WIRRAL LOCAL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

EXECUTIVE SUMMARY

SUBJECT: A
4 YEARS

October 2009

CIRCUMSTANCES LEADING TO THE SERIOUS CASE REVIEW

A, a four-year old girl was found dead at her family home in late April 2009. This followed a telephone call from her mother, B, notifying the Police that her daughter was dead and that she (B) was responsible for her death.

B was arrested and later charged with the murder of her daughter.

The actual circumstances of the death were that A was drowned in a bath in the family home. The mother then attempted to commit suicide and after failing in this attempt she telephoned the Police to inform them of the death of her daughter.

The criminal case was heard in October 2009, when B was sentenced and detained indefinitely for hospital treatment following a plea of diminished responsibility to manslaughter.

Because of the circumstances of the death there was immediate notification to the Chair of the Local Safeguarding Children Board (LSCB), who has responsibility for the management of child deaths when abuse or neglect is a feature.

A number of agencies and services had been involved with A and her mother prior to the death and they are listed in section 3.

1. DECISION TO HOLD A SERIOUS CASE REVIEW

A died in late April 2009. On the day of the death the Chair of the Local Safeguarding Children's Board (LSCB) was notified and the LSCB Chair and the Serious Case Review (SCR) Panel Chair met to discuss whether the criteria to undertake a Serious Case Review were met. A decision was taken on the same day that a Serious Case Review was required as the criteria set out in '*Working Together" (2006)* were met.

The Serious Case Review Panel met on the following day. They concurred with the view of the Chair of the LSCB.

Government Office, North West (GONW) were notified on the 30th April 2009 and agreement was reached that the final submission of the Serious Case Review would be 29th August 2009 which concurred with national timescales for completion. Ofsted were notified of the death and the decision to undertake a SCR on the 30th April 2009.

Because of delays in collated information due to the holiday period in August 2009, an extension to October 16th 2009 for the completion and submission of the SCR was agreed by GONW.

2. AGENCIES CONTRIBUTING TO THE REVIEW

The following agencies were requested to undertake Individual Management Reviews:

Local Authority Children's Social Care
5 Housing Providers:

Regeneration Housing Department
Riverside Housing
Forum Housing Association
Carr – Gomm
Arena Options
A Children's Nursery
A Children's Centre
Cheshire & Wirral Partnership NHS
Merseyside Probation Trust
Merseyside Police
Wirral University Teaching Hospital NHS Foundation Trust
NHS Wirral
Connexions Service.

Members of the Serious Case Review Panel were:
Colleen Murphy - Independent Chair
Helen Stuart – Designated Nurse Safeguarding Children
Mark Tivendale – DI Merseyside Police
Catherine Kerr – Manager, Children's Centre
Amanda Bennett- Designated Doctor, Safeguarding
Sue Brown – Assistant Chief Probation Officer. Merseyside Probation Trust
Caroline McKenna – Principal Safeguarding Manager. Wirral Children's Service
Tony Burscough, Principal Manager, Children's Social Care
Phil Spilsted – Cheshire and Wirral Partnership NHS Foundation Trust
Maggie Chessall- Named Midwife, Safeguarding, Wirral NHS Foundation Trust.
Emma Perris – Head of Young People's Services, Arena Options
Catherine Green, Rehousing Services Manager- Regeneration Department

The Independent Overview Report author, Dennis Charlton, attended some of the Serious Case Review Panel meetings as an observer and to clarify any issues as appropriate. The Overview Report author also examined some key documentation including some of the assessments that had been undertaken on A and B. The Overview author also met with the Consultant Psychiatrist overseeing the medical care of B and members of A and B's family.

3. KEY POINTS TO BE CONSIDERED BY THE REVIEW

The following key issues were considered by the SCR Panel as being fundamental elements for the SCR:

- To establish what services were provided for A and to what extent those services met the identified and assessed needs of the child.
- To identify any gaps in inter-agency working within the Children's Trust arrangements with regard to the duty to promote and protect the child.
- To establish good practice by highlighting any significant features of the case and to make any necessary recommendations
- To consider whether the mental health needs of the mother of A were appropriately identified and provided for
- To examine whether the services offered by adult providers were appropriately child focussed in terms of their ability to identify whether

there were signs of risk or not. To further consider whether the Children's Trust working arrangements were sufficiently coordinated.

- To consider the relationship and fluidity between the Team around the Child Model and whether there was an appropriate level of need recognised.
- To gather information on the background histories of both parents and to consider if there were any identified risks and vulnerabilities.
- To consider whether information sharing between agencies was sufficiently robust.

4. TIME PERIOD FOR THE REVIEW

Each contributing agency was asked to examine their records for undertaking an Individual Management Review (IMR) including individual chronologies, from the point at which they first became aware of the individual parents and the child within the family. This decision for the start date of the SCR timeframe was taken to ensure that all historical information was considered. The SCR end date was at the point of A's death although additional information from the criminal proceedings process was used to inform the SCR. This review began in April 2009 and was completed in October 2009.

