

As there were other parallel processes underway at the time of this Review, this Serious Case Review 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 Child Z 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.

Appendix Two and Three to this Report summarise the learning from the review and how partner agencies responded to the learning gained from this review and the impact that applying the learning has had on practice.

2. The approach we used

Following Baby E's death a formal referral was made to the Suffolk Safeguarding Children Board (SSCB) on the 22nd January 2016. Their Case Review Panel met on the 15th February 2016 to consider the case under *Regulation 5 of the Local Safeguarding Children Board Regulations 2006.* The Panel found that the case met the criteria in *Working Together to Safeguard Children 2015*[i] and agreed to commission a Serious Case Review (SCR).

Working Together to Safeguard Children 2015 allows LSCBs to use any learning model consistent with the principles in the guidance, including systems-based methodologies. After careful consideration the SSCB commissioned a Concise Child Practice Review which is based on the framework set out for concise reviews in the *Local Safeguarding Children Board (Wales) Regulations 2006 as amended 2012*[ii]*.* The criteria for such a concise review were met, and the methodology set out in *Protecting Children in Wales 2012*[iii] facilitated an interactive, learning and reflective style of review. This involved agencies, staff and the family in a collective endeavour to reflect and learn from what has happened in order to improve practice in the future, with a focus on accountability, fairness and justice rather than on culpability.

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?”

The subjects of the SCR are Baby E, his Mother, X, his Father, Y and his brother, Z. The review scope is from the point of Baby E’s birth in August 2014 whilst taking into account the family context and background. Baby E’s mother and father both contributed to the review, supported by independent advocates. Father Y also gave permission for access to his medical records.

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

Each agency prepared an agency timeline of significant events (chronology) together with an analysis of relevant context, issues or events. Information about the action taken in response to the analysis was included as appropriate. These reports were completed by managers who had no operational responsibility for the case. After consideration by the Lead Reviewer and Panel, the consolidated timeline and analysis was considered in depth at a full day learning event.

This event was extremely helpful, allowed for a high level of debate, reflection and learning. The event provided a significant amount of factual information and analytical discussion. It helped shape the Lead Reviewer’s own thinking and analysis.

The material provided at meetings with Father Y and Mother X was also considered in depth. The Report builds on all the material provided and on the debate at the learning event and the Panel meetings. The structure and terms of reference for the SCR are attached as Appendix One.

3. Key messages and conclusion

The key messages and conclusions of the Review are set out in Appendix Three as well as in the main body of the report so they can be easily identified.

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

- Professionals need to 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.
- Staff need to 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.
- The importance of a workforce that recognises professional challenge and a positive practice cycle.

4. Baby E and his family

Baby E

Baby E was born on the 24th August 2014 and died on the 21st January 2016 when he was 17 months old. He was found by his mother in his cot at about 3.00pm on the 21st January 2016. The Sudden Unexpected Death in Infancy (SUDI) protocol was put in place, leading to concerns that before his death Baby E was in a cold room, had not been fed for a long time and may not have been checked for a considerable period of time.

The Post-mortem concluded the death was a Sudden Unexpected Death in Epilepsy with no identifiable causal factors.

Baby E lived with his Mother X and his older brother Z, who was 4 years older than him. Baby E had a lot of contact with and at times was cared for by his father Y. Baby E was Father Y's first child. He did not officially live with Baby E, Child Z and Mother X but they spent time living together at different stages of Baby E's life, for example when housing issues arose. Father Y always lived close to the family.

Baby E was diagnosed with epilepsy in April 2015 and required additional care and support as a consequence. During his short life he had 9 seizures, one possible febrile convulsion, 12 attendances at the Emergency Department and 5 admissions to hospital of varying length. Whilst he was not a seriously ill child, his chronic condition was significant enough to require regular tertiary medical treatment. He needed regular feeds, to be kept warm, and to be well supervised. He had a range of treatments including a specific drug (Buccal Midazolam) to be administered during a seizure. Both his parents were shown how to administer the drug, and both demonstrated they could do this at different times when required.

Baby E, for the majority of his short life, presented as a normal, happy, sociable baby, who was behaving in an age appropriate way, meeting his milestones and charming everyone involved with him. Whilst there were a range of concerns at intervals about neglect and poor care, and at one stage, developmental delay, this was not always evident in how Baby E behaved.

Baby E and his Family

The household Baby E was living in was not always a particularly easy or happy one. Both Mother X and Father Y have a number of challenges in their own lives, which have made parenting harder for both of them. Both need significant levels of support for themselves.

Baby E's parents separated for a short period after Baby E was born, and then separated permanently in April 2015. Their relationship was volatile, and often confusing for professionals, in that, even after they separated Mother X regularly called on Father Y for help in a crisis. The situation with regard to access and contact changed regularly. After Private Law proceedings began (initiated by Father Y) there was a period of no contact at all but that too changed. Mother X was inconsistent in her attitude and approach to contact and to her relationship with Father Y.

Mother X

Mother X, who is 27, was looked after in the mid-nineties but was placed with her mother by the Local Authority. Social care records show that her family life as a child was unsettled and includes significant incidents of harm. There are also many difficulties in her relationships with her extended family including her own father. Her family experiences have had a negative impact on her ability to make and sustain strong relationships.

Mother X is at times emotionally fragile, and is very dependent on her relationship with her mother, despite the difficulties that arise between them from time to time. At times she appeared to manage Baby E's epilepsy well, at times she was clearly less able and at other times she needed Father Y to deal with it.

Through interviews with Mother X and professionals supporting her and from evidence in Case Notes, it is possible to identify key issues that impact on Mother X's parenting. Mother X can at times manage some of the practicalities of everyday life with regular support from others, especially her mother. At other times she finds it very hard. Sometimes during Baby E's life she needed daily visits from the Family Support Practitioner (FSP) in order to meet the children's basic care needs. She can present as more able than she is, has learnt a range of ways to deflect professional concerns and is often defensive when speaking to professionals.

She is (understandably, given her own life) distrustful of social workers and others if they challenge how she is parenting her children. She has a tendency to avoid telling professionals things. She also has a tendency to look to others to take responsibility for what is wrong at any point in time. When challenged she tends to become oppositional. She frequently makes complaints about the professionals involved with her. This was particularly evident in relation to the way she reacted when professionals were concerned about how she parented her children.

Baby E's maternal grandmother, MGM, is a very important figure in Mother X's life and is her key support. MGM is usually present at meetings between professionals and Mother X. MGM tends to be the person who organises meetings for her daughter. Most professionals have to contact Mother X via MGM. A range of professionals describe them both in terms such as "formidable" or "intimidating".

Father Y

Father Y who is also 27 has additional needs, periods of depressions, and struggles to process things. He needs clear plans and clear routines to alleviate his stress. He has struggled with emotional, mental and behavioural issues. Records refer to his challenges variously as Asperger's syndrome, (part of the Autistic Spectrum Disorder), and behavioural disorder. He has a diagnosis of Attention Deficit Hyperactivity Disorder, mild learning difficulties and a history of low mood.

He has been supported by Children and Young People's Services (CYPS) and then Adult Social Care (ASC) with his additional needs since he was a child. During his adolescence he had problems with aggression and violent outbursts. He was a looked after child between October 2006 and October 2007 under S20 CA1989 whilst living in an NHS Young Person's in-patient service. He has problems with relationships at times and does not always find it easy to relate to women appropriately. He also has experienced some significant problems in managing his emotions, including problems with anger management and controlling his physical urges and behaviour. He told us he always wanted to be a Dad and was very happy when Baby E was born.

He lives alone with help from a Personal Assistant whom he employs, and manages daily life capably with support. He uses professional support from psychologists and psychiatrists as necessary and has regular GP contact. He is very familiar with social workers and other professionals being involved in his life, uses them well, and seeks their support and help. He has a good understanding of his own capabilities and capacity to cope.

He understands, when shown, how to manage specific tasks and parenting responsibilities. The review saw evidence that his parenting was seen as appropriate in most (but not all) of his contacts with professionals. He researched his son's epilepsy in depth via the internet, including the treatment regime required and the medicines that were prescribed. He is used to being supported by professionals, trusts them, and tends to tell them everything, without any attempt to dissemble. He demonstrated in meetings, including with the Lead Reviewer, a good understanding of how to parent.

Baby E's paternal grandmother, PGM, is a very important figure in Father Y's life. She has consistently supported him in everything he does. He is very dependent on his mother for support. She knows him well, and works well with the professionals who support him. She understands how his additional needs affect him, and helps him to manage himself appropriately. A range of professionals describe her as determined and a strong advocate for Father Y, but cooperative and constructive.

Baby E and his extended family

MGM and PGM were both very involved in the lives of Baby E and the family, and provided significant levels of support to their children and grandchildren. They were both significant adults in Baby E's life. The relationship between PGM and MGM is difficult, with a lot of tension and at times it was and is very adversarial. This tension is played out regularly by Father Y and Mother X too and will have frequently been heard and witnessed by Baby E and Child Z.

The situation became very difficult after Baby E's parents had separated. PGM and Father Y were, for a period of time, excluded from having access to Baby E, or from receiving information about his health. Some medical appointments were cancelled

and rearranged by Mother X and MGM, in order to prevent or disrupt Father Y's attendance at them. Mother X and MGM also frequently asked professionals not to talk to or involve Father Y or PGM.

The impact of the family on Baby E

It is important to fully understand the issues affecting Baby E from his birth onwards and to understand how his parents related to him, his brother, his extended family and the wide range of professionals involved with him. Whilst most of the time Baby E's care was seen as "good enough" at times it was not as good as it appeared or was presented.

For example, hospital staff noted that both parents appeared to be attentive, caring, loving and appropriate towards Baby E when he was in hospital, both wanted to attend appointments and both wanted to be fully involved. However records from the learning event indicate that some hospital staff commented that Mother X sometimes ignored Baby E or failed to respond to him when he needed care.

It is clear that the family had a number of challenges which made life tough for them all. As a consequence, Baby E and Child Z did not always get the level of care they needed to ensure they were healthy, developing well, meeting their milestones, happy and supported. Most of the concerns expressed by professionals relate to Child Z's care, behaviour and physical development.

During most of his life the care Baby E was receiving from his parents appeared to be good enough to prevent significant child protection concerns among professionals. Those professional staff who were more involved with the family expressed worries at regular intervals about his wellbeing and welfare, which varied in their degree and intensity. Baby E's presentation and care was clearly inconsistent but never extreme.

Baby E seemed much loved by his parents and grandparents, appeared to be well cared for much of the time, and got good treatment for his illness. Professional concerns about his care were strongly rebuffed by his maternal family and his behaviour did not indicate he felt anything but secure and cared for. As a consequence there were very different professional perceptions throughout his life about the quality of the care he was receiving, and his parent's ability and capacity to parent him well enough.

With hindsight it is clear that Baby E's life was significantly affected by variable care arrangements, periods of less than good enough care from his mother, family tensions and rows, and regular experiences of seizures of varying length and intensity and hospitalisations.

It is also clear with hindsight, that the concerns expressed by professionals at intervals about a cold house, sporadic and sometimes insufficient food, poor stimulation, and being left alone in his bed or pushchair for very long periods of time were episodic in nature, evident at times but not all the time. These examples of poor care, coupled with very varied professional perceptions of the quality of parenting being provided by Mother X and the periods of good enough care she was able to provide meant concerns about Baby E were not consistently identified.

5. The family's perspective

Baby E's parents are no longer in a relationship and live apart. They both contributed freely of their time to the review despite the distress they feel, in order to provide the review with their view of what happened in their family and household, what support they were given and how much it helped them to care well for Baby E. We are very grateful to them for their openness and honesty.

Father Y

Father Y met with the Lead Reviewer and the SSCB Business Manager. He agreed to have an independent advocate to support him, as well as his Support Worker. He had thought very hard about what had happened and what he wanted to say. He was able to tell the Reviewer lots about Baby E, his needs and his care.

He also talked a lot about how difficult it was to play a consistent role in his son's life, particularly after he split up with Mother X. He felt that he had tried everything possible to learn how to be a good parent including attending Triple P and the Treehouse Centre (both parts of the Suffolk Early Help system). He told the reviewer he found it hard when Mother X did not take up the offers of support available to her. He also acknowledged that he could be difficult to relate to.

He found his relationship with Mother X difficult, and sometimes frustrating. They split up after Baby E was born for a short while. He said that it became very hard for him after they separated properly and Court proceedings in relation to contact began. He often felt in the middle between his family and Mother X's family. He also felt quite powerless and sometimes unable to intervene when told to stay away from his son. He worried about his son after he was diagnosed with epilepsy and he did not always hear about Baby E having a seizure or about hospitalisations. Sometimes though, Mother X panicked and called him for help and he had to go to their house. He did not mind this.

He also found the tension between the grandmothers very hard. He told us that his mother, PGM was very supportive of him, but she was unhappy with how MGM and Mother X cared for Baby E and Child Z. He felt that overall professionals tried to help him and Baby E and they did try to make sure Mother X looked after Baby E properly. He said he always told them when he was worried about how well Mother X was caring for Baby E, and gave a lot of examples of practical concerns he had had about Mother X's ability to meet his son's needs well enough.

