Response to Serious Case Review: Child N (May 2015)

Lancashire LSCB has this month published a Serious Case Review about a child known as Child N. The full review report is available at this link:

http://www.lancashiresafeguarding.org.uk/resources/serious-case-reviews.aspx

The death of Child N was a tragic event and members of Lancashire and Liverpool Safeguarding Children Board would like to extend their sympathies to Child N's family members.

A statement has been issued on behalf of Jane Booth, Independent Chair of Lancashire Safeguarding Children Board and Howard Cooper, Independent Chair of Liverpool Safeguarding Children Board:

> "This child's death was a tragedy and our sympathies go out to everyone involved. The Serious Case Review, carried out by the NSPCC, has looked into the complex circumstances around his life and death and found that it would not have been possible to predict that he would be harmed in this way.
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> The review enabled professionals to look at their actions to see if there was anything that could be done in future to further improve working between agencies and safeguarding for children. The findings and issues for consideration from the review have been endorsed by both Lancashire and Liverpool Safeguarding Children Boards.
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> The agencies involved have already begun to make changes based on the review's findings. Both boards will continue to make sure that all agencies have put in place effective responses which ensure that learning from this tragic event improves the way professionals keep children safe in the future. "

Family members have contributed to the review and been kept informed of progress. Their contribution has helped inform the learning from this review. Lancashire and Liverpool Safeguarding Children Boards and the independent reviewer would like to thank them for their contribution which we know has not been easy due to their loss. It has enabled us to develop a fuller picture of the child's life and greatly assisted in identifying key learning points that will enhance professional practice for children and young people.

Both LSCBs wish to acknowledge that, following the conclusion of the review, child N's father has expressed dissatisfaction with some aspects of the review process and the outcome of the review, particularly in respect of whether Child N's death was preventable. Both LSCBs acknowledge this frustration whilst also noting that the father has commended the review for identifying and bringing about changes to professional practice. It is important to emphasise the key lessons from this review will be subject to intense scrutiny from both LSCBs.

Background

In May 2014 Child N and his mother died in a house fire in Liverpool. At the subsequent inquests, the coroner ruled that Child N had been unlawfully killed and that his mother had deliberately started the fire.

The case was considered by the Lancashire Local Safeguarding Children Board at its serious case review subgroup on 5 June 2014 under Regulation 5 of the Local Safeguarding Children Board Regulations 2006. The subgroup found that this case met the criteria for a serious case review and agreed the commissioning arrangements in order to meet the requirements of such reviews as laid out in HM Government 'Working Together to Safeguard Children', 2015

Kevin Ball, senior consultant with the NSPCC, a safeguarding specialist, was commissioned as the lead reviewer to complete the work using a systems-based methodology. This methodology allows full participation by both front line practitioners and surviving family members. The primary purpose of the review was to examine the involvement that many agencies had with Child N, and his family, and identify the learning for practitioners and organisations that may help when working with families in the future.

The family had extensive involvement with professionals (with longstanding on-going private law proceedings). The review therefore included professionals from both Lancashire and Liverpool and both safeguarding children boards. The review was presented to a joint Lancashire and Liverpool special safeguarding children board meeting on the 15th April 2015. Its findings have been accepted.

The Serious Case Review concluded that the professionals involved with Child N and his family, in both Lancashire and Liverpool could not have predicted or prevented Child N's death. However, the review has identified areas of learning for practitioners and organisations that will assist in working with families in the future.

Detailed action plans have been produced by individual agencies in response to the findings of the review. The progress of these action plans will be monitored on both a short and long term basis by the serious case review group of Lancashire Safeguarding Children Board and by both the Lancashire and Liverpool boards.

The following is a summary of some of the work undertaken to address the findings of the review.

Key progress to date:

Lancashire Children's Social Care

A briefing has been issued to all staff reminding them that all recording case files involving other Local Authority areas should be kept up to date. Private law training has now been made available to all social workers.

Lancashire Care Foundation Trust (LCFT)

A programme of training updates and improved supervision models have been implemented across the organisation focused on addressing the lack of professional challenge and over-optimism identified within the review. The trust has committed to increased attendance by LCFT representatives at 'out of area' children in care Reviews. Measures to increase the continuity of health professional in care cases have been introduced.

School

Has developed a template and building communication links for obtaining information from nurseries when children enter school, increased awareness of who to contact for safeguarding advice, and is implementing clearer policies for communication with allocated social workers.

