

MULTI-AGENCY CASE REVIEW Executive Summary

REVIEW ON:	DATE OF BIRTH:
JW:	26.06.1997
KP:	16.05.2000
BLP:	08.06.2002
AP:	06.01.2004
MP:	22.08.2005

DATE OF DEATH (if applicable)
Not applicable

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Author: NP
Post: Panel Chair
Date: 31.01.08

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S1 The Review Process

- a) Agencies that have contributed to the Review by producing Single Agency Review reports.
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|----------------------------|------------------------------------|
| Children's Social Care | - Stockton-on-Tees Borough Council |
| Sure Start | - Stockton-on-Tees Borough Council |
| Housing | - Stockton-on-Tees Borough Council |
| School Effectiveness | - Stockton-on-Tees Borough Council |
| Health Agencies | - NTPCT |
| National Probation Service | |
| Cleveland Police | |
| NSPCC | |
- b) The Chair of the Overview Panel met with mother of the children within this family who were the subject of interim care proceedings, to discuss the review.
- c) The Overview report was written by the Chair of the Serious Case Review Panel based on the analysis, findings and conclusions of the Panel to make focused and specific recommendations capable of being implemented.
- d) The author of the Overview report drafted this Executive Summary. It summarises the key issues arising from the case and lists all of the recommendations contained in the Overview report.

S2 Key Issues

- a) This review covered a period of nearly nine years involving five children and at least 60 staff from agencies within the Local Safeguarding Children Board.
- b) The analysis is broken down into four key areas:
1. Areas of Concern
 2. Recurring Themes
 3. Significant Events
 4. Examples of Good Practice

What is clear from the outset of this review is the lack of focus on the children within this family and the inability or unwillingness to see circumstances through the eyes of the children, by the vast majority of agency staff who were involved with the family during the period of the review.

Areas of Concern:

Neglect

- c) Despite 'neglect' being the largest category of registration on the Stockton-on-Tees Child Protection Register it is clear that agency staff struggle with a definition and response to presenting circumstances of neglect. This family's circumstances were at times exceedingly neglectful, but it is clear that there is not a common understanding of what neglect means for children amongst agency staff. Child Protection Conferences lacked focus and clarity about the categories of registration, which changed without any significant level of assessment. There was insufficiently robust challenge of the assessments that were presented and some staff were too passive in their approach to planning. The risk to the children by the presenting

neglect was rarely assessed within Conferences. It is acknowledged that all Agency staff have a role within conference to challenge decisions and information.

- d) Operational staff cannot escape their responsibilities in dealing with neglect. Core groups did not function, supervision plans were not followed through. Two Agency professionals did not receive or pursue clinical supervision for many months.

Recording

- e) The overview chronology highlighted that agency recording within this case was generally inadequate. Whilst the recording from health professionals was much more comprehensive, there were significant gaps in all agencies' recording in terms of what was said to staff from other agencies and more importantly what was recorded. The chronology highlights a number of significant pieces of information that were not passed on to colleagues from other agencies.

The Experience of Staff

- f) This case is one of chronic neglect, the SCR Panel was concerned by the lack of experience of some of the front line staff involved. It is also of concern that these workers were managed by experienced managers who should have supervised their workers more robustly.
- g) Within one agency this case was at times allocated to inexperienced qualified staff, unqualified support workers and students.
- h) Within another agency, the member of staff who was allocated and worked with the family for a number of years had only 5 months experience in their profession when work was first undertaken with this family.
- i) Whilst it is acknowledged that there are systems in place to support staff, the SCR Panel queries whether enough of the staff involved within this family had the knowledge and skills to work in these circumstances.

The Role of Line Managers and Supervisors

- j) The responsibility for assessment and decision making does not lie solely with practitioners. Within the overview chronology of this case there is a consistent pattern of assessments being commissioned and plans being made, only to find that they have not been followed up at the next Review, Core Group or Supervision.
- k) Within this Review it is clear that the mother did not co-operate with the Protection Plan, such as it was, and yet the children were ultimately de-registered from the Child Protection Register.
- l) This area of activity should be the core business of first line managers and supervisors, they should have ensured that actions were carried out and assessments were robustly challenged.
- m) It is clear that one agency worker had placed too much emphasis on the 'alleged' domestic violence that the children's mother was experiencing and appears to have played down the significant signs of neglect that were apparent at many of the visits that were undertaken.
- n) Similarly, another agency worker focused on the perceived mental health problems of the children's father/step-father and lost focus on the children.

- o) Most significantly, this case was closed just three weeks after an assessment had indicated that the home conditions were poor.

Lack of Continuity

- p) It is acknowledged that the world of employment is more turbulent than it ever was, as staff move posts, have sickness leave, receive promotions or cases are re-allocated for a variety of pragmatic reasons, however, the introduction to this section of the Executive Summary does give an indication of the lack of continuity in this case. Over a nine year period 60 agency staff played their part in this family.

The Role of Agencies with Statutory and Regulatory Powers

- q) During the course of the work for the Serious Case Review it became apparent that the circumstances of neglect that were being presented in the family home could have been addressed in part by statutory powers within the Housing Department and Environmental Health. It is important that operational staff are aware of the powers and responsibilities of these agencies.