He said he was particularly worried about whether Baby E was getting regular feeds. However he said that Baby E was eating well two days before he died, his nappy routine was fine and there was nothing to be concerned about at that time. He did not think anyone could be blamed for Baby E's death but he wanted the review to help ensure other families did not go through the same things.

He was concerned that the specialist hospital treating his son took, in his view, too long to deal with blood tests. He was upset the family were still waiting for the outcome of the tests when Baby E died. He also felt that services did not always respond quickly and took too long to intervene at times. He felt everyone did their best to support Baby E and care for him especially in emergencies.

Mother X and MGM

Mother X met with the SSCB Business Unit Manager. She was supported by her mother, MGM, and her own grandfather for part of the time. She too agreed to have an independent advocate present on her behalf. She and her mother MGM said that they thought that the reason for the meeting was to talk about the way they feel they have been treated following Baby E's death.

They are aggrieved about what they feel is a lack of support with their grief from Children's Services and the NHS after Baby E's death and had prepared a dossier of their concerns for the meeting. They were not expecting to talk about the period during Baby E's life. On being asked they gave a lot of helpful information about how they felt and their perceptions of how agencies worked together to support them.

Mother X said that she felt that she was pushed and bullied by professionals, that she was not listened to and that she was invisible and being judged. They both felt strongly that PGM negatively affected how professionals acted, with the attention shifting from Child Z to Baby E, the school being diverted by discussions about Baby E rather than Child Z, a Health Visitor being bullied and in turn bullying Mother X, and by professionals being "walked over" by PGM.

They told us that the school did nothing when they asked for help with Child Z and that Children's Services did not explain any of their actions. Both MGM and Mother X said that they did not know what was expected of them. They said that they did not know why the first Health Visitor (HV1) wanted to make a referral to Children's Social Care and felt threatened by her. Mother X also said she felt she could talk to her Family Support Practitioner (FSP) in a 1:1 but when other professionals got involved things changed and Mother X felt powerless. She said that she did not know she could ask for an advocate for herself.

Mother X and her family also expressed their concerns about the slowness of the specialist hospital to deal with blood tests, and posited the possibility that the results could have led to other more effective drugs to stop him having fits being used. This concern was fully explored by this review. The results of the blood tests that were done were returned within the normal timescale of three months, and were not delayed. The results would not have changed the drug regime as they were designed to identify whether there were any rare genetic issues that needed to be understood. Baby E's epilepsy, whilst unpleasant for him, was not of itself a risk and was not severe. His seizures were not daily and although they were regular they varied in length, and were not showing any sign of escalation over 12 months.

Both parents clearly have very different perspectives about the way in which agencies worked together to support Baby E, Child Z and themselves as parents. They expressed different views as to the role of their own mothers in the way the family functioned. They had different views about the influence of their mothers on others.

Father Y expressed and gave evidence of appropriate concerns about Mother X's care of Baby E, and his own needs as a new father as well as about the situation he found himself in, Mother X talked about the issues and problems in the family as things that everyone else did, and therefore their fault. She demonstrated less concern about the impact of the family situation on Baby E or about the care he was given by Father Y or herself than concern for the impact on her.

This fundamental difference between Baby E's parents is at the heart of the way professionals related to the family and the degree to which they focussed on Baby E's needs and on how best to improve his life experiences.

6. Key events during Baby E's life

Throughout Baby E's life there was a significant level of contact by professionals with the family. Much of this was related to the usual contacts from Health Visiting, Midwifery and school staff that occur with all young families. In addition there was concern about Baby E's older brother and a lot of support being provided to Child Z throughout Baby E's life. The hospital also knew Baby E well.

The records show that much of the practice from these universal services meets or exceeds basic standards, service requirements and expectations. There is also a lot of evidence of tenacious and committed practitioners continuing to offer support when problems arose with either parent or when the tensions between family members impacted on professional inputs, decisions and actions in relation to Baby E and Child Z.

There were a number of key episodes including 4 major events where a different response could have had a bigger impact on Baby E's life, and on the way in which practitioners related to the family. There is no evidence these events had any bearing on his death. However there is evidence the quality of Baby E's life could have been improved. Where appropriate, reference is also made throughout the Review report to the organisational context at the time and to recent changes to practice since the events under review.

The background and early weeks after Baby E's birth

The support initially provided to Baby E by staff in universal services (Midwifery, Health Visiting, the Children's Centre, the school Child Z attended and Early Years services) was the same as that provided to any new baby.

Baby E's older brother Child Z was born in June 2009 (nearly 5 years older than Baby E). His early life was marked by major tensions and allegations of domestic violence between his birth father and Mother X, some of which included police intervention and court orders.

Concerns about Mother X's ability to care for Child Z were raised with Suffolk Children and Young People's Services by MGM in October 2010. MGM also raised concerns with the police in February 2011. Other concerns from a neighbour and the ambulance service were raised in 2011 and 2013.

In February 2014, 6 months before Baby E was born, the Health Visitor for Child Z (HVa) undertook an assessment of Child Z's needs using the Suffolk Common Assessment Framework[iv] tools. This was done following a referral in February 2014 and an initial assessment by Social Workers, because of concerns about whether Child Z was being neglected, his developmental delay and the cold and sparse living conditions they were living in. In addition Child Z was believed to be left in his bedroom on his own a lot of the time. The school were also concerned about Child Z's care and development.

A very practical plan was agreed by the multi-agency team of professionals known as the Team around the Child, (TAC), working together with Mother X to improve her parenting and care of Child Z and support her to manage everyday life. A Family Support Practitioner (FSP) began to work with the family to make changes and follow the plan. At this point the FSP was named as the lead professional for the TAC plan.

The concerns that led to the original plan had reduced by the time Baby E was born in August 2014. Whilst there was a TAC plan in place at this point for Child Z, it was not changed to include Baby E and the impact of his birth on the family. Baby E was initially supported by the midwife and then Health Visitor in the same way as any other new baby through the "universal offer".

In September 2014, HV1 evaluated the degree of Health Visiting services provided to the family and felt the family's complex circumstances following Baby E's birth required a "Universal Plus Service", with additional Health Visitor input and monitoring. This did not change the TAC plan and the focus of concern for that plan remained Child Z.

Comment

There are two learning points arising from the early part of Baby E's life. Firstly it is important to see the family as a whole unit, rather than have different approaches and plans for each child. Secondly practitioners need to automatically reassess a TAC plan when a new baby is born into a family, and for any plan to be a "whole family" plan.

Professionals need to be alert to the fact that changes in family life such as relationship changes or a new baby may add to the challenges in a family, and potentially increase the risk of reduced parenting capacity as well as change the family dynamic.

Key Period 1 - September 2014

In late September 2014, Child Z's school made a referral to the Multi-Agency Safeguarding Hub, (MASH) despite the imminent TAC meeting in early October. Child Z was demonstrating increased developmental delay, and the school recognised that the additional learning and support needs of both parents as well as the impact of a new baby was creating increased pressure for Child Z. Other parents had seen Child Z's parents shouting at him, and Father Y had been physically aggressive towards him by grabbing him. MGM had also asked to be informed by the school if Child Z's care was neglectful because of the new baby's arrival.

The MASH considered the referral and decided to pass it on to FSP, who was recorded as the Lead Professional for the TAC for Child Z. They requested that FSP discussed with Mother X and Father Y the concerns the school had and refer back to them if necessary. This was in line with the agreed procedures at the time, in that the MASH passed referrals on where there was a TAC plan and a Lead Professional was already involved with the family.

Comment

This action prevented an evaluation by MASH as to whether the risks in the family for the children's wellbeing were changing. MGM's request to the school was not given sufficient weight and her intentions in making that request not explored. In addition

professionals did not share a common understanding about the fact that the MASH response was in line with standard practice. It left the school feeling unsupported in terms of their anxieties about the risk to Child Z and his baby brother. Despite this, the school did not initiate the Suffolk LSCB Escalation Policy in order to challenge the MASH's actions.

The impact of the procedure as it then stood also left a FSP holding case responsibility for assessing changing risk without necessarily having access to the skills and tools that would support them to do that effectively.

Key Period 2 – October 2014

In late October 2014 and early November 2014 a number of professionals observed specific incidents that raised concerns in relation to how Baby E's parents were caring for Baby E. The FSP also did some direct work with Child Z, who gave her some clear messages about his negative experiences at home. In early October Father Y's psychiatrist wrote to the family GP about Father Y's difficulties in sleeping and the impact on him of tensions between him and Mother X. In late October the GP referred his own concerns about Father Y's rough handling of Baby E via the Paediatric Department at Ipswich Hospital. The Department advised the GP to pass them on to the MASH (via the Emergency Duty Team) which they did.

The MASH contacted Baby E's parents who were angry and refused to give consent for information about the GP's concerns to be discussed with HV2 as part of an initial response to the referral. As a consequence the MASH did not evaluate the information they held on the family and the previous referrals to assess whether the risks to Baby E justified sharing information without parental consent. The MASH decided instead to talk to the FSP as the person recorded as the Lead Professional at the time, who agreed to follow the concerns up. This was a misunderstanding of the Information Sharing Policy and the Review was told that changes have been made subsequently to ensure such a misunderstanding could not arise again.

Comment

It is clear that the anger expressed by Baby E's parents about the referral had a strong impact on the MASH decision. The FSP again was left holding responsibility for holding the degree of risk within the family without the framework of professional support needed to facilitate that. This was the second time this had happened in a short space of time, and it had an impact on how key professionals viewed the value of making a referral to MASH.

Whether an initial assessment and fuller information sharing would have meant the threshold[v] for undertaking a specialist assessment by Children's Social Care was met, or would have improved Baby E's life at home more than the TAC was doing is not clear, but in terms of effective practice the increased risk should have been recognised and responded to. It is possible that, for example the FSP could have been asked to assess Baby E's parents parenting capacity using specific tools available such as the graded care profile tool.

It is also of note that none of these concerns were communicated to Adult Community Services in relation to Father Y's needs for support as a parent with his own diagnosed difficulties. A "whole family" approach to understanding and meeting Baby E, his half-

brother, his father or his mother's needs was not considered at this point. Issues were being considered separately by separate professionals in separate parts of the system, the ACCORD protocol was not initiated, and there was no consideration of assessing parenting capacity.

Whilst various assessment and early help tools were available there was no clear multi-agency "kitbag of tools techniques and interventions" or early help pathways available to all professionals which they understood and could apply easily and effectively.

Key Period 3 – December 2014

At the beginning of December 2014 the next TAC meeting took place at school. This was a very stressful meeting. Mother X became extremely distressed and left the room. After a period of attending to Mother X the meeting resumed and a range of concerns about Child Z's behaviour and needs were discussed. Father Y expressed his concerns that Child Z's tantrums were difficult for him to handle.

A number of observational records, concerns raised by various professionals as well as the 2 referrals to MASH prior to the TAC should have been considered at this meeting. However the TAC was diverted from reflecting on and addressing some of the issues causing concern by Mother X's extreme distress.

The TAC plan still did not appear to reflect Baby E's needs, or the impact on family of a baby despite the growing number of indicators of increasing concern about Child Z and Baby E's daily life experiences. It also did not include any intervention or assessment activities designed to assist in identifying and meeting the parent's needs for support and improve their ability to parent better. The possibility that the things that were affecting Child Z might also be equally affecting Baby E did not appear to be explicitly discussed.

Comment

It is clear that the professionals in the TAC reacted to the circumstances at the time, and were unable to properly evaluate what was happening within the family. Concerned about keeping Mother X engaged, this led to a focus on maintaining a relationship with Mother X in particular through a practical set of actions. The revised plan was not based on any evaluation of the children's changing needs, Baby E's needs in particular or on setting out what needed to change or what could happen if it did not.

In addition no specific practice tools were used to evaluate the capacity of either parent or to identify their strengths and areas of concern as none were routinely available apart from the standard CAF Assessment. The voluntary nature of the TAC process appears to have been seen by professionals as a barrier to more assertive interventions.

Key Period 4 – January/February 2015

Over this period, concerns about the children's home environment continued to surface. Conditions at home were recorded as cold; relationship issues were noted; Mother X and the children moved house; a difficult relationship continued between Mother X and the school; the Children's Centre was concerned about Baby E's care and PGM and Father Y both expressed a number of worries and concerns about Mother X's inconsistent care of the children. When challenged about specific issues Mother X went to considerable lengths to demonstrate to those raising the challenge that she was caring well for both children.

In early January at the TAC review meeting, Mother X was adamant the TAC should be closed although she was subsequently persuaded to change her mind. No further TAC review meetings were planned at this point and the plan was not changed. Why this did not happen is not clear from the records. At this TAC both HV2 and FSP were named on the plan as the lead professional which introduced a degree of confusion for the rest of the Baby E's life. It is also not clear why this was done or by whom. At the learning event, both HV2 and FSP said that they did not think that they were the Lead Professional.

Following the TAC, despite the concerns about Mother X's possible withdrawal, a multi-agency professional discussion did not take place to consider whether Mother X's threatened withdrawal increased the degree of risk or concern, and should therefore trigger a risk assessment or a request for a formal assessment of need by Children's Social Care. This was affected by professional concerns that Early Help was voluntary and that the threshold for statutory intervention was not met and that the MASH would not respond. There was no consideration of whether the LSCB Escalation procedures should be initiated in order to address the lack of confidence professionals had about making another referral.