Lancashire Constabulary

In all 'local' cross border investigations the victim will be interviewed by the investigating officer where appropriate, rather than transferring responsibility to the neighbouring force. Training has been provided to officers to always consider whether Police Protection Powers should be used in cases of private law orders not being adhered to.

Private Day Nursery 1

Clarity has been introduced about not offering medical advice or opinions about children, about improving recording processes and also about always dealing with any unexplained marks or bruises in an appropriate and safe way. The nursery has also implemented improved templates and supervision arrangements.

Liverpool GP

Enhanced links with health visitors have been developed and improvements to the electronic templates for recording GP information. Further work is planned on a baseline audit of safeguarding arrangements in primary care, and improving the registration process for children.

Liverpool Children's Services

Significant work has taken place in line with this review and the service has adopted the key findings and recommendations found in a recent Ofsted inspection. Realistic and appropriately "weighted" caseloads have been introduced. A number of associated tasks have also been completed, such as introduction of caseload management tools and a significant service restructure. Work is on-going around reducing stress related sickness absence. Clear timescales for completion of risk assessments have also been established. Where necessary social workers always use interpreters with families whose first language is not English. Significant resources have been invested in procuring a new electronic system of recording which is to be implemented shortly. This new system will enhance practitioner and management functions and bring significant improvements to performance. A clear quality assurance framework has been developed around recording.

Liverpool Women's NHS Foundation Trust Hospital

Has developed and is progressing an action plan to review and clarify the referral process into the safeguarding team.

Liverpool Community Health NHS Trust

Has developed a clear action plan to improve supervision processes, awareness rising about specific issues (such as domestic abuse and mental health issues), communication with other agencies (which should also include seeking information about other siblings when visiting younger children) and the completion of chronologies as per expected procedures.

Royal Liverpool & Broadgreen Hospitals Trust

Identified an issue with illegible signatures on records, which has been addressed by training. This will be audited on an on-going basis. Increased awareness of cultural issues is being addressed through training.

Alder Hey Children's NHS Foundation Trust

Enhanced management of allegations procedure with clear timescales are being introduced. Training around professional challenge has been introduced and reflected in the trust's procedures.

Merseyside Police:

Liverpool Basic Command Unit (BCU) has increased staffing to manage increased investigations. It has also invested in additional Police Support Staff to ensure timely inputting of Vulnerable Person Referral Forms 1 (VPRF1) and Risk Assessing. This has had a significant impact on administrative delays and provides front line operational officers and investigators with an accurate intelligence assessment of the incidents they are dealing with.

Merseyside Police has adapted its Command and Control deployment database (Storm) to ensure that basic question sets and activities are completed before an incident is closed. It has also ensured that incidents cannot be closed without the knowledge and endorsement of an operational supervisor and a control room supervisor.

Training has been delivered to all front line officers and control staff to support the new processes.

The Multi Agency Risk Assessment Conference (MARAC) process has been reviewed and continues to be re-assessed to measure its capacity and effectiveness.

Liverpool now has a Multi-Agency Safeguarding Hub (MASH) to support and co-ordinate effective agency referrals and communication. This went live on 7th April 2015.

Private Day 2 Nursery

Procedures have been updated, training has been delivered and supervision processes improved to ensure practice is quality assured.

Lancashire LSCB

1. To oversee the implementation of single agency action plans arising from this Review and reflect on progress in the annual report. In overseeing the implementation the LSCB will establish timescales for action to be taken, agree success criteria and assess the impact of the actions.

The SCR sub group of Lancashire LSCB will actively monitor progress on actions from the Lancashire agencies by requiring updates every other month. In addition, the SCR sub group will request quarterly updates from Liverpool LSCB detailing progress Liverpool agencies have made with their action plans.

All the findings from SCRs are built into training courses delivered and commissioned by Lancashire LSCB. In addition, all the findings form key lines of enquiry in multi-agency safeguarding practice inspections, so the impact of actions taken can be audited.

2. To ensure the learning from this Review is actively disseminated to all relevant agencies and practitioners.

All agencies that had involvement with this SCR have been asked to ensure their practitioners have been given feedback from the review prior to the publication of the final report.

At the point of publication, to ensure that the wider workforce is aware of the learning, Lancashire LSCB will publish a newsletter. This will set out the key findings from the review, and also offer links to further advice and guidance should practitioners need it. In addition, all the learning from this review will be included in the next large SCR briefing that Lancashire LSCB delivers in November 2015.