5. INVOLVEMENT OF FAMILY MEMBERS

The mother of A has been sentenced by the Court following the death of her daughter. Consideration about actively seeking B's contribution was made in consultation with the medical staff responsible for her care and also her legal advisor. It was felt that it would be inappropriate to involve B primarily because the nature and level of her illness precluded a meaningful contribution. A's paternal and maternal grandparents were consulted in relation to their views. Arrangements were made to inform them of the SCR findings.

6. CRIMINAL TRIAL/PARALLEL PROCEEDINGS

The criminal case of B began in April 2009 and concluded in October 2009. It had previously been agreed between the police representatives and the LSCB that both the criminal process and the Serious Case Review would take place in parallel to the criminal trial proceedings.

7. INDEPENDENCE WITHIN THE SCR PROCESS

All of the IMR's were written by Managers who had no direct line management responsibly for the staff who were involved with A or her family.
The Serious Case Review Panel was chaired by Colleen Murphy, an Independent Social Worker. Ms Murphy has had considerable experience in safeguarding children's work and has undertaken a number of Serious Case Reviews previously.

The author of the Overview Report was Dennis Charlton. Mr Charlton has held posts at senior management level in a local authority Children's Service and has extensive experience of child protection and safeguarding issues. He is self-employed as a consultant in child protection. He has undertaken a number of the Serious Case Reviews and is a qualified Psychiatric Social Worker.

8. CONSIDERATION OF RACE, EQUALITY AND DIVERSITY ISSUES

Specific consideration was given to racial, cultural and other equality issues. There were no such significant issues identified in this case. The families are white British with strong local connections to the Merseyside area.

9. CONSIDERATION OF LEGAL OR EXPERT ADVICE

It was not considered necessary to have specific legal advice or specialist, although such considerations would be reviewed on an ongoing basis throughout the Serious Case Review.

10. OVERVIEW OF EVENTS

The first significant information within the timeframe of the SCR was in January 2003 when mother B was admitted to hospital after taking an overdose. She was 16 years of age at this time. This was considered to be an impulsive overdose in response to emotional distress. Some previous history emerged in B had received counselling in 2001, when she was 14 years of age, because of problems in family relationships.

A was born in the January 2005. There had been no significant issues identified throughout the pregnancy. There were some concerns about domestic violence in relation to mother's boyfriend and these were dealt with effectively by liaison between the various agencies involved. There were later some additional concerns about the potential for domestic violence in relation to another adult male. Again these matters were dealt with between the responsible agencies.

There was limited agency involvement until summer 2007 when maternal and paternal grandparents started to express concern to Children's Social Care about B's mental health and her capacity to care for A. There were also problems in relation to B finding suitable accommodation.

In early September 2007 B was assessed at Hospital under Section 136 of the Mental Health Act. The Police had found B at home and were concerned about her unusual behaviour. The mental health assessment could find no indications of a serious mental illness but concluded that she was suffering from mild to moderate depression. B was advised to contact her GP for counselling.

From September 2007 onwards there were increased concerns expressed by maternal and paternal grandmothers about the mental health of B and her ability to care for her daughter. B at this time had agreed to the involvement of a package of family support services. There were also some continuing accommodation problems.

In October 2007 Children's Social Care made a decision that an Initial Assessment would be undertaken. The conclusion of that assessment was that A was a "happy and well looked after little girl". The case was closed to Children's Services (Social Care) on the 23rd October 2007 on the basis of the positive findings of the Initial Assessment.

There were a series of contacts to Children's Social Care throughout the next few months with paternal grandmother expressing concern that she had not seen A for some months and was worried about B's mental health. There were continuing concerns expressed in early 2008 that B was neglecting her daughter and that B was becoming more socially isolated and depressed. This resulted in the case being reopened and a core assessment undertaken by Children's Social Care. These concerns led to heightened agency involvement with A and B and B agreed to accept a package of family support measures including attending a local Children's Centre and a nursery with A. The ongoing accommodation problems were also resolved with B and A moving into a new home.

Shortly after this agreement however problems started to arise as B was not keeping appointments and being difficult to access through home visits. On the occasions that A and B were seen they were described as "well". These contacts seem to have eased agency anxiety a little. However, during a significant part of the summer of 2008 there were a number of failed access attempts and appointments establishing contact with B and A through home visits. At this stage professional contact with B and A was extremely sporadic. This pattern stayed constant throughout the remainder of 2008.

In mid January 2009 there was a joint home visit by the Family Support Worker and the Housing Support Worker. A was seen and was reported as energetic and vocal although her language was difficult to understand and she was wearing a nappy. This was followed by a number of unsuccessful visits from a Health Visitor and Family Support Worker. In early February 2009 A and B were seen at home. B was described as difficult to engage in conversation and reported that she felt isolated and had no friends. It was also noted that A's speech was poor.

Because of escalating concerns about A and B's isolation a multi agency meeting did identify a package of support for A and B including a nursery placement and more support for B to reduce her social isolation.