The school met with MGM and PGM together to discuss how best to ensure Mother X continued to engage with professional support and help. The FSP began to search for other forms of support for the family, as the TAC felt that the TAC plan was not providing enough support on its own. The FSP also contacted Adult Community Services (ACS) in line with the Suffolk ACCORD framework protocol[vi] in order to obtain support for Baby E's parents.

ACS had not engaged proactively previously despite their regular in depth involvement with Father Y. They were not sighted on what was happening within Father Y's family life. ACS involvement was not sought by children's professionals or challenged as multi-agency understanding about the role of ACS, their organisation and approaches was also limited. In addition Early Help professionals had not sought to involve ASC in the work they were doing with the family earlier on. This reduced the potential to gain a far better understanding of Father Y's ability to parent.

In January 2014 FSP made a request for ACS involvement under the ACCORD protocol and thereafter consistently tried to get ACCORD implemented. ACS were unable to provide a service on behalf on Mother X who would not agree to any form of assessment of her learning disability. ACS felt that Father Y may not fall within the remit of ACCORD as he did not have full time care of Baby E and at times Mother X refused to allow contact despite the fact that Father Y was known to Adult Services in his own right.

In early February the school expressed strong concerns about the potential closure of the TAC and the absence of multi-agency monitoring of the children as a result. They discussed this with FSP, who was working hard to engage, support and challenge Mother X and support Father Y in increasingly difficult circumstances. School decided not to make a multi-agency referral to MASH because they were not confident the MASH would accept the referral given their previous experience.

In February, Baby E also had his first seizure and was admitted to hospital, He had a possible febrile convulsion due to a high temperature two days after he was discharged. Concerns about his health increased the stress on the family members significantly.

Comment

It is clear that these two months marked a significant change in the degree of concern about the family which was not matched by a significant change in approach to meeting Baby E and Child Z's needs. The concerns coincided with a marked deterioration in the relationship between Baby E's parents. The school, HV2 and FSP were trying to find ways to address what they saw as increasing risk, but lacked confidence in the response they felt they would get from MASH (given previous responses) and children's social care so did not refer to them.

At the time multi-agency understanding of the role of the MASH for cases held in early help was unclear and when to use other approaches such as step up processes was not well developed. The two previous referrals (from the school and the GP) had been seen as "being rejected" by Early Help professionals.

As concerns grew the School, HV2 and FSP did not utilise the SSCB threshold guidance, they did not have the confidence to make a further referral or seek advice from MASH given their previous experiences. Nor did they consider whether the case should be formally escalated. This meant the case was not "stepped up", the TAC plan stopped being progressed and the TAC ceased to meet. Professionals stopped explicitly working together for Child Z and Baby E which took the pressure off the family to meet common multi-agency professional expectations.

This was the first time Adult Social Care were involved in a planned way, despite the long relationship they had had with Father Y and their in depth knowledge and understanding of his needs, capabilities and ability to act appropriately as a parent. They should have been consistently involved in the TAC process from the point Father Y first became part of the family rather that from sporadic inter professional contacts.

This was a missed opportunity by those involved with the children to enhance their understanding of what life was like for both children. The Review was told that the ACCORD protocol is currently being revised and new guidance developed as part of the learning from this review.

In addition Mother X was behaving in an increasingly challenging, avoidant manner. The care she was demonstrating was increasingly inconsistent. The focus on working with her, and trying to keep her voluntarily engaged, involved and able to cope in her own right diverted the attention of professionals from focussing on or really addressing Baby E and his brother's needs and lifestyle.

Key Period 5 – March 2015

In early March after a discussion between HV2 and the Named Nurse for Safeguarding a decision was made to convene a new TAC to address the various concerns that were raised by other agencies. The records show that at this point Health Visiting Services felt there were no safeguarding (ie child protection) concerns as Baby E was presenting as a happy, clean, fed, socialised baby. However, some other agencies were clear mother was not engaging, and her capacity to parent her children was not good given the circumstances (Baby E's epilepsy, Mother X's limited ability to keep her children consistently warm, properly clothed, clean, and her deteriorating relationship with Father Y).

It is not clear how well line managers were engaged in supervision and support to HV2 and the FSP in order to address these differences of view and help professionals to make decisions about the best way forward. Nor is it clear why a Named Nurse for Safeguarding was involved if the HV2 felt there were no safeguarding (ie child protection) concerns although HV2 did feel there were some concerns about the quality of care.

The Initial TAC meeting took place. HV2 chaired the meeting and FSP took notes. Following this Initial TAC meeting the relationship between the FSP and Mother X got harder, as both the FSP and HV2 were assertively challenging Mother X. The school continued to be concerned about Child Z, and have difficult conversations with Mother X. MGM became increasingly hostile to the FSP.

First major practice episode – May 2015

In April Baby E's parents separated permanently

Between March and May 2015 the pattern continued of contacts, concerns, upsets, and difficulties in engaging positively with Mother X, as well as coping with incidents arising from the hostility between PGM, MGM, Father Y and Mother X. Contact with Baby E became a very contested issue, regardless of what Baby E himself needed.

The TAC met and noted that Mother X was making some progress but that the fundamental issues in terms of her care of the children remained the same.

Between the 18th to the 21st May 2015 there was a period of intensive communication between the FSP, her Clinical Team Manager (CTM) and HV2 about what to do in order to address and respond to their increasing concerns about Mother X's capacity to care for Baby E and Child Z well enough. At this point a developmental assessment of Baby E by HV2 identified some developmental delay.

At school Child Z was indicating home life was not good and the school had growing concerns about Mother X's parenting ability and mental health. However professionals did not always cross reference what was happening for Child Z with what was happening for Baby E and vice versa. The FSP felt she needed more support from others to manage the issues and risks she saw in the family. A decision was made by FSP, CTM and HV2 to take the case to the regular early help case transfer meeting for consideration for "stepping up" to children's social care.

However, the planned transfer meeting did not take place. Why this was the case was discussed at the learning event. The cancellation of the meeting itself was unremarkable. What did not happen was a proper follow through of cases to the next scheduled meeting so the case was not discussed at the subsequent meeting. The front line practitioners or the manager involved did not pick up on this or immediately establish what had (or had not) happened and kept on trying to maintain the status quo.

Comment

These incidents were happening following the introduction in April 2015 of a new CYPS operating model 'Making Every Intervention Count' which included the development of an integrated multi-agency Early Help service to support families before they became families with children in need, or in need of protection, in Suffolk. Practitioners and managers were in new teams and did not appear to have a clear and robust understanding of the Early Help framework, or the pathways and processes across the system to ensure effective responses to changing need between Social Care and Early Help services. Step up and step down processes, and case transfer systems were not well understood, and Early Help practitioners were not always as robust as they needed to be with social work practitioners. For Baby E assertive case management was not very evident at this point although tenacious efforts to engage the family went on.

In addition there were some challenges at the time, in terms of developing accountability and line management arrangements which provided a single clear line of accountability. These were quickly identified and resolved as the new approach settled in.

Second major practice episode – June 2015

Between the 4th to the 17th June 2015, another period of intensive communication took place as there were some significant concerns that the children's needs not being met. A series of discussions about what course of action to take occurred after the FSP quite properly set out the issues, concerns and evidence in a report, and asked for advice and support from the Health and Children's Centre Manager (HCCTM), a role which had just replaced the Clinical Team Manager role for Health Visitors and line managers for the Family Support Practitioners.

A range of options were considered by different individuals and a range of proposals made, none of which progressed. As a consequence the case was not passed to another early help transfer meeting, a referral to the Consultant Social Worker for a case review did not occur, and instead, an agreement to discuss what to do at the next TAC meeting was made.

HV2 was clear that there were now serious concerns about Baby E's medication, safeguarding concerns and some developmental delay for Baby E as well as Child Z. The SoS work proposed by HV2 took place but the outcomes were not fully reflected in the subsequent multi-agency plans.

A discussion between HV2 and FSP had taken place where HV2 suggested that the case might need to be stepped up to Social Care via a multi-agency referral to MASH.

HV2 was also considering a transfer of the case to another Health Visitor because of the level of hostility towards her, and a maternal family request that she be changed.

At the same time as these discussions were taking place in early June 2015 Suffolk Police (who were not involved in the TAC) made a referral to the MASH following a domestic incident at Baby E's home involving his parents, after Father Y had visited Baby E. A strategy discussion took place at the MASH and no action was taken as the case was subject to early help services and there was a TAC in place. This was in line with normal practice at the time (as previously noted). The FSP was informed as the MASH understood that she was the lead professional. She accepted the information from MASH despite not being clear she was the lead professional and continued to try hard to manage the responsibility of dealing with it.

A TAC meeting (8th June 2015) attended by some family members and professionals and a Family Support Network Meeting (12th June 2015) attended by a wider group of family members and professionals together created a new TAC Delivery Plan designed to address the concerns, existing strengths and safety issues identified and discussed plus next steps were set out in relation to Child Z and Baby E. Despite HV2's explicit concerns, the June network meeting agreed that if all went well over the summer period the TAC may close for Baby E, dependent on the Health Visitor assessment. A third Health visitor (HV3) was involved in these meetings as the family had moved and HV3 was the named HV for their new address.

The plan referred to the possibility of social care becoming involved in providing support "*if there is no progress within the next 4 weeks".* The TAC plan was implemented and in line with the Signs of Safety (SoS) approach introduced as part of the early help framework by Suffolk. HV3 took on the case fully on the 21st June 2015.

At the same time Baby E had a number of admissions to hospital following seizures. Each of these created some challenges for the hospital as different family members asked the hospital to exclude or not communicate with other family members.

Comments

The Early Help Service at that time did not have easy access to professional social work advice and support with case consideration. It was available but not well used. The review was told that since that date additional professional support has been made available and Children Centre staff (Health Visitors and, if they wish, Family Support Practitioners) now receive clinical supervision from named nurses as well as clear pathways in place to access Consultant Social Worker support and advice.

The Early Help professionals involved were concerned about the family but were also increasingly giving mixed messages about what was expected of Mother X and about the possibility of the TAC for Baby E being closed. They swung from strong messages about the possibility of statutory intervention, to conversations about the TAC being closed. Rather than using the TAC plan as the foundation for working consistently with the family and using tools and techniques to evaluate the degree of change, the plans varied depending on the circumstances at any one time.

The need to keep Mother X engaged was a dominant concern, rather than concern about whether the inconsistencies in Baby E's life at home required a review of the TAC plan and a more robust plan and approach. Advice, management supervision,

professional supervision and support to the frontline staff was not helping frontline staff to identify this dynamic or to maintain a strong grip of case management.

At this time the MASH was developing its' systems and processes. Whilst there was clear understanding by the MASH itself that when a case was open to Early Help they would not get involved this was not well understood by other professionals and agencies. For Baby E this process meant his needs were still not being properly recognised or fully addressed. By this point there had been a number of referrals to MASH about the family within a relatively short period of time. This should have raised concerns at the MASH and led to a more in depth information gathering exercise and evaluation of the issues raised.

The Review was told that the learning from this review and the early period of the MASH service has subsequently been addressed. Any referral involving a child under three with three or more past referrals will now automatically trigger an in depth consideration of the matter. This is intended to assist with more integrated working and increases the ease of transfer into statutory services.

Third major practice episode 10th – 27th July 2015

In early July there was another TAC meeting. This was a very difficult, hostile meeting. MGM and Mother X both challenged the minutes of the previous meeting. Concerns were expressed by MGM about professionals putting too much pressure on Baby E's parents and asking too much of them.

Mother X declined the offer of a parenting course. Mother X robustly presented evidence of the changes she had made and how well she was playing with her children. There was a strong focus in the meeting on the need to increase Father Y's contact with Baby E.

The meeting agreed that some progress was being made and discussed the possibility of closing the TAC after the next review meeting scheduled for September 2015 despite the limited evidence things had improved. The termination of the TAC was recorded as dependent on the assessment of HV3. A reassessment of Baby E's development noted no ongoing concerns, and the previous delay was no longer identified as an issue to be concerned about.

The FSP continued to try to address issues and mitigate the poor parenting that Mother X sometimes displayed, to negotiate between the adults in the family, to encourage professionals to remain engaged and to try to encourage Mother X to address the shortfalls in her parenting of Baby E.

Later in July HV3 and the FSP had a further discussion. The FSP indicated that she intended to make a referral to CSC due to the level of family hostility at the TAC. There is no record of her doing so.

The MASH then received a further referral from Child Z's Physiotherapist who was worried the contact disputes were getting in the way of addressing Child Z's needs, and about Mother X disengaging. The MASH again made a decision to pass responsibility back to the FSP. This was in line with practice at the time. However the FSP was still unclear about whether she was the Lead Professional which meant the referral back was not necessarily receiving the response expected by MASH.

FSP continued to be seen as responsible for holding things together and ensuring Baby E was safeguarded, whether that was still appropriate or not.

Matters between the maternal family, FSP and HV3 had deteriorated significantly by now. The final home visit that took place was on the 27th July 2015. The FSP and the HCCM visited the family at home to see if relationships could be improved both between the extended family members and with professionals since the last TAC had been so acrimonious. This was seen as a positive meeting as the family did not indicate any wish to withdraw from Early Help services. The outcome was that that the family agreed the TAC would continue until the next meeting due in September. Baby E was observed to be well. However, the family were not willing to discuss any work to improve relationships with Father Y and PMG.

