Serious Case Review Child K

Learning and Improvement Report

18 February 2015

Preface

As a result of the tragic death of Child K in 2011 the Southampton Local Safeguarding Children Board commissioned a Serious Case Review (SCR), which has now been published. Members of the Board deeply regret the failings across the child protection system which have been identified through this review. The purpose of the SCR was to analyse the actions of each agency during the time they were supporting Child K and his family, to determine if lessons could be learned from the ways in which safeguarding services worked both individually and together.

This SCR has given the Southampton Local Safeguarding Children Board the opportunity to examine the effectiveness of our local child protection systems. The agencies involved in the review have shared information about their involvement with Child K and his family. This has ensured an honest and transparent enquiry into the quality of work undertaken so that we could identify gaps in services and missed opportunities.

In May 2014 the Southampton Local Safeguarding Children Board published three other Serious Case Reviews, relating to the tragic deaths of Bradley and Jayden Adams in 2011 (Child I and M) and to the abuse suffered by Child L and the children in the case of Family A.

The findings of the Child K Serious Case Review, along with the three other reviews published last year, showed significant failings in our child protection systems between 2007 and 2011. We have identified important lessons for all of our local agencies and significant action has already been taken to improve the safeguarding arrangements for children in Southampton.

I am confident that while more work needs to be done, a great deal of progress has already been made to address the gaps identified. This report summarises the learning and improvement actions agreed by the Board and its partner agencies to further strengthen our procedures, knowledge and skills.

Keith Makin, Independent Chair
Southampton Local Safeguarding Children Board

Introduction

In January 2015 the Southampton Local Safeguarding Children Board (LSCB) received an independent Serious Case Review report relating to Child K. Child K was taken to hospital in December 2011 with head injuries. He was unconscious and his condition deteriorated until his death two days later. Child K and his family were known to local safeguarding services as a result of repeated serious incidents of domestic abuse and concerns about the safety and welfare of the other children in the family. No criminal charges were brought in relation to Child K's death. HM Coroner's inquest took place 4th November 2013, recording an open verdict. The CPS have confirmed that there will be no criminal charges relating to Child K's death. The LSCB members wish to express their deepest sympathy to the family of Child K.

This document has been produced by the LSCB as a response to the recommendations made within the SCR report. It describes the actions taken by the LSCB and safeguarding services in the City to respond to the SCR's recommendations. It identifies the lessons for all agencies and improvements implemented since Child K's tragic death. It outlines how we will work to maintain the highest possible standards to safeguard children in the future. It should be read in conjunction with the LSCB improvement report and action plan [1]published in May 2014 in response to this case.

This Serious Case Review follows the publication of an additional three SCRs in May 2014. All of the Serious Case Reviews cover the period from 2007 to 2011 and identify significant failings in our child protection systems. The LSCB and its partners have taken radical action to improve safeguarding services in the City over the past two years.

The LSCB first considered the case of Child K in January 2012. The previous LSCB Chair deferred a decision as to whether there should be an SCR until it was known whether there would be a criminal prosecution and, also, until the results of a "Finding of Fact"[2] hearing from the Family Court were known. This was in relation to the siblings of Child K who had been brought into the care of the local authority. In June 2012 the Police reported to the Board that there would be no criminal prosecution and in January 2013 the Family Court reported its findings. At this time it was decided at a meeting of the Serious Case Review sub group that an SCR would not be commissioned, however this decision was subsequently reviewed by Southampton City Council and the LSCB and it was agreed in July 2013 that a Serious Case Review should be undertaken.

Hampshire Constabulary made a decision to review the original inquiry into Child K's death at the time of the inquest, the outcome of which led directly to a full reinvestigation by officers from the Major Investigation Team. Following a comprehensive investigation, a file of evidence was presented to the Crown

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[1] See http://southamptonlscb.co.uk/about/seriouscasereviews/

[2] A Finding of Fact Hearing is a court hearing that considers evidence to decide whether alleged incidents did or did not happen. They are commonly held in Care Proceedings.

Prosecution Service. The CPS decided in December 2014 that there was insufficient evidence and the case has now concluded.

Format of the Serious Case Review

Southampton LSCB appointed Moira Murray and Kevin Harrington as Independent Lead Reviewers for this Serious Case Review.

This Serious Case Review followed a thorough 'traditional' methodology and approach to ensure the practice and policy applied to the case was robustly analysed. This consisted of a multi-agency panel receiving individual agency management reviews from those agencies closely working with the family of Child K. The lead reviewers produced the SCR report highlighting lessons to be learned and recommendations for changes to policy and practice to ensure similar cases are prevented in future.