Findings

- r) **Core Groups** – Within this case, Core Groups are insufficiently frequent and were not used effectively to plan and monitor actions, they were frequently poorly attended and consequently give the wrong messages to families about how seriously agency staff are viewing the registration of their children on the Child Protection Register.
- s) **Lack of Focus on Child Development and Growth** – The single agency reviews and overview chronology identified an absence of attention given to the development of the children within this family.
- t) **Effectively Managing Change in Neglect Cases** – the overview process raises a range of issues around how neglect cases are managed, within this case, supervision appears to have been insufficiently challenging, visiting lacked focus and appeared to be about monitoring rather than change and outcomes. There was a lack of effective assessment, staff involved in this case appear to be vague about neglect and its impact on the children and visits were often pre-arranged.
- u) These issues require further consideration within practice. The definitions of 'neglect' should be revisited at each review and there needs to be a general consensus around the 'tipping point' in a neglect case, when the level of neglect is no longer acceptable.
- v) **Core Assessments** – Despite the implementation of the Framework for Assessment in 2000 it still seems that core assessment is seen as a Children's Social Care exclusive responsibility rather than a multi-agency responsibility. Throughout this review there is very little evidence of a thorough Core Assessment.
- w) **Purpose of Visits** – Within this case there was a high number of abortive visits, the visits that were successful were scheduled rather than unannounced and it appears that the mother was allowed to dictate the frequency and timing of visits. This is unacceptable in a case like this and line managers and supervisors should have clearly identified the need for unannounced visits. There appears to be a lack of clarity as to why staff were visiting this family.

- x) **Injuries to the Children** – Whilst the main focus has been neglect, the number of injuries to the children cannot be ignored and whilst taken singly they were often explained, although not always satisfactorily, the overall picture is worrying, particularly when AP had 40 plus bruises on the day he was accommodated, none of which have been explained.

S3 Conclusions and Recommendations

Conclusions

- a) The Serious Care Review Panel has reached the conclusion that five children were let down by the agencies who are given the responsibility for protecting them. It would seem that in this case much of the focus of agency staff was on the behaviour of the principal adults, Mr LP and Ms AB rather than ascertaining whether the needs of the children were being met. This resulted in the children being neglected by their parents and failed by some of the constituent and failed by some of the constituent agencies of the Local Safeguarding Children Board. The Chair of the Serious Case Review Panel met with Ms AB on 24 July 2007 to discuss the review and has subsequently met with her regarding the findings.
- b) These were significant system failures within this case, as staff supervision, professionals meetings, strategy meetings, child protection conferences and protection plans failed to ensure active intervention in the lives of these children. These failures can be particularly attributable to line managers, supervisors and independent reviewing officers, although it is recognised that all agency staff/supervisors have to accept their share of responsibility for this failure.
- c) Individual staff involved in the case also contributed to failing these children. They did not see the impact of the neglect, domestic violence and possible physical abuse on the children nor did they visit the children frequently enough. At least two of the key workers did not receive supervision for months at a time. They were in regular communication with each other but did not seek out the challenge and guidance they could have received from regular supervision. Equally, Managers did not ensure that they were appropriately supervised.
- d) The history of this case appears to have been ignored and significant incidents were treated in isolation rather than considering the cumulative history of events and behaviour. The archiving of the original file and opening of a new one by the student social worker was a key event insofar as it created a 'year zero' effect.
- e) There were several missed opportunities to identify the potential significant risk of harm to the PW children from Mr LP's history of a sexual offence against a 3 ½ year old child until the February 2004 Child Protection Conference.
- f) The frequency of the Core Groups was insufficient to meet the purpose of the group, which was to meet on a regular basis in order to share up to date information and ensure the implementation of the protection plan stemming from the one child inter-agency report.
- g) The Review cannot ignore the fact that at least 60 agency staff worked with this family over a period of nine years. This is unacceptable and agencies, particularly Children's Social Care need to consider how this can be avoided and how change is managed in the future to ensure continuity of support.
- h) Managing 'neglect' appears to pose a significant challenge to the Local Safeguarding Children Board, it is clearly recognised by agency staff as half the children on the

Register are registered for neglect and yet ongoing chronic neglect was apparent in this family without a decisive intervention taking place. The Local Safeguarding Children Board must re-assure itself that this is an isolated case and that other children who are registered for neglect have thorough assessments and purposeful plans, which lead to positive outcomes in future.

Recommendations

- a) All Local Safeguarding Children Board agencies should investigate fully the conduct of their staff whilst working with this family and take any appropriate action that is deemed necessary in accordance with their own agencies procedures and advise the Local Safeguarding Children Board accordingly. Subsequent decisions should be immediately and appropriately acted upon.
- b) Child Protection plans and the process around them, with a particular focus on strategy meetings, protection plans and core groups must be child centred and comply with procedures.
- c) Independent Reviewing Officers/Conference Chairs must ensure procedures are followed, tasks are addressed and outcomes are achieved. Conference Chairs must use the appropriate management systems to highlight any difficulties in following procedures across agencies, or any irreconcilable differences.
- d) Local protocols and procedures should be reviewed, including the requirement for records to be signed off by managers and supervisors. All children's agencies records must be child focused, outcome driven and accurately reflect the work that is being undertaken.
- e) A mandatory Multi-Agency training programme must be developed and implemented, which identifies a common definition and understanding of neglect and its impact on children. This will include:
 - i) 'Think Child'
 - ii) The use of chronologies/critical incidents
 - iii) Standards in home conditions
 - iv) Effective visiting
 - v) Inter-agency guidance and training to be developed regarding action needed where sexual offenders are living with and in contact with children.
 - vi) Working Together
 - vii) The Framework of Assessment, including the purpose and function of Core groups.
 - viii) The conference reports to identify the professional who has provided the information.
 - ix) The statutory frameworks within which other agencies operate in relation to standards and neglect.
 - x) E Learning – Awareness of Child Abuse and Neglect.
- f) A review should be commissioned to audit all current cases on the Child Protection Register for over one year where the main or secondary presenting factor is neglect. This will identify whether procedures are being followed.
- g) A Sample of recently de-registered cases of neglect will also be reviewed to ensure full compliance with procedures.