Yet again reflecting the fluctuations in concerns and the different professional views about the family, the FSP describes this visit as not presenting any specific concern that would require step up for Social Care involvement. This was a significant change in view following the FSP's previous concerns.

Comments

Despite a range of discussions in relation to the concerns in July 2015, action to escalate the situation through case transfer or via a referral did not happen. In fact professionals began to disengage with the family. The more difficult the situation became, the more uncomfortable a life Baby E was experiencing, the more the behaviour of the adults in Baby E's life diverted attention from what was actually going on for Baby E himself. In addition the MASH continued to pass the case back without sufficient analysis of the situation. It is clear professionals felt disempowered by the family dynamics, convinced the situation had to be managed through voluntary engagement and compromise and unclear about what the best approach should be. Assertive case management was missing and supervision insufficient for the situation.

Fourth major practice episode – August 2015

Contact issues escalated significantly in August, with periods of spending time with his child by Father Y and his family being denied regularly, and professionals being caught by or drawn into acrimonious actions between the various extended family members. The maternal family became increasingly adversarial and challenging of anyone who challenged them. There were no further visits from early help services following letters from Mother X to the FSP and the Health and Children's Centre Manager (HCCM) stating she no longer wanted a service and making a formal complaint.

Mother X disengaged from Health Visiting, the FSP, the Physiotherapy Service supporting Child Z, the Occupational Therapist and Specialist Epilepsy Nurse and made formal complaints about a number of them. Instead of stronger more assertive interventions, the interventions became fewer and fewer. Those professionals who knew the family well were withdrawn due to complaints and the coordination of multi-agency support deteriorated significantly. Those people who had the greatest concerns were no longer actively engaged in trying to address them. The early help service, and TAC Plan was no longer being followed.

The situation for Baby E and Child Z continued to be less than positive, with them both being exposed to difficult and often tense relationships between professionals, Mother

X and MGM, and increasingly adversarial behaviour in relation to Father Y spending time with his child. The degree to which the children's needs were being put first was clearly very limited. Baby E also continued to have regular seizures and hospital admissions. Complaints by Mother X and MGM to the hospital resulted in Father Y being excluded for some time from Baby E's medical care planning and interventions.

Following the letter from Mother X on 20th August 2015, The HCCM decided that the TAC meeting planned for 11th September should be cancelled. HV3 was asked by her to "review" the situation. As a consequence the last TAC meeting was the one on 8th July 2015.

Comment

There was by this point no independent multi-agency view being taken of how Baby E's welfare was being promoted by his family, or whether the changing situation was increasing the risk to him, and no expectations being laid on his parents about the care they were providing. Plans were in effect abandoned and Mother X and MGM's adversarial behaviour drove defensive practice and system withdrawal. The Early Help service completely ceased to be involved. Interventions were related to trying to minimise the impact of parental behaviour on the child's receipt of specific services (school, GP and hospital for example). Exactly what HV3 was being asked to review was not clear.

At the point the strongest possible professional interventions under the circumstances were required in order to ensure Baby E's needs were being properly met, all the professionals withdrew. No consideration of step up or escalation as a consequence of the maternal family's behaviours took place, no management grip was apparent, and professionals took the view that as child protection thresholds were not met, interventions gave rise to complaints and voluntary support rejected there was no point in remaining engaged.

Key period 6 - September and October 2015

In early September 2015 the police made a further referral to MASH (in relation to an incident in July2015) because they were concerned about Baby E's health and the level of care being provided to meet his health needs. This time the MASH did initiate early inquiries but decided to pass the case back to the Early Help service for the 5th time. The case records were not fully considered or a whole family evaluation of what was going on undertaken. The deterioration in early help involvement and termination of the TAC was not clearly recorded, known or understood.

As a consequence the MASH analysis was limited and did not take into account or analyse Baby E's life story, and experiences. This was a crucial missed opportunity to escalate concerns about Baby E and ensure assertive interventions were considered at the point all early help professionals were withdrawing, engagement deteriorating and plans falling apart.

Cafcass become involved in early September 2015 as consequence of private law proceedings after a Child Arrangements Order Application was made by Father Y. Cafcass quickly identified that there was an ongoing pattern of difficult conflict between parents, rejection of various professionals by Mother X and a very positive impression of her capacity to parent to others.

The Family Court Adviser (FCA1) undertook a clear, thorough and well-articulated assessment of the case. This included a thorough review of those Local Authority records provided through the court process and a proper risk assessment of the parenting capacity of Father Y. The conclusion was that Father Y should be allowed to resume limited carefully managed contact with Baby E. Mother X's care was not risk assessed but the shortfalls in her parenting capacity were noted.

A clear articulation of a range of safeguarding concerns was laid before the court by Cafcass on the 2nd October 2015. This clarity was notable given the previous lack of it in terms of the issues affecting Baby E's life in the preceding months. FSA2 was on duty when the court considered the issues on 14th October 2015 and made sound recommendations about Father Y's contact with Baby E. The recommendation to court was that Father Y had gradually increasing contact with Baby E.

The case was then transferred to a Service Manager. It is notable that, for the remaining months of Baby E's life the primary contact professionals had with the family, including Child Z, was through specialist medical staff, Child Z's school and school Family Liaison Officer and Cafcass.

As a consequence Cafcass Social Workers were the first social work professionals to be actively involved in assessing the quality of Baby E's care by both parents. They undertook a range of assessments using a variety of research and evidence based tools to evaluate Father Y and Mother X's parenting capacity, quality of care and ability to put Baby E's needs first. Following these assessments they concluded that the situation did not require statutory child protection intervention and they did not seek an order requesting an assessment by the Local Authority, nor make a referral to CYPS for additional support as a child in need.

On the 8th October 2015 the Health Visiting Service downgraded their prioritisation of what was offered from Universal Plus to a Universal Service and on the 12th October 2015 a decision was made by the HCCM to close the case. They recorded that the case would remain with the Health Visiting Service under normal universal provision. The specialist epilepsy nurse and paediatrics were also still involved although Mother X had disengaged from them.

The rationale for closing down the interventions taking place was that change was not possible due to Mother X and MGM's lack of engagement and their formal complaints about the Health Visitor. The view taken was that there was still a protective element for Baby E as the Universal Health Visiting service meant that he was still being seen by a Health Visitor. The Epilepsy Service was also involved and this was seen as a protective factor.

Comment

It is clear that the sometimes aggressive and often assertive responses to professionals from the maternal family, coupled with a string of complaints and active disengagement in effect acted to frighten staff who as a consequence felt disempowered, bullied and undermined by both the actions of adults in the family, and their agency's response to the complaints.

Interestingly Mother X describes herself as feeling both disempowered by professionals and bullied by PGM and professionals. She also describes herself as not

"knowing" what she needed to do to change or why. The inconsistent approach by professionals may well have had this effect. In addition Father Y felt disempowered by Mother X and MGM. The entire situation with everyone involved feeling bullied and disempowered needed strong, assertive and confident, well led multi-agency intervention if any change was to occur for Baby E

Disengagement from the case was the opposite of what should have happened. The impact on professionals of the behaviour of the adults in the family was not translated into an understanding of the impact such behaviour might have on Baby E and Child Z. The response by professionals was perverse and was adult not child centred.

The presence of Cafcass was protective, despite their involvement being through private law proceedings. The involvement of CAFCASS was limited and would not provide direct case management in improving Baby E's care in the same way as a CAF, Child in Need of Child Protection process would. As there was no risk of serious harm identified this may have been appropriate but it did not help improve the quality of Baby E's daily life experiences as In fact the situation may have benefited from CYPS involvement.

7. Analysis of practice, key learning points and messages from the Review

It is always easy, with hindsight, and with access to all the information available in one place, to identify things about practice that could have been done differently or more effectively. Key points are identified in the story of a case where, had something different happened, the course of that child's experience of care, help and support could have been different and missed opportunities are highlighted. There is a risk that this distorts judgement about the predictability of an adverse outcome.

In reflecting on what happened it is important to recognise that for Baby E as with any other child and family that is vulnerable and requires professional support and help, it is not an exact science. In many ways it is easier to make decisions where serious harm is clear and unequivocal than where strengths and vulnerabilities need weighed up and balanced. The exercise of professional judgement is essential in situations where there are a range of views and interpretations about what is happening, and evidence of serious harm limited or not available. It is then that the facts have to be considered in terms of the impact on a child's lived experience, and assertive, respectful practice exercised in terms of the adults involved.

In Baby E's case the family situation was complex, and family dynamics had a very significant impact on how professionals related to the situation. In addition, this was a family that, on the whole, was managing to cope with circumstances they were living in and where the children were loved, there were supportive extended family members and the care was, most of the time, seen by professionals as good enough.

Munro (2011)[vii] suggests that once we know about a serious injury to a child it becomes too easy to look back and conclude that certain assessments or actions were critical in leading to that outcome. Woods (2010)[viii] writes that this '*hindsight bias' oversimplifies or trivialises the situation confronting practitioners and masks the processes affecting practitioner behaviour…. Hindsight bias blocks our ability to see the deeper story of systematic factors that predictably shape human performance'*. In

this case Baby E was not injured but it is clear his life was not always as good as it should have been, and that he was often cold, hungry and unsupervised.

The Review Panel were mindful of the dangers of hindsight bias but wanted to understand why certain actions and decisions would have made sense to front line practitioners and managers at the time and importantly, what systemic factors in place then may still be affecting front line practice in 2016.

From studying key documents and listening to the views and experiences of front line practitioners involved in the learning event, the Review Panel identified a number of Key Learning Points (KLP's). These Key Learning Points and themes were used to explore in detail the actions and decisions of professionals working with this family to help the Review Panel understand why professionals acted as they did or why they may not have acted at all. These are identified and discussed in more detail in the related sections below.

The analysis seeks to address three questions:

I. What did professionals do well to support Baby E?

2. What could have been done better?

3. What can we do differently in the future as a result?

The key learning points the panel identified are:

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

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

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

KLP 4: Epilepsy and its impact.

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

KLP 6: Leadership, management and supervision.

KLP 7: Working with adults with additional needs.

KLP 8: Assertive confident practice with challenging parents.

Good Practice

It is important to recognise that overall practice in this case met required standards and there was some good effective professional work in difficult circumstances.

Communication

There were many individual examples of good communication between professionals about practical and environmental factors. Frontline practitioners communicated and discussed actions regularly.

Practice Advice

The practical advice given to Baby E's parents about baby development and care, and the access to children's centre services and parenting courses was good, whether it was accepted and used or not.

Record keeping

The recording of information was mostly good, particularly by the NHS staff, although how well it was evaluated, reflected on and analysed in order to inform professional practice and judgement is unclear.

NHS Support

There was a strong effective epilepsy pathway and practice, the medical support provided was good, and the support effective, taking account of the complex family circumstances and the additional needs of Baby E's parents. There were some strong and sound interventions from the Specialist Epilepsy Nurse. The Hospital staff were clear, and assertive about exercising their understanding of parental responsibility, and continuing to work with Father Y as well as Mother X despite the complaints against them that this led to.

The School

The school was tenacious, committed and alert to the impact of family life on Child Z and his baby brother and were persistent about raising concerns with others. They recognised a range of cues about the reality of family life for the children that others were not alert to and were strong advocates for Child Z. They demonstrated assertive confident professional responsibility in challenging Mother X, setting out their expectations of the family, working with both parents and the extended family with courage at times and with consistency and competence.

The Family Support Practitioner

The Family Support Practitioner was committed, tenacious, insightful and focussed on addressing concerns and challenging as well as supporting the family. She worked well with Health Visitor 2 and they became the key professionals in the case. She persisted for a long time, despite the absence of engagement from others as the risk changed, and she built up a relationship with Mother X that contributed significantly to maintaining a basic standard of care in the home.

Adult Community Services

Whilst regrettably Adult Community Services were not included in or part of the Team Around the Child processes or the Family Support Network (a learning point in its own right), they tried hard to implement the ACCORD protocol despites its limitations and to accommodate the request made by the FSP for support to both Father Y and Mother X (after persistent efforts from the FSP to engage them).

CAFCASS

CAFCASS undertook clear assessments, engaged proactively with the family in order to ensure Baby E's needs were identified, the right steps to ensure Baby E could have a relationship with all his family members were taken and the decisions for the court were well informed. In the circumstances they were also in effect "holding the risks" in the family for Baby E (although they did not make any referrals to CYPS) as early help had withdrawn and Children's Social Care were not involved.

Key Learning Points

KLP 1: Early Help systems, processes and tools

Baby E was born into a family that had a number of challenges. Already receiving input in relation to his older brother, it is clear the family would have always needed some form of additional support to help them cope with and care for the baby.

Whilst there was an established framework in Suffolk for undertaking an assessment of need using the Common Assessment Framework tools (CAF) and working with vulnerable families through a Team around the Child (TAC) approach the way this was applied was not necessarily as it was intended. It focussed on one child rather than the whole family and on practical issues that needed to be addressed.