Theme – Using Child Protection Procedures Effectively

Recommendations:

1. The Board should require the key local statutory agencies with child protection responsibilities to demonstrate that, where a child may be at risk of significant harm, this is recognised and reported appropriately, investigations and assessments are conducted without delay and all procedural and good practice requirements are met.

2. The Board should evaluate the quality of strategy meetings and child protection conferences and audit the decisions being taken at those meetings.

LSCB Response

The LSCB recognises and accepts the recommendation for the partnership to ensure that effective child protection procedures are in place. The LSCB ensures that statutory child protection procedures are adhered to as part of its duty to quality assure and coordinate local work. This is set out in Working Together 2013, the Children Act 1989(as amended) and reflected in local 4LSCB procedures (covering the four areas of Southampton, Portsmouth, Hampshire and Isle of Wight). The LSCB understands the vital need for services to work closely together to respond to and prevent harm to children and young people at risk of and in need of protection. The LSCB seeks assurance from Southampton City Council Children and Family Services, Police, Health, Education and other statutory partners regularly through its Quality Assurance work[3] to ensure this duty is met. The LSCB will continue to ensure that they are delivering on this commitment, with a particular focus on the recommended actions above.

Actions taken and changes made

- Southampton City Council has set up a Multi Agency Safeguarding Hub (MASH). This offers a single point of contact for all safeguarding concerns regarding children and young people. It brings together in one location expert professionals from all services supporting children, young people and families and makes the best possible use of their combined knowledge to keep children safe from harm. Representatives from the different agencies in the MASH use their expertise to build a holistic picture in order to determine the risks to a child or adult. As a result, better decisions are made about what action to take and support can be targeted on the most urgent cases. MASH procedure includes specific timescales for

[3] See www.southamptonlscb.co.uk for details of the Quality Assurance Framework used.

appropriate action. The LSCB currently has oversight of the MASH and receives regular updates on its progress and efficiency. As part of the MASH process, local agencies have signed up to an Information Sharing Protocol.

- The LSCB hosted a series of workshops focussed on the child abuse investigation process, these were held in July and September 2014. This is also a key feature of new core LSCB training.

- 4LSCB procedures offer guidance on strategy discussions, this was updated in 2014.

- The LSCB has completed an audit of Child Protection Conferences and has recently commissioned an audit of strategy discussions / meeting process. The audit found the threshold for meetings was appropriate, the full findings of this review will shortly be reported to the LSCB. All partners are committed to learning from the findings and responding promptly to any recommendations that arise.

- The format and chairing of child protection conferences has been revised since the period of the review. A recent inspection by Ofsted found: "Conferences are well recorded and develop outline protection plans which address the presenting risks. Inspectors observed the 'Strengthening Families' model being used well with parents, who were encouraged and enabled to contribute their views. A recent evaluation of the model has been positive, with parents stating that seeing the problems written on boards assisted their understanding of what needs to change. "

- The 4LSCB procedures include guidance on Child Protection Conferences; this was also updated in 2014.

- All local NHS agencies are actively involved and engaged in the work of Southampton LSCB, and have placed greater emphasis on scrutiny of frontline safeguarding practice and challenge across the wider system. As part of the inter-agency response to safeguarding, the NHS is a key member of the MASH which enables seamless coordination of information so that sound decisions about child protection are made.

- The National Probation Services have a clear communications channel through the MASH and a better understanding of thresholds and the process of referring through to different teams within children and family services.

Actions to be taken by the LSCB

- Review findings of recent Independent strategy meeting / discussions audit and take further action as required.
- Deliver an audit of cases where strategy discussions and meetings have been delivered and reported to the LSCB.
- Ensure awareness and clarity in the process and procedures for strategy discussions and meetings, reinforcing statutory process and procedures.
- Six monthly MASH reports will evaluate the success of strategy discussion with each report to include a sampling of cases.

Theme – Domestic Violence and Abuse

Recommendations

3. The Board should review and strengthen as necessary arrangements across all agencies for recognising and responding to children who need to be protected as a result of domestic abuse.

4. The Board should use the findings of this review to raise public awareness locally of the links between domestic abuse and the safeguarding of children.

LSCB Response

The LSCB recognises and accepts the overall learning for the partnership on the need to raise awareness of domestic violence and abuse and ensure that links and arrangements are made to safeguard children where this is an issue. The LSCB has taken the lead in coordinating responses to this crime and has led the way in sending a message that this will not be "accepted, excused or ignored" in our City. The LSCB has recently agreed a strategy and plan which will reshape the way that specialist domestic and sexual violence services in the City will work together with statutory services to ensure a coordinated community response.