3. To consider the most effective means of providing guidance to Nursery settings about best practice around information sharing when concerned about the welfare of children.

At present, there is training offered by the Local Authority across Private, Voluntary and Independent day care settings, child-minders and out of school settings. There is an emphasis for the Level 2 training that the CP Nominated Officers should attend as they take the lead within the setting if any concerns arise. However, some Private Voluntary and Independent/Early Years providers will not access Local Authority training and will access it elsewhere, which they are entitled to do. They are required to meet Ofsted regulations but that does not necessarily mean accessing training via the Local Authority.

In both the Level 1 and Level 2 CP training that the Local Authority offers, 'information sharing' is discussed and addressed. More specifically, issues such as sharing concerns with parents (when to share and when not to share) when to refer direct Children's Social Care, multi agency working within the areas of CAF and statutory support are all covered. The Local Authority will update its training package to reflect findings from this and other SCRs.

The Local Authority will also provide additional resources for all settings. This will this include; The 7 Golden Rules for Information Sharing and the Information Sharing for Managers booklet.

Liverpool Safeguarding Children Board

1. To oversee the implementation of single agency action plans arising from this Review and reflect on progress in the annual report. In overseeing the implementation the LSCB should establish timescales for action to be taken, agree success criteria and assess the impact of the actions.

- The Critical Incident Group (CIG) of Liverpool SCB will actively monitor progress on single agency actions to ensure delivery against all actions agreed. Progress on actions will be presented, by CIG single agency representatives, to the monthly held Liverpool SCB CIG meetings. Monitoring of action plans will include; action delivery against timescales, assessment against agreed success criteria and assessment of the impact of actions.

- A quarterly summary on Liverpool agencies' progress on actions will be provided to Lancashire SCB Business Manager by the Chair of the CIG group and the Liverpool SCB Business Manager.

- An Escalation of Concern procedure has been introduced to enable all agencies to trigger detailed scrutiny of safeguarding issues in relation to any partner. This operates at a strategic level (in relation to performance city-wide), a tactical level (relating to the implementation of plans and actions) and an individual level (addressing concerns about individual children and families).

2. To ensure the learning from this Review is actively disseminated to all relevant agencies and practitioners.

- All agencies that have had involvement with this SCR will ensure that practitioners have been given feedback from the review prior to publication of the final report.

- At point of publication Liverpool SCB will share the Lancashire newsletter (or issue and amended Liverpool SCB newsletter) so as to ensure the wider workforce is aware of the learning from this review.

- Learning from this review, in conjunction with the SCR report, will be presented to the Liverpool SCB Learning & Improvement (L & I) Sub Group. L & I Sub Group members will be tasked to develop single agency learning from review dissemination action plans which will ensure that multi and single agency learning is disseminated widely within their respective organisations. Progress on dissemination activity will be reported to the L & I sub group.

- Learning from this SCR will be incorporated into LSCB 'Learning from Review Sessions' delivered as part of the LSCB multi-agency training programme.

- Learning from this SCR will be incorporated into LSCB Working Together and Working Together update training delivered as part of the LSCB multi-agency training programme.

- A multi agency learning event will be delivered to members and practitioners of the LSCB partnership which will focus on the learning from this review.

3. To schedule audits of single agency recording practices in order to judge the quality of recording against LSCB procedures and statutory guidance for safeguarding children.

- Liverpool SCB will require that a specific report is provided, by the main agencies in this review; Children's Social Care, Merseyside Police, Liverpool Community Health and General Practice, to the Liverpool SCB Executive Group on the outcome of case file audits in relation to the issues stemming from this SCR.

- Liverpool SCB will require partner agencies, as part of single agency Quality Assurance (QA) procedures, to undertake case file audit which incorporates a review of recording standards.

- Liverpool SCB Audit Sub Group will receive from single agencies 'quality assurance audit reports' which will provide findings from audit activity and detail of remedial actions implemented in response to any findings.

- Liverpool SCB will revise its Section 11 Audit standards for 2015/16 so that the existing standard *11.4; Organisation has in place a programme of internal audit and review that enables them to continuously improve the protection of children and young people from harm or neglect*, reflects the LSCB expectation that organisations include, within internal audit programmes, case file audit which includes a review of record keeping standards.