The family did receive services through the Children' Centre aimed at strengthening the parent child relationship such as baby massage, a range of drop in services, parenting groups etc. but these were open ended general support services without specific, explicit goals, or expectations of either Mother X or Father Y. These were not linked in the TAC plan to what outcomes were needed for the children

The TAC team were unclear for most of the time who the Lead Professional was. It was unclear from the plan exactly what changes were looked for in the way the family functioned, what outcomes were wanted for either child or what exactly was expected of either parent or the consequences if change did not take place. It also did not set out what the team would do to support the family to address the issues raised as well as to receive practical support and advice.

Once it was known that a baby was expected, the family's needs should have been reassessed. This assessment could have included whether to widen the TAC membership to include Adult Services who already had a significant role in Father Y's life. It could have evaluated who beyond the core team needed to be part of the TAC and the TAC Plan. As it was, whilst Baby E was mentioned in the TAC process, the TAC continued to consider Child Z's needs only for several months after Baby E's birth

The Review Panel took the view that this may have been because the whole system was not fully familiar with the principles behind the CAF/TAC system. It may also have been because some (if not all) professionals had a perception that the CAF/TAC process was a preventative approach to families who needed practical support rather than a key safeguarding intervention to better protect vulnerable children and promote their welfare.

Another reason may be that Early Help planning was not treated with same degree of attention as care planning and child protection planning by professionals and managers or given the same degree of weight and importance. Whatever the reason,

Baby E's needs, as part of a vulnerable family group, were not identified, nor was the impact of his birth recognised.

Suffolk County Council, working with the NHS was, in 2014 moving towards a new approach to Early Help, based on the principle that assertive professional interventions early in the life of a problem would be more effective in avoiding statutory intervention and subjecting families to unnecessary child protection processes. However the tools and processes available at the time were not supportive of a "more professionalised" Early Help service. Professionals felt restricted by the voluntary nature of the CAF/TAF and ill equipped to manage increasing levels of concern, intervention and risk through a CAF and TAC.

Culturally it also appears that despite this change in emphasis the front line staff did not have the same set of expectations or give the same weight in relation to the CAF/TAC as they did for Child Protection processes. It is clear it did not, at the time, have the same degree of organisational or "system value" as child protection processes did.

The professionals in the TAC meetings appeared to best understand the TAC process as one which needed to support Mother X, yet Early Help Services were intended to be extra support for Baby E, and his brother. It is difficult at some points in time to see what impact the TAC and Family Support Network meetings actually had on improving outcomes for Baby E as much of the recording relates to Mother X, her behaviours, her needs and her threats to disengage rather than her child's needs.

Over time the professionals within the CAF/TAC system struggled to address the changing needs of the family and the growing concerns about neglect and poor care in relation to Child Z and Baby E. Whilst the Suffolk wide Signs of Safety and Wellbeing (SoSWB) model was available practitioners and managers were only starting to acquire the skills required to use the framework. This limited the effectiveness of its use at the time. The professionals involved found it hard to exercise the assertive challenges needed when the process was a voluntary one and below the threshold for statutory interventions. They also did not have access to a wide range of easy to apply or specific models of assessment or tools and techniques to support the wider application and use of the SOSWB model or to assess changing need and risk.

In addition they were frustrated by the consistent rebuff they experienced when trying to refer the case to the MASH. The appropriate systems to "step up" an Early Help case as risk grows were not used for a variety of administrative and organisational reasons. Assertive line management was missing. In addition the SSCB Escalation Policy was not used, nor were frontline practitioners or line managers sufficiently familiar with its use and purpose.

There is considerable research[ix], which suggests that without the use of tools to assess risk, professional judgment can too often be flawed, with assessments being '*only slightly better than guessing*'. When concerns about a child are identified, professionals working with parents and families need to take account of not only current circumstances, but also past history and the potential for future harm. This means that professionals have to investigate and explore family circumstances in some detail in order to understand how the needs of a child may go unmet and how and where risk circumstances may emerge. Had professionals had easy access to tools such as the Graded Care Profile, or the Bruce Thornton Risk Assessment Model[x]

to inform their professional judgment, they may well have been better equipped to identify areas of concerns and strengths and measure where, when and if any progress was being made

Key Learning

Shared Framework for effective work with Families

The key learning for Suffolk in this case:

- *SSCB need to 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 assuring itself it is at the forefront of everyone's practice.*
- *The essential importance of ensuring 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. This finding was recognised by professionals at the learning event as a current issue and not just specific to this SCR.*

Signs of Safety

Signs of Safety[xi] as an approach was formally adopted as the overarching practice framework for all work with children and families in Suffolk in January 2014 and used in child protection conferences from June 2014. This is a purposeful and collaborative way of working with families to secure the best outcomes for children and young people.

During Baby E's lifetime, the Signs of Safety model was in its roll out phase, was still unfamiliar to many staff, and was not fully embedded into practice. The introduction of a coherent, whole system model of practice will over time make a difference to how the system views Early Help but it was too early to have an impact on Baby E's life. The ongoing roll out of Signs of Safety across all agencies in Suffolk may need to be reviewed and additional work on embedding it and integrating it into daily practice at the front line considered.

- *The Board should consider what range of tools and practice methodologies need to be put in place to support the use of SoSWB and the Early Help workforce to confidently assess, evaluate and balance risk and the family capacity to adapt and change and to adapt plans if that balance changes.*
- *The Board may want to consider how best to support partners to develop clear early help pathways, assessment and intervention tools and coordinated approaches on a whole family basis*

Staff Training and Support

The skills of the Early Help work force in relation to analysis, assertive interventions and ways to work with complex families are not necessarily sufficient to deal with the more complex and higher risk cases they are increasingly being asked to work with as part of the policy changes. Early Help staff need to be as well trained, supported and managed as social workers. Early Help is not a less costly or less resource intensive option although if practiced well it certainly reduces the need for high cost high intensity interventions when harm is more likely to have already occurred.

- *All front line practitioners working with Early Help arrangements need to be sufficiently well trained, informed, confident and competent if effective early help services and systems are to fulfil the purpose they are designed for.*
- *The Board may want to consider how best to refresh, disseminate, communicate and train staff across the whole system in working in a whole family way, and, in particular to use the ACCORD protocol as part of Multi-Agency Safeguarding Training.*
- *They may also want to consider how to refresh, reissue and reinforce the use of the Escalation Procedures.*

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

Baby E and his family were similar in terms of their needs and the issues and challenges they face to many other families across the country. Their story is similar to many others and an analysis of other Serious Case Reviews identifies similar issues for professionals who are working with families that “bump along”, providing care that is most of the time just about ok, but veers into neglectful care at times. It is paradoxically far harder working in these circumstances than working where there are clear and unequivocal indicators of serious harm.

Research [xii] suggests that professionals most readily recognise neglect in terms of poor home conditions, rather than in terms of poor parent-child relationships. In families where neglect is recognised as a concern, it is often the appearance of the child and the home conditions which first catch the attention of professionals, and traditional views of neglected children have tended to rely on these physical signs.

There were many recorded incidents where Mother X’s behaviour clearly demonstrated the extent to which she placed her own needs above those of her child but much of the time Baby E was clean and cared for, and he always presented as a well socialised, happy, secure and healthy baby. Professionals placed significant reliance on this. Research is clear that it is dangerous to assume that simply because children appear to be healthy and well cared for, and do not stand out from their peers they are not likely to be at risk of significant harm.

In these circumstances it is important to consider the cumulative and interacting risks of harm arising from the context the child is living in. For Baby E there was evidence of severe domestic discord, mental health problems, maternal ambivalence and inconsistent care, adverse childhood experiences for Mother X, and an acrimonious separation. These factors, combined with the clear messages Child Z was giving about

life at home, and the physical evidence of episodic poor physical care should together have provided sufficient justification to take more assertive action on Baby E's behalf.

The focus on practical care made it harder for professionals to be confident about challenging Mother X, or about the degree of concern there was, and led to professional differences of opinion. Whilst there was some awareness of and a degree of focus on strengthening the relationship between Mother X and Father Y and the impact of their actions on the children in home visits and at the Children's Centre it was not an explicit clear focus for much of the time. This alongside the absence of clear systems and tools for identifying and managing risk within an Early Help context confused thinking about how best to improve life for Baby E.

Although limited resources or insufficient training may act as obstacles to recognising neglect and taking effective action, there is evidence to suggest (not least from analyses of Serious Case Reviews for example Brandon *et al.,* 2009; 2013) that there are a number of professional assumptions, or mind-sets, which prevent indicators of neglect from being acknowledged or acted upon. These include fears about being judgemental or appearing overly critical and this can lead professionals to focus more on the parent than the child.

What was evident to the Review Panel was that, professionals lost sight of Baby E and Child Z's lived experiences. This is despite records showing that Child Z tried to articulate in drawings or conversation his unhappiness at home a number of times. The quality of the relationship between Child Z and Mother X, did not explicitly inform the professionals' perception of Baby E's attachment behaviours towards his mother and father.

A multi-agency neglect strategy and guidance was introduced by Suffolk Safeguarding Children Board in January 2015. This is a helpful and comprehensive document designed to support the Signs of Safety and Wellbeing methodology and it provides a helpful definition of neglect. It would have given staff a helpful tool to inform their work and their approach to Baby E and his family. Although it was available at the time it does not appear to have been used by staff, which raises questions about why not.

Working with neglect will always be one of the areas of multi-agency safeguarding practice that is subject to the greatest degree of professional judgement, and the widest range of professional views. It is invariably contested territory. It requires effective management of risk, whilst containing and holding that risk within a context of collaborative and restorative relationships with families.

Key Learning

What is important is that in managing neglect cases the rationale for professional judgements is clear, based on research and evidence based practice, and through the use of evidence based assessment and intervention tools and frameworks. Practitioners need to be able to confidently assess, evaluate and balance risk and family capacity to adapt and change and to adapt plans if that balance changes.

Whilst practitioners were working incredibly hard to maintain that balance they were not doing so within the most helpful context or with the right professional tools. 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.

- *The Board should consider whether they need to relaunch and promote the neglect strategy, after refreshing it.*
- *The Board should consider the implications of this SCR for their multi-agency training and workforce development programmes, as well as for the development of a shared set of systems, processes and tools to supplement and enhance the Signs of Safety and Wellbeing. The training should ensure frontline staff are fully alert to the impact of neglect and poor care on children's lives and outcomes over time.*

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

One of the most important things that this review has identified is the issue of repeat referrals, and the use of the Suffolk Local Protocol for multi-agency thresholds guidance. Coupled with this is the failure to use assertive escalation in situations of professional disagreement, and the absence of other tools available to support case consideration when concerns are increasing, and the risk balance is shifting, such as step up and case consultation with the Consultant Social Worker.

During Baby E's life there were 5 referrals to MASH from four different agencies. In every instance the end result was to refer back to the Family Support Practitioner to deal with. It is unsurprising that practitioners were frustrated, and felt they had more responsibility on their shoulders than they were equipped to deal with.

It is clear that referrers felt Baby E's situation needed to be reviewed by a professional social worker but the MASH staff responded by questioning whether the referral "passed the threshold" for an assessment, or S47 investigation. Referrers felt they then had to emphasise the risks and justify why it did pass the threshold rather than think about what was really needed to best respond to need.

This is sometimes referred to as "threshold gaming" and happens when the focus is on the system of making referrals, and whether the issue is "yours or mine" to deal with rather than on the content of the concerns underpinning the referral.

There is no doubt that each time a referral was made the staff in the MASH (which was a relatively new service) did not take full account of the previous referrals, treating each one as a single event, not interrogating what was known about the family, and not evaluating whether there was increasing concern and risk. In addition they were doing what they thought was right by following agreed protocols.

Systemically it is clear that practitioners in a range of agencies were used to making referrals to Social Services when they felt safeguarding issues existed. The shift to a model based on equity of intervention between Early Help and Child Protection (a whole system approach to safeguarding) needs practitioners to be able to evaluate the information they have and the concerns they identify and apply the threshold guidance in place in the area.

Other factors were also at play. It is clear from the discussions between frontline practitioners at the learning event that there was a subtle "hierarchy of professionalism". Social workers did not necessarily always place the same professional weight and value on what they were being told by non-social work professionals when discussing referrals. Some professionals felt that social workers "knew better than them" whether the risks were growing and others felt frustrated and cross that they were not being listened to. There is again no doubt that after a couple of referrals the key professionals in the TAC felt there was no point in making a referral leaving them feeling "stuck" about what to do for the best. The school in particular was not listened to as well as it should have been.

An effective MASH has staff who recognise that referrers frequently do not have the skills or knowledge, let alone the training to exercise subtle professional judgements about thresholds for intervention when concerned about a child. They should not only provide but insist on a mutually respectful conversation between the social work professionals and the individual making the referral. This allows everyone to consider the concerns from the point of view of not only what is happening, but what is known about the whole situation and context, what that tells us about need and risk, and to arrive at an agreement about how best to respond.

Suffolk County Council have now put a failsafe in place to reduce the potential for this pattern of repeat referrals happening. In addition organisational changes mean stronger inter-professional relationships within early help services and between early help and other professional groups are now in place too.

Key Learning

Professional Conversations

The process of making a referral is not one of exchanging information and expecting the recipient of that information to act on it, but an interactive process of discussing the matter, sharing what is known (and researching what else is known). Having a reflective, analytical and mutually respectful professional conversation about what is happening in that family for that child, and what that child's life is like, will result in a better more sophisticated and nuanced response and a shared agreement as to the best way to respond. A number of Local Safeguarding Children Boards across the country are introducing "a professional conversations model" as part of their approach to meeting need and applying threshold guidance.[xiii] This ensures that process does not trump professional conversations or relationships.