Actions taken and changes made

- In 2014 the LSCB agreed a new robust strategy to reshape services provided to families where domestic violence is present. This will encompass services for victims of domestic abuse alongside work to challenge perpetrators and hold them to account for abuse.
- The strategy includes a focus on community engagement and awareness raising.
- Focus groups with survivors of domestic violence have shaped the future working arrangements.
- A conference to raise awareness of domestic violence and its impact on Children and Young People took place in December 2014, this. This included direct input and influence from local adult and child survivors of domestic violence and abuse.
- The LSCB has adopted domestic violence and abuse as one of its key priority areas for action, including establishing a focused multi-agency steering group to champion this issue, this is led by the Director of People from Southampton City Council.
- Strategic leadership and commitment has been gained for this issue through the LSCB group reporting to the Safe City Partnership and Local Safeguarding Adult Board.

Actions to be taken

- Ensure continued progress of the Southampton domestic violence strategy implementation plan, in order to fully integrate a coordinated community response to domestic violence and abuse.
- Deliver regular focus groups with survivors.
- Coordinate public awareness raising activities to highlight the impact of domestic violence and abuse on children and young people.
- Build on existing workforce development opportunities to highlight the impact of domestic violence and abuse on children and young people in single and multi-agency training opportunities.

Theme - Escalation of concerns

Recommendation

5. The Board should require all agencies to promote the use of escalation procedures when there is disagreement between professionals, and should audit the use and effectiveness of escalation arrangements.

LSCB Response

The LSCB considers effective challenge throughout the partnership to be a key factor in safeguarding and promoting the welfare of children and young people. Knowledge of procedures relating to challenge were not widely known or understood in Southampton during the period covered by this Serious Case Review. A range of activities have taken place in the City during 2014 to address this and the LSCB is assured that this continues to be a key priority. A 4LSCB procedure is in place to direct professionals on the course of action where there are concerns about the way a case is dealt with. The LSCB has ensured that the procedure is fit for purpose and being used by staff in Southampton.

Actions taken and changes made

- 4LSCB procedure *Resolving Professional Disagreements* is available online and is currently being reviewed by the 4LSCB.

- Escalation is regularly highlighted to professionals in Southampton as part of the LSCB 'Weekly Wednesday Workshops' and through LSCB core level 3 training.
- Awareness of the importance of this issue was raised through specific workshops in 2014 and through the LSCBs website and newsletter.
- Southampton City Council's Principal Social Worker presents data and information on this issue to the LSCB on a bi-annual basis.
- NHS staff are required to raise their concerns about children to a more senior level whenever necessary to ensure safety. This escalation process is being logged to enable audit across the LSCB.
- The National Probation Service has promoted the appropriate use of escalation in their organisation
- Schools have promoted the use of escalation as appropriate.

Actions to be taken

- Ensure participation in a review of the current 4LSCB procedure for escalation.
- Test staff awareness of the procedure through learning and development evaluation (three months after attending training).
- Continue to seek assurance from Board Members regarding internal escalation procedures through Section 11 audits and Singe Agency Reporting.
- Request that Southampton City Council's Principal Social Worker includes data in their report regarding cases where concerns are escalated by partners.

Theme – Staffing and Supervision

Recommendations

6. The Board should require all agencies to demonstrate that there are safe and effective arrangements for the professional supervision of staff.

7. The Board should require the local authority to demonstrate that the deployment and supervision of social work students is appropriate and safe.

8. The Board should require schools and pre-school provision, where relevant, to demonstrate that there are reliable arrangements for the appointment, training, supervision and management of the Child Protection Lead Officer.

9. The Board should ask the agencies contributing to this review to re-consider their performance, in the light of this overview of events, to determine whether any further action is necessary in respect of individuals, teams or safeguarding practice generally.

LSCB Response

The LSCB recognises that safe and effective supervision is essential and has recently adopted core safeguarding supervision standards. The LSCB requires all agencies to implement and provide evidence of progress against these standards. The LSCB acknowledges the need to regularly assess and review all local supervision and de-briefing arrangements for staff working in children and family services in the City and to seek assurance that the issues raised in the Serious Case Review have been actioned.

A Workforce Development team headed by a Practice Educator is in place within the Local Authority. This role includes responsibility for student placements and the training of student supervisors and practice educators. This is delivered with partners based within Southampton Solent University.

The LSCB accepts that there is a requirement to ensure Child Protection lead officers including CPLO's NOTE – spell out this acronym within schools are appointed, trained, supervised and managed appropriately. The LSCB now systematically receives regular six monthly assurance reports from the lead officer for Early Years and from Education Services. The LSCB is currently reviewing arrangements to enable the monitoring of the requirements under Section 156 of the Education Act for all schools directly.

The LSCB has been assured that staff involved in the case, who continue to work for the local authority, understand the findings and learning from the review. All NHS organisations have reviewed their contact with Child K and considered any learning or development needs for individual staff. Board members from other key partner agencies will provide formal assurance as part of this action plan.