- *The Board should think about how best to equip staff across the system to use the support and help available to them and how best to work together at the point of referral through holding professional conversations about the issues, as well as how and when to consider using step up and step down procedures*

Use of escalation processes if staff do not agree

Not only were referrals in effect "sent back" to the FSP and HV's1 and 2, a decision to take the case to a Case Transfer Meeting did not take place, not did a request for a consultation with the Consultant Social Worker. This latter request was attempting to utilise one of the new mechanisms introduced to prevent cases getting "stuck"

None of the professionals utilised the SSCB Escalation Policy and processes. It is crucial that professionals understand and use the processes available when they disagree professionally and the difference of view cannot be resolved.

- *Professionally respectful challenge is important, but so is confident escalation when concerns are not allayed and the actions suggested will not achieve better outcomes for the child involved. The Board needs to 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.*

KLP 4: Epilepsy and its impact

Not long after his birth Baby E was diagnosed with a chronic condition. Whilst he was not a sick baby he had recurrent sometimes prolonged seizures, required medication, especially when a seizure was happening, and required both regular specialist treatment, and regular hospital admissions.

The pressure for any new parents of having a baby with a diagnosis of a specific challenging condition is significant. It made caring for Baby E harder as it required far more focus, as well as the ability to maintain good routines, attend regular appointments and deal with often frightening seizures. The degree to which this was taken into account when considering how best to support the family to meet Baby E's needs is unclear, but it did not feature as a specific part of any assessment of parenting capacity.

Much of the focus of epilepsy specialists and others was on the health care plan and use of medication. They were not however included as part of the TAC/Family Network or asked to contribute to the TAC plan.

There is also evidence from the review that Mother X relied heavily on Father Y to respond even after they separated. Even though she demonstrated she could deal with Baby E's seizures and administer his Buccal Midazolam medication there is strong evidence she frequently failed to carry it with her, or contacted Father Y to come and administer it.

Much of the concern expressed to professionals by Father Y and PGM as well as by HV1 HV2 and FSP (and the police in relation to one referral) was that that she was not providing optimal care to avoid seizures. Baby E's feeding patterns were erratic, he was sometimes cold and underdressed, sometimes overheated and overdressed and he was often left unsupervised or checked for considerable periods. MGM was a protective factor in that she spent a lot of time with Mother X and ensuring Baby E's care was good enough.

Key Learning

It is 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. It seems to have been seen as a separate set of needs requiring a separate set of professional plans and networks rather than as integral to how well Baby E was cared for. The fact that Mother X was not always avoiding things that could exacerbate Baby E's epilepsy was a real concern to those professionals directly involved but it does not

appear to have been sufficiently taken into account by the wider network, particularly in relation to whether the TAC process was achieving sufficient change.

It is also not clear how much weight was given to the concerns expressed by Father Y in particular, and whether his entirely appropriate concerns were not heard because of the distractions caused by the tensions between the maternal and paternal family members for professionals, or because his additional needs led professionals to underestimate of discount his views, or both.

- *The Board should consider how best to ensure frontline practitioners 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.*

KLP 5: Working with a case that is not progressing

It is clear that throughout Baby E's life professionals sought to change tack in different ways to respond to the changing circumstances of his family life and the way in which his parents, and in particular his mother were behaving. Each attempt was for one reason or another (well documented in the records) thwarted. Staff felt "stuck" and supervisors felt "stuck" too.

Looking retrospectively at what happened in Baby E's life things went up and down in a cyclical way, with peaks of activity, involvement and concern followed by periods of relative calm, where plans were made to improve how Baby E's family cared for him but not necessarily achieved. It is noticeable that the more complex the situation became, the less clear interventions and plans were.

It is also clear that when concerns grew practitioners looked to Social Care to intervene and when this did not happen they felt unable to address the concerns as effectively as they wished. The more risk grew the more the system withdrew. This is linked to the perceived limitations of the Early Help TAC/CAF approach, and to the MASH believing that Family Support Staff and Early Help Services had the skills and abilities in place to manage the degree of growing risk safely and well without discussing this with them.

Linked to the other learning points in this review is the significant issue of how practitioners and frontline managers move a case forward when it is stuck and not progressing, or is at danger of the adults withdrawing their cooperation.

Towards the last stages of Baby E's life, professionals took the perverse action is to close a case because Mother X had withdrawn her cooperation. Added to this was the fact that those key practitioners who knew the family well and were committed to ensuring Baby E was properly cared for and had tenaciously and increasingly challenged the maternal family withdrew or were withdrawn one by one after complaints were made by the maternal family about them. The removal of Baby E's strongest advocates in the absence of clear explicit plans for addressing risk had the effect of dissipating the degree of concern about the family and Baby E's welfare and safety.

The logical thing to do in these circumstances is to seek to escalate and transfer the case for a stronger more risk and safeguarding focussed intervention and a full

assessment. Although attempts were made to do this each one failed. There was an absence of any effective assessments of and understanding about family functioning, or of the needs of the adults and their capacity to change. Such assessments would have informed more robust decisions about “what to do next”.

There is also no doubt that whilst the MASH and Social Care staff thought step up and step down processes were clear and in place, externally other agencies were unclear. Similarly the SSCB thought there was an escalation process in place but agencies were not ensuring front line staff were aware of it and using it.

It is also noticeable that as Cafcass became involved the rest of the system (with the exception of Specialist Nursing and Universal Health Visiting) pulled out.

The Review Panel took the view that in Baby E’s case there was a systemic combination of circumstances, which meant the more the case got “stuck” the more practitioners felt unable to act. The absence of clarity about step-up/step down processes, the impact of repeat referrals resulted in no helpful interventions.

The increasing ability of the maternal family to use complaints systems and anger to prevent their own problems being challenged effectively resulted in staff who felt undermined and unsupported by their agencies.

The absence of strong and effective management and leadership, alongside a lack of clarity about who was “in charge” of multi-agency efforts to work with the family significantly reduced the impact of early help interventions. These factors, combined created the opposite approach to what should have happened.

This occurred at a time when health visiting and early help services had been integrated after the Making Every Intervention Count new operating model was introduced in April 2015 but the appropriate lines of clinical, professional and management supervision had not been fully resolved, and supervisors skilled up accordingly. It is clear managers as well as staff found it hard to take a whole family, whole system, risk aware and assertive practice approach. Those in supervisory roles were not familiar with the potential professional tools and models of intervention that could have been used to intervene, assess, understand, and underpin purposeful TAC plans and provide evidence of change. Nor were they sufficiently aware of step up, step down processes or the escalation policy.

Key Learning

In Early Help Services, there needs to be a clear strong, unequivocal and easily accessed process for stepping up intervention when needed, without relying on referral processes to increase the degree of statutory authority brought to a case.

This needs to be coupled with a strong application of a practice framework which values escalation of cases as an appropriate course of action. Simple clear pathways and practice frameworks assist and the LSCB has a crucial role is ensuring those simple pathways, processes and framework are in place.

Simple frameworks are important and necessary but the key ingredient in successful case progression is effective supervision, and reflective management. This was not well evidenced in any agency although there is evidence of case and task focussed supervision and management oversight. The nature of that oversight in this situation

was insufficiently informed by appropriate skilled professional challenge or interrogative reflection about what was actually happening for the children, or by analysis of the underlying behaviours of family members and their impact on professional relationships.

- *The Board should 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 Protection.*
- *The Board needs to review and refresh 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.*

KLP 6: Leadership, management and supervision

At the heart of good safeguarding practice is the ability to make sound decisions about the safety of children. Decision-making tools are helpful and should only ever be used to *assist* in decision-making and only where the validity of such tools has been seriously explored. Good decisions still depend upon frequent and high quality dialogue with expert practice supervisors to help develop and test hypotheses about what is happening within families whilst the use of tools as part of single agency and multi-agency processes can only support decision-making and lead to more structured professional judgments about risks and the safety of children.

It is clear that throughout this case frontline staff dealing with the family needed a high level of support and supervision. For the majority of time frontline staff were given practical supervision and were supported to an extent with the challenges of the case. The review shows however that some practitioners got limited supervision/support and they were not well supported to better understand, reflect on and analyse what was going on for Baby E.

It is also clear that frontline managers were also not always as robust as they needed to be in terms of having a good strong grip on case management. They found it challenging to step out of the detail of case management and take a “helicopter vision” view of what was happening systemically.

Their capacity and ability to provide support and also opportunities for practitioners to reflect and evaluate as well as analyse what was happening within the family, the family support network and the system was limited. Discussions designed to try to understand the causes of what was really going on were not consistently used. Processes at times trumped analysis, reflection and evidence as did a focus on “what to do” rather than on “why” to do it. Managers were also unclear about the interface between step up/step down and the relationship between the threshold model and step up/step down processes.

The use of the tools available to practitioners was not always suggested by front line managers and access to tools and frameworks to support the practitioners in their interventions not promoted. There was not always a thorough understanding of policies and processes.

Key Learning

The behaviour of the adult family members was not properly recognised and analysed, and action to address it properly did not happen. This was all the more an issue when both frontline practitioners and their managers were worrying about the voluntary nature of Early Help and the perceived need to keep Baby E's parents engaged.

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.

- *The Board should consider what additional workforce development and knowledge acquisition, as well as system and process change, is required in order to support and equip leaders, managers and supervisors across a range of agencies to*
    - *manage Early Help services effectively,*
    - *to take a whole family approach,*
    - *to work systemically and*
    - *decide what specific support is required for lead professionals to act to best effect.*

KLP 7: Working with adults with additional needs

Both of Baby E's parents had additional needs but the degree to which these were properly assessed and understood, in relation to the capacity of both of them to parent well enough with or without support was limited. Whilst Father Y had his own Social Work support, as well as ongoing input from Mental Health Services the practitioners providing that support were not drawn into, or engaged with the Early Help being offered, asked for advice or information or included as part of the family support network. If they had been it is unlikely the difficulties in implementing the ACCORD protocol would have been experienced as engagement in a whole system/whole family approach would have automatically triggered it.

In addition someone who knew Father Y well would have been able to help children's practitioners understand and interpret Father Y's behaviours, engage with him in a collaboratively and cooperative way and build on his strong desire to be a good father. It is noticeable in his discussions with the Review Team that Father Y could articulate

what he was concerned about in terms of what poor parenting looked like. The degree of weight to put on that understanding whilst working with the family would have been better informed if his Personal Assistant or Social Worker was involved.

In addition they would have helped practitioners understand that Father Y genuinely saw professionals as a source of help, support and advice, was cooperative despite his challenges in terms of impulse control and anger management, was predisposed to look to others to tell him what to do and was potentially scared of Baby E's mother's behaviour and willingness to block his access to his son if he disagreed with her. It may also have improved the weight given by professionals to Father Y's entirely legitimate concerns about the quality and consistency of care being provided by Mother X.

Whilst it was clear that Father Y had diagnosed conditions and additional needs which had an impact on his ability to parent Baby E it was never clear whether Mother X also had additional needs. Some records referred to her as having learning difficulties, and practitioners believed that she did but she never referred to herself as having additional needs. It is clear that her adverse experiences in her childhood had affected her ability to make and sustain good relationships, and given her a deep routed negativity about social work intervention.

The Review panel found no evidence that Mother X's experiences as a child and adolescent were considered in the work undertaken with Mother X. Professionals should have been aware of the significant body of research evidence from a wide range of disciplines showing that without strong protective factors, adverse childhood experiences are likely to have long-term consequences for the adult the child will become.

The extent to which these factors impacted on Mother X's capacity as a parent was never explored. Nor was her capacity or motivation to change what amounted to neglectful parenting behaviour. This latter issue is an important one as there is considerable evidence that Mother X did not accept the concerns expressed by professionals and was not committed or motivated to change the way in which she parented Baby E.

Brandon et al (2009) noted that '*many… families are not straightforwardly voluntary or co-operative, which provides considerable challenges for making voluntary systems [such as TAC and Child in Need] work*.' These systems only succeed in helping and protecting children if professionals are confident about working with and supporting parents, but importantly also maintaining a focus on the needs of the children. Professionals must be able to recognise when it is necessary to step-up to a different framework for intervention, and how to put this across when there is no obvious change in presenting circumstances. They must also be able to evidence why it is necessary to do so.

Key Learning

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 to a new level o 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 of how best to work with them and safeguard their children.

- *The Board should consider how to build on and develop the current review of the ACCORD protocol to develop a whole family approach, with clear cross service pathways, protocols and practice standards.*

KLP 8: Assertive confident practice with challenging parents

Throughout the whole of Baby E's life there is ample evidence of the ability of the family, to undermine, challenge, divert attention onto themselves and their own needs, behave aggressively and threateningly and use hostility and complaints to avoid too much of a focus on the children's care. MGM and Mother X were also able to use their previous experiences of the system and working with professionals to present with what is often called "false compliance" or provide short term reassurance rather than long term sustained change.

There was also an absence of clarity about MGM and PGM's roles in terms of both the support they were providing, the degree to which they were acting protectively towards Baby E or putting their own child's interests first, and the degree to which the deep rooted conflict between them diverted the attention of professionals from Baby E himself. The focus on conflict between Baby E's parents and grandparents had the effect of obscuring the reasonable concerns and issues expressed by Father Y and PGM to professionals about what was happening.

Whilst to an extent this was "family business" it became a very successful diversionary tactic. Professionals were also deflected from focussing on what needed to happen for Baby E by the way Mother X and MGM controlled their access to the household or to being able to observe how care was provided. Mother X also forced professionals to ameliorate their challenges by threatening to withdraw from the CAF/TAC process whenever she felt threatened by the legitimate challenges being raised.

In addition at least one agency, the school, did not make a referral when they normally would because they were afraid of the reaction it would provoke from Mother X.

Another major piece of learning from the review is the degree to which the use of complaints procedures de-skill and paralyse staff. An organisational expectation that staff who are the subject of a complaint withdraw from active engagement with the complainant is unhelpful and disruptive, and can exacerbate risk. In addition the fact that there were multiple complaints running was not discussed or shared across the family support network. This is not unusual as complaints tend to be kept confidential. If each agency had known about the other complaints responses may have been different but so would the multi-agency understanding of what was actually happening and how Mother X and MGM were avoiding challenge.

Suffolk SSCB has provided sound and clear practice guidance on working with hard to engage families within the context of safeguarding. Adopted in 2010 it was revised and reissued in September 2014 not long after Baby E's birth. The Review Panel found no evidence to suggest that this guidance was accessed or used by practitioners or managers to help them manage the case more effectively. There is also ample research available to practitioners on effective ways to engage.

It is also clear that whilst Father Y was frequently seen as challenging, he was well known by adult services and his skills and abilities understood. If adult services had been more engaged the degree to which Father Y was demonstrating appropriate parental concerns about Mother X's parenting, and behaviours may have been better recognised.

Key Learning

As set out already Early Help requires a workforce that is as well trained, skilled, informed, supervised and managed as the Child Protection and Social Work workforce using the same tools, assessments, intervention techniques and frameworks, and similar rigorous processes.

Brandon et al are clear 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.

A range of SCR's in the past five years have shown that professionals working with adults who have additional needs who are also parents, should automatically consider the additional needs of those adults in relation to their parental responsibilities. This includes assertive challenge of those parents by adult service professionals and advice about how best to interpret certain behaviour when assessing parenting capacity and risk. Adult professionals should be part of the TAC or child in need plans as well as by children's service providers and practitioners in any circumstances where the parents involved have specific additional needs and are known to Adult Services.

"Ordinary Lives" protocols should ensure children's practitioners involve adult services and vice versa in these circumstances as should the local working together requirements.

- *The Board needs to consider reviewing its standards and protocols for working with challenging adults, jointly as necessary with the Adult Safeguarding Board*
- *The Board would benefit from re-evaluating what the curriculum for multi-agency as well as single agency training should contain in order to give frontline staff and managers the skills they need*
- *The Board should also work with each partner agency to evaluate how best to ensure complaints procedures are robust, respectful and focussed on the needs of children and adults but are not applied in a way that undermines or disempowers staff*
- *The Board may want to consider developing a protocol for when to share information about complaints made by challenging parents with the family support network*

8. Conclusions

This was not a high risk Child Protection case, but a “normal” Early Help case. The nature of the concerns would be regarded as a challenge for CYPS whatever the level of intervention needed. However the family were similar to many others that came to the attention of a range of professionals, and would not have raised many high level alarm bells. The concerns were significant but inconsistent and never as easy to identify as acute neglect or physical injury would have been.

Baby E died unexpectedly and there are at present no known causes for his death. His life was not always as good as it could and should have been and at times he was caught between feuding adults, neglected, and used as a “tool” in an unhappy relationship breakdown. His needs were not always met.

What does looking at Baby E’s life tell us and what can agencies in Suffolk collectively learn from it?

As well as all the Key Learning Points addressed in this Report, and many others identified by each agency in their own review of what happened and discussed at the learning event it is clear that for Early Help to work most effectively for this and many other families the local partnership needs to develop two key cultural expectations of all practitioners and managers:

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

The changes needed to ensure Early Help is effective requires the conscious embedding of responsive cultures across the workforce; practice that is based on long term models of support rather than episodic interventions; that takes a long term view from the child’s perspective as well as the parent (ie will this intervention help this child grow up as a well-adjusted adult rather than will it solve the immediate issue); that understands cumulative adversity and its impact on children; and that is underpinned by regular explicit planning, monitoring, reviewing and revision.

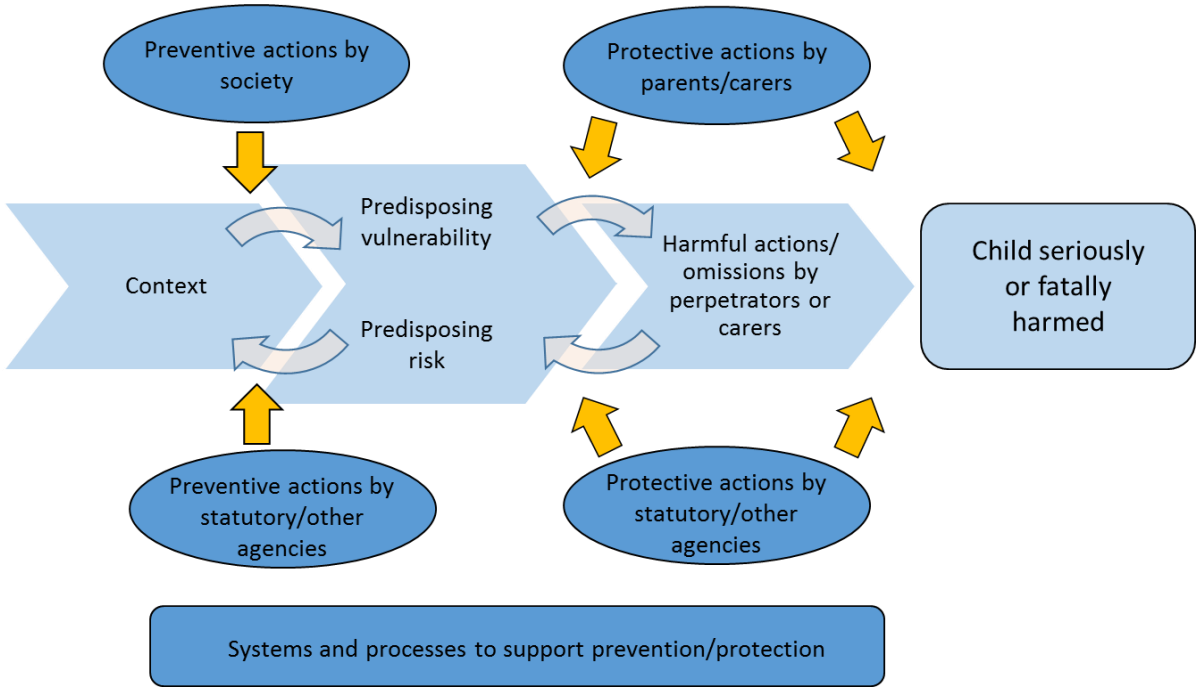
Two issues were identified where system change would result in improved frontline practice.

- The need for a system which recognises Early Help as an opportunity for prevention and protection.
- The importance of a workforce that recognises professional challenge and a positive practice cycle

The first issue is related clearly to the learning about how Early Help was working in Suffolk, the degree to which the task was fully understood by those involved, the support offered and the guidance, tools, systems and processes in place to support it. It is helpful when considering how to address this, to consider findings of the Third

Triennial Review of SCR's 2011-14 (ibid). The review concluded that systems thinking needed to be expanded to address exactly this issue. A revised model of multi-agency systems was developed as a consequence and is set out below.

Model 1 Identifying Opportunities for Prevention and Protection



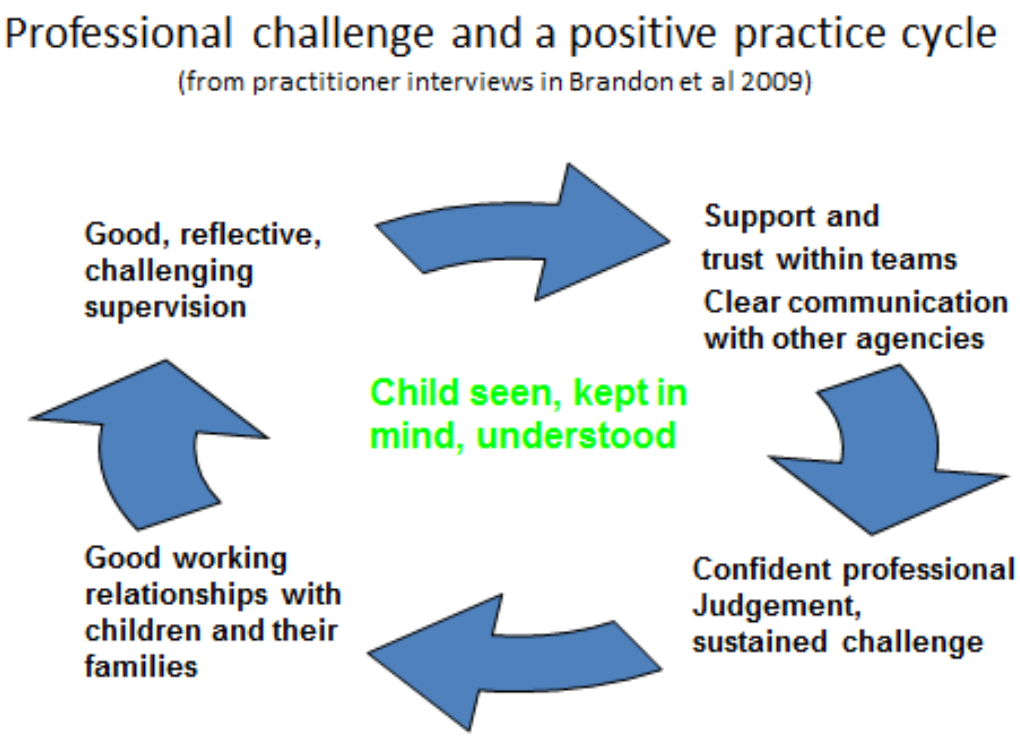
This is entirely in line with the intent of the changes in Suffolk that have been underway in the last three years. However this Review demonstrates that the degree to which those changes resulted in system, process and practice change in 2014 and 2015 is limited. How this has changed subsequently is a matter that the review would suggest needs clarification.

The Review concludes that it would be appropriate for the Suffolk Safeguarding Children Board (SSCB) to evaluate the current multi-agency Early Help and Child Protection (ie the whole safeguarding) system against this model, assure itself as to the effectiveness of changes made since Baby E's death and support the implementation of any organisational, operational, system and practice changes that may arise as a consequence of this review and system evaluation exercises.

The model also provides a helpful framework for multi-agency front line staff to better understand their own roles and responsibilities within the system. A range of briefing materials for different professional group arising from the Triennial Review is available as are some group work material to help develop staff understanding. It may be helpful for the SSCB to utilise this material whilst disseminating the learning from this review.

The second issue is the importance of a workforce that recognises professional challenge and a positive practice cycle. This is clearly related to the learning about staff confidence, competence, management, support and supervision. A clear model which describes this well was developed by Brandon et al in 2009.[xiv]

Model 2



This review has identified that on a single and multi-agency basis there was insufficient evidence of this professional practice cycle being part of everyday practice. Whilst elements of it existed practice frequently fell short. This family were similar to many others that professionals from every agency that has contact with children would and are involved with. The SSCB would benefit from considering whether it provides sufficient clarity of expectation to agencies in terms of what a strong workforce development framework should include and the standards of practice it should aspire to.

Finally it is clear that much of what happened was in response to adult behaviour and adult concerns. Baby E, whilst the focus of concern, was not always the subject of discussions, debate, and professional practice. It is salutary to recognise that even when much of what happened for him was likely to improve if only temporarily his life experiences but that no one really kept asking “what is life like for this baby?.

SSCB needs to consider how best to ensure every agency and every practitioner uses that question as the core practice question and assuring itself it is at the forefront of everyone’s practice.

Appendix One

SERIOUS CASE REVIEW – Baby E

STRUCTURE & TERMS OF REFERENCE

Introduction

Baby E was a 17 month old infant child who was found by his mother cold and blue at approximately 1500 hours on Thursday 21 January 2016. He was bought to Ipswich Hospital by ambulance but attempts to resuscitate him were not successful. It appears he had probably passed away some hours prior to his arrival at hospital.

Since 2009, a range of services have had contact, and at times, direct involvement with the family. The family was open to CYPS Specialist Services prior to Baby E's birth. The case was stepped down to the Early Help Team in February 2014 until October 2015 when it was closed.

The case was referred formally to the Suffolk Local Safeguarding Children Board on 22nd January 2016 and their Case Review Panel met on 15th February 2016 to consider the case under Regulation 5 of the LSCB Regulations 2006. The Panel found that this case met the criteria for a SCR and agreed commissioning arrangements in order to meet the requirement of such reviews as laid out in HM Government 'Working Together to Safeguard Children 2015.

The names of the family and the circumstances of Baby E's death may be known locally, but the SCR Panel is not aware of any wider media coverage. **For the purposes of the administration, the subject of this Review will be referred to as 'Baby E'**.