Actions taken and changes made

- A recent workforce survey asking staff about their experience of safeguarding supervision received over 400 responses which are being used to inform future plans for improving local standards across all agencies.
- A key priority for Southampton City Council is 'a well-trained, stable and effectively supported workforce'. The workforce development strategy has been developed in order to maintain a permanent and stable workforce within Children's Services. The Professional Development Programme invests in the skills and knowledge of our staff and in particular first line managers.

- Since 2011 stronger models of staff supervision, training and development have been put in place for staff across the NHS. These processes are audited and reviewed. During the time period covered by the SCR the NHS had commenced a period of significant reorganisation. During this reorganisation the utmost priority has been given to the leadership and governance of child protection and safeguarding. All local NHS organisations in Southampton are committed to continuous improvement in safeguarding services and close working with the LSCB in future.
- Supervision Standards and Principles adopted by LSCB in December 2014.

Actions to be taken

- Seek assurance from all LSCB partners of implementation of supervision standards.
- Regularly monitor this through reports to the LSCB from key services and through Section 11 (of the Children Act) audits
- Identify action to be taken by key agencies to ensure Safeguarding Standards are met.
- LSCB Chair to request information from all schools and pre-schools to ensure the requirements of this recommendation are met.
- Agree a format for regularly monitoring school and preschool safeguarding requirements under Section 156 of the Education Act.
- LSCB Chair to formally seek assurance from Board members where this has not already been gained, regarding individuals involved in review.

Theme –Response to Child Death

Recommendations

10. The Board should require the relevant agencies to review and improve as necessary their compliance with the statutory requirements arising from the death of a child

LSCB Response

The LSCB accepts that during the timeframe of this review the response to child death arrangements were insufficient. The LSCB has been since been assured that changes have been made to the arrangements. The role of designated paediatrician for unexpected deaths in childhood has been confirmed in post in Southampton since 2013. The Child Death Overview Panel management and local rapid response procedures are currently under review by the

4LSCBs. Hampshire Constabulary force policy has been changed to ensure compliance with the ACPO Child Death Investigation Guidance regarding joint paediatric and Home Office post mortems (the same section of the guidance incorporates use of paediatric specialists to report on skeletal surveys, MRI and CT scans). Secondly all Senior Investigating Officers responsible for investigating child deaths attend the ACPO Child Death Investigation Course and are trained to the required national ACPO standard

Actions taken and changes made

- Designated Doctor for rapid response in place for Southampton
- Multi agency rapid response process training taken place and continuing

Actions to be taken

- Review of current CDOP and Rapid Response Procedure to take place
- Audit of recent cases of Child Death via CDOP to provide assurance of improvements.

Theme - SCR process

Recommendations

11. The Board should raise with the relevant NHS commissioning body the failure of the South Central Ambulance Service NHS Foundation Trust to provide a full report for this review.

12. The Board should ensure that there are reliable arrangements for making timely decisions as to whether a Serious Case Review should be carried out.

13. The Board should require local agencies with child protection responsibilities to confirm their arrangements for the quality assurance of submissions to any future Serious Case Review.

LSCB Response

The LSCB recognises the vital importance of engagement of all Board members in SCR process to ensure full opportunities for learning are understood. The LSCB, through its lead board members for the Clinical Commissioning Group, have followed up on the omission of the Ambulance Services full report and have been assured that engagement from SCAS is now prioritised.

The LSCB recognises that the timescale for undertaking this review impacted on learning opportunities being taken and actioned in a timely way. The LSCB has ensured systems are now in place to prevent this delay happening in future. The LSCB developed a Learning & Improvement Framework in January 2014 to set out its clear process for receiving referrals of cases that are considered to offer a learning opportunity. The LSCB has appointed an independent person to chair its Serious Case Review Group, who receives referrals and makes recommendations for potential reviews of all levels to the LSCB Independent Chair.

The quality of submissions to case reviews such as this need to be of a high quality to ensure that learning opportunities are maximised and those involved in the review can make full use of the information available. The LSCB through its Learning and Improvement Framework will ensure that quality assurance has been carried out by senior board members from the appropriate agencies.

Actions taken and changes made

- The lead Commissioner for South Central Ambulance Service (Fareham and Gosport Clinical Commissioning Group) was approached regarding this issue, attendance and engagement with the LSCB from SCAS has now improved.
- A new Learning and Improvement Framework was agreed, this sets out a clear and robust system for receiving and agreeing case reviews and disseminating learning and improvements.
- Health organisations require executive director sign off for their submissions to Serious Case Reviews to quality assure the report and to ensure organisational ownership of the findings.

Actions to be taken

- Review the Learning and Improvement Framework to ensure a system is in place to report any non-compliance by agencies at an early stage and to ensure quality assurance of submissions to case reviews.