1. Subjects of review

The subject of this review is:

Baby E

Date of Birth: 24.08.2014

Date of Death: 21.01.2016

Mother of the Child is X

Date of birth: 02.04.87

Half-sibling of the Child is Z

Date of birth: 27.06.09

Father of the Child is Y

Date of birth: 17.10.88

2. Purpose and Aim of the review

To complete an independent review report for presentation to the Local Safeguarding Children Board (LSCB) within 6 months of commencing the review. The review should:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and LSCB;
- Examine inter-agency working and service provision for the child and family;
- Determine the extent to which decisions and actions were child focussed;
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress;
- Take account of any parallel investigations or proceedings related to the case;
- Hold a learning event for practitioners and identify required resources; and
- Support professional and organisational learning to promote improvement in future inter-agency child protection practice.

The completed report should:

- Be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- Be suitable for publication without needing to be amended or redacted.

This review is commissioned under statutory guidance issued by HM Government in Working Together to Safeguard Children 2015 and will be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight
- Is transparent about the way that data is collected and analysed; and
- Makes use of relevant research and case evidence to inform practice.

3. Methodology of the Review

The Government Guide *Working Together to Safeguard Children 2015* allows LSCB's to use any learning model consistent with the principles in the guidance, including systems based methodology. After careful consideration of the options it has been decided that this review will be conducted utilising the framework as set out for concise reviews in the Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012. The criteria for a concise review reflects the requirements set out in Regulation 5 of the LSCB Regulations 2006, Regulation 5(1)(e) and 5(2) as laid out in Working Together.

The Welsh framework requires the use of a concise child practice review in any of the following cases where abuse of neglect of a child is known or suspected and the child has

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health or development; and

The child was neither on the child protection register nor a looked after child on any date during the 6 months preceding –

- The date of the event referred to above; or
- The date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

These criteria are reflected in this case and so the model is appropriate.

This Review will be conducted using an Independent Reviewer, and supported by a Multi-Agency *Review Panel* chaired by an Independent Chair.

The *Review Panel* manages the review process and plays a key role in ensuring the learning is drawn from the case. Representatives should be appointed to the *Panel* from those agencies involved in the case, including adult services. The panel members should have working knowledge of the services but not have had had direct involvement in the case. Because the *Panel* is an integral part of the review process, it is essential that, once appointed, there should be consistency in *Panel* membership and in attendance at *Panel* meetings. Deputies should only be permitted in exceptional circumstances.

Services that have been involved with the child(ren) and family will be requested by the Review Panel to provide information of contact with the family by preparing an agency timeline of significant events (chronology) together with a brief analysis of relevant context, issues or events. Information about action already taken or recommendations by staff for future improvements in systems or practice may be included, if appropriate. The preparation of timelines (chronologies) and analysis should be undertaken by managers who have not had operational responsibility for the case but understand the service.

The Independent Review Panel Chair and Overview Report Writer will be supported by the LSCB Support Team, in particular, the LSCB Manager.

Timelines and Genogram

A timeline of 12 months preceding the incident should be prepared. The 12 month timeline may be extended only if there are exceptional circumstances to ensure the focus of the review is on current practice**. In this particular instance the panel has chosen to start the review from the birth of Baby E in August 2014.**

Where there is significant background information or a previous significant concerns, this can be included in the brief analysis accompanying the timeline (chronology). Family history is seen as important, but the critical issue in the Review is who was familiar with the family history, how it was shared within the professional network and how it was taken into account in the current decision making. **In this case the Case Review Panel has requested that permission be sought from both parents to allow access to their medical records.**

Review Panel

The *Review Panel* should produce a full and accurate genogram to be used during panel discussions and be available for reference during the review process, but not included in the published report. The *Review Panel* will produce a merged timeline of significant events. The merged timeline, genogram and agency analyses will then be used by the *Review Panel* and *Overview Reviewer* (Report writer) to develop questions and ideas about what happened in the case.

This initial understanding will inform the preparation of a learning event for practitioners and line manages to test out and further explore operational practice issues. The *Overview Reviewer* will also have access to and will read documentary and other relevant written material as appropriate. During discussion, issues for clarification may arise and the *Review Panel* will ask services to respond; the terms of reference for the review may be amended or extended as a result.

Involvement of family members

Suffolk LSCB recognises the value that the involvement of family members can have in the SCR process and will ensure their expectations are managed appropriately and sensitively.

As part of this review process the Overview Reviewer or a person nominated by the Overview Reviewer will engage with family members, if appropriate, so that views from family members can be included within the discussions and analysis of professional practice.

Learning Event

Practitioners and managers are expected to attend if asked. *The Review Panel* has responsibility for supporting the *Overview Reviewer* and *Panel Chair* in carrying out a successful event. At the conclusion of the learning event, the practitioners should have identified single and inter-agency issues and practice learning points for consideration and further discussion by the *Review Panel*.

Organisations who should contribute to the review:

Initial scoping suggests the following agencies:

a) Suffolk County Council Children and Young People Services
b) Suffolk County Council Adult Care Services
c) Suffolk County Council Legal Services
d) Suffolk Constabulary
e) Ipswich Hospital
f) Addenbrookes Hospital (via Ipswich Hospital)
g) CAFCASS
h) East Of England Ambulance Service
i) SCC Health (Health Visiting)
j) GP

Parallel investigations

Where the case is subject to police investigations or judicial proceedings, these should not inhibit the setting of a review or delay the holding of a multi-agency learning event with practitioners.

However, in the event that a parallel criminal investigation is, or becomes, active the Police representative member of the SCR Review Panel will work closely with the Review Panel Chair and Senior Investigating Officer to ensure that any interviews and/or information sharing takes place appropriately so as to minimise the opportunity for conflict between the SCR process and criminal investigations / CPS activity. This would be informed by current ACPO / CPS Guidance[1] around such parallel processes.

Media Liaison

Prior to final completion of the SCR Report the LSCB will determine an appropriate media strategy.

In the interim no information concerning this review or comment about this case attributed to the LSCB should be shared with the media without the express authority of the LSCB Independent Chair or in her absence the Vice Chair.

Liaison with outside bodies, including the DfE and National Panel of Independent experts on SCR's

Until full completion of the report and consideration of the content by the LSCB no information arising from it or in connection with it should be shared with any organisation outside of the review process without the express authority of the LSCB Independent Chair or in her absence the Vice Chair.

[1] Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews 2014, ACPO & CPS

For further information on the Welsh Model - Protecting Children in Wales

Guidance for arrangements for Multi-Agency Child Practice Reviews

www.cymru.gov.uk

http://gov.wales/docs/dhss/publications/121221guidanceen.pdf

http://gov.wales/docs/dhss/publications/121221learningen.pdf

Appendix Two

Core Tasks:

- Determine whether decisions and action in the case comply with the policy and procedures of named services and LSCB;
- Examine the inter-agency working and service provision for the child and family;
- Determine the extent to which decisions and actions were child focused;
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress;
- Take account of any parallel investigations or proceedings related to the case;
- Hold a learning event for practitioners and identify required resources.

Specific Tasks of the Review Panel:

- Work with the reviewer in accordance with guidance for concise reviews;
- Agree the time frame;
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken;
- Produced a merged timeline, initial analysis and hypotheses;
- Plan with the Overview Reviewer a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback;
- Plan with the Overview Reviewer contact arrangements with the family members prior to the event (where appropriate and in consultation with Police if there are parallel proceedings)
- Receive and consider the draft report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report;
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the LSCB for consideration and agreement;
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Tasks of the LSCB

- Consider and agree any Board learning points to be incorporated into the final report or the action plan'
- Review Panel complete the report and action plan;
- LSCB hold an extraordinary meeting to agree final report and sign off.
- LSCB confirm arrangements for multi-agency action plan, including how service improvements will be identified, monitored and reviewed and incorporate into a response document to accompany the Report.
- Plan publication on LSCB website
- Agree dissemination to agencies, relevant services and professionals
- The LSCB Chair will be responsible to making all public comment and responses to media interest concerning the Review until the process is completed.

Appendix Three

Key learning and messages from the Review for the Board

- *SSCB need to 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 assuring itself it is at the forefront of everyone's practice.*
- *The essential importance of ensuring 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. This finding was recognised by professionals at the learning event as a current issue and not just specific to this SCR.*
- *The Board should consider what range of tools and practice methodologies need to be put in place to support the use of SoSWB and the Early Help workforce to confidently assess, evaluate and balance risk and the family capacity to adapt and change and to adapt plans if that balance changes.*
- *The Board may want to consider how best to support partners to develop clear early help pathways, assessment and intervention tools and coordinated approaches on a whole family basis*
- *All front line practitioners working with Early Help arrangements need to be sufficiently well trained, informed, confident and competent if effective early help services and systems are to fulfil the purpose they are designed for.*
- *The Board may want to consider how best to refresh, disseminate, communicate and train staff across the whole system in working in a whole family way, and, in particular to use the ACCORD protocol as part of Multi-Agency Safeguarding Training*
- *They may also want to consider how to refresh, reissue and reinforce the use of the Escalation Procedures.*
- *The Board should consider whether they need to relaunch and promote the neglect strategy, after refreshing it.*
- *The Board should consider the implications of this SCR for their multi-agency training and workforce development programmes, as well as for the development of a shared set of systems, processes and tools to supplement and enhance the Signs of Safety and Wellbeing. The training should ensure frontline staff are fully alert to the impact of neglect and poor care on children's lives and outcomes over time.*
- *The Board should consider whether they need to relaunch and promote the neglect strategy, after refreshing it, and whether they need to specifically address the understanding across the multi-agency workforce of how neglect and poor care can be identified and addressed, and provide staff with a range of additional ways to use SoS to best effect.*
- *The Board should consider the implications of this for their multi-agency training and workforce development programmes, as well as for the development of a shared set of system, processes and tools to supplement and enhance SoS.*

- *The Board should think about how best to equip staff across the system to use the threshold guidance available and work together at the point of referral through professional conversations*
- *Professionally respectful challenge is important, but so is confident escalation when concerns are not allayed and the actions suggested will not achieve better outcomes for the child involved. The Board needs to 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 should consider how best to ensure frontline practitioners 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 Board should 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 Protection.*
- *The Board needs to review and refresh 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.*
- *The Board should consider what additional workforce development and knowledge acquisition, as well as system and process change, is required in order to support and equip leaders, managers and supervisors across a range of agencies to*
    - *manage Early Help services effectively,*
    - *to take a whole family approach,*
    - *to work systemically and*
    - *decide what specific support is required for lead professionals to act to best effect.*
- *The Board should consider how to build on and develop the current review of the ACCORD protocol to develop a whole family approach, with clear cross service pathways, protocols and practice standards.*
- *The Board needs to consider reviewing its standards and protocols for working with challenging adults, jointly as necessary with the Adult Safeguarding Board*
- *The Board would benefit from re-evaluating what the curriculum for multi-agency as well as single agency training should contain in order to give frontline staff and managers the skills they need*
- *The Board should also work with each partner agency to evaluate how best to ensure complaints procedures are robust, respectful and focussed on the needs of children and adults but are not applied in a way that undermines or disempowers staff*
- *The Board may want to consider developing a protocol for when to share information about complaints made by challenging parents with the family support network*

The impact of applying the single and multi-agency learning arising from this review to be completed by the Board when they have agreed what action to take to deliver the key learning.

References and Source Documents

[i] Working Together to Safeguard Children – A guide to Inter-agency working to safeguard children and promote their welfare; 2015 – S7 Guidance Her Majesty's Government HMSO 2015

[ii] Local Safeguarding Children Board (Wales) Regulations 2006 as amended 2012 Her Majesty's Government HMSO

[iii] Protecting Children in Wales 2012 – Guidance for arrangements for Multi-Agency Child Practice Reviews Welsh Government HMSO

[iv] The Common Assessment Framework is a framework for multi-agency assessment of the need to provide additional help and support to a child where without that help the child may not have their welfare promoted well enough, or the risk of significant harm may grow. It is usually used when the criteria for intervention by social workers is not met

[v] Meeting the Needs of Children in Suffolk - Local Protocol for Assessment including Multi Agency Thresholds Guidance

[vi] The Suffolk ACCORD protocol is designed to ensure that adults with specific needs of their own for social care support who are also parents are given additional support to enhance their parenting capacity

[vii] Munro E. A child-centred system DfE 2011

[viii] Woods D (2010) Behind Human Error

[ix] Brandon M et al: (2008) Analysing Child Deaths and Serious Injury through abuse and neglect: What can we learn? A biennial analysis of serious case reviews 2003-2005. Research Report DCSF-RR023. University of East Anglia

[x] www.rip.uk

[xi] Signs of Safety is a specific model of intervention adopted by many local safeguarding boards with their partners. It was adopted by Suffolk in November 2015. It is a model based on working with the whole family, restoratively, and collaboratively, in a multi-agency and systemic way

[xii] Brandon et al. DFE Neglect Missed opportunities (2014)

[xiii] Leeds LSCB and Medway LSCB based on ethnographic action learning by Professor David Thorpe

[xiv] Learning from Serious Case Reviews - Report of a research study on the methods of learning lessons nationally from serious case reviews Brandon et al 2009 Research Report DfE-037