These measures were only partially successful and a pattern started to develop of B missing appointments, sometimes turning up at the nursery with A but sometimes not.
There were then a series of concerns about the care of A. These included some bruise marks on A and some signs of neglect through her physical care. There appeared to be some improvement in the care of A in March 2009, however, B was difficult to access and a number of home visits proved unsuccessful whilst nursery attendance was intermittent. The pattern of difficulties in accessing A and B continued throughout April 2009. In late April 2009 B telephoned the Police to say that she had killed her daughter by holding her down in a bath.

11. FINDINGS OF THE SERIOUS CASE REVIEW AND LESSONS TO BE LEARNED

Overall the Serious Case Review is critical of interventions in relation to a number of areas however predicting whether B could harm her daughter in such a way was not possible. Whilst detained, mental health professionals considered B to have been suffering from mental illness at the time she killed her daughter and this illness had been undiagnosed some years beforehand.

The overarching issue being that agencies failed to recognise the extent of B's mental health problems and to devise more appropriate interventions when it should have been clear that the family support measures being offered to help A and B were not working.

There is criticism about the quality of assessments undertaken by various agencies including the mental health assessment and the core assessment. There is also criticism of the failure to undertake health development assessments of A. In particular the Overview Report comments upon the failure to understand that assessment is a dynamic process and that new information needs to be constantly analysed to allow reconsideration of the original assessment. Recommendations are therefore made to address these issues.

The Serious Case Review also comments upon the lack of understanding of parental mental health and the possible implications for the care of children when a parent has a severe mental illness. In this case professionals had expressed concerns about B's mental health but had taken no positive action to address those issues.

There had also been a number of concerns expressed by paternal and maternal grandmothers about B's mental health and the conclusion of the Serious Case Review is that those concerns were not taken seriously enough and should have formed part of a contribution to provide a more complete understanding of the problems being experienced by B.

The Serious Case Review also focuses on the difficulties inherent in working with difficult to access families and how in this particular case the family support services being offered were not taken up by B. This should have led to agencies reconsidering the level and form of intervention being followed. There does appear to have been considerable "professional drift" where the intermittent contact agencies were having with A and B was accepted as being adequate when with hindsight it was clearly not.

The Serious Case Review comments upon the number of housing providers and the problems experienced by B in terms of changes in accommodation arrangements. In particular the SCR is critical of the level of support that B received for her housing needs in the early stages and the decision to make her homeless without making a proactive effort to gain a fuller picture of her problems and support needs. It should have been clear from an early stage that B was going to struggle to manage a tenancy (this was almost certainly compounded by her mental health problems)

Concern is expressed in the Review about the decisions by Children's Social Care to withdraw their involvement in the case. In particular the rationale for this, that B was not cooperating, should not have been a reason to close contact but rather should have

acted as a catalyst for reconsidering whether a more robust or different form intervention should take place. Similarly the decision, based on the assumption, that there was no need for Children's Social Care to be involved because other professionals were gaining access to B and A was inappropriate and flawed. The Serious Case Review raises questions about potential weaknesses in the Child Concern Model, now known as the Team Around the Child (TAC). The model is in principle an effective and integrated means of delivering good quality family support services. The SCR however comments that the model, whilst being suitable for families where there is a reasonable level of cooperation, needs to have a clear pathway for the re-involvement of Children's Social Care when the TAC approach is not working and thresholds for intervention have risen.

In this case the lack of meaningful access to A and B, the failed health assessments for A, the concerns about B's mental health and the unwillingness of B to take up services should have led to the re-involvement of Children's Social Care.

Throughout the later stages of agency involvement there were concerns shown by some professional about the direction in which the case was moving and also the role being undertaken by some professionals. This is particularly noteworthy in the inappropriate expectations being placed on the Housing Tenancy Support Worker. This worker was the only person having anything like regular contact with A and B and much of this contact was not focused or satisfactory. The SCR, in this context, comments critically on the expectations of other agencies in relation to the role of this worker and how there was professional over optimism that this could act as an adequate monitoring mechanism.

The SCR also comments on the need for agencies and professionals to be able to challenge decisions and plans by colleagues from other disciplines in order that there is sufficient examination and rigour applied to work with families. In this case there was inadequate challenge and scrutiny.

There were some positive elements identified within the Review process. On an individual level there was evidence of some very committed and caring professionals. The energy and willingness to support and help B and A was demonstrated through the input from a number of workers.

Overall however there is a sense that the professionals involved with A and B did not have adequate skills, training or knowledge to understand what they were dealing with. With hindsight there were a number of indications of underlying neglect that should have been addressed in a much more robust manner. It should be emphasised that the issues of neglect were almost certainly directly related to the mental health problems experienced by B which probably hampered her ability to engage with the programme of work. In addition there was no evidence that B was in danger of serious physical harm from A, the main indicators were in relation to whether A was failing to develop emotionally as a consequence of B's isolation and mental health problems.

It is not possible to state with any degree of certainty whether the death of A was preventable or not. At best it can be said that had a thorough assessment been made and appropriate (including mental health) services been utilised then there may have been a much greater likelihood of effective engagement of A and B.

12. RECOMMENDATIONS FROM THE INDIVIDUAL MANAGEMENT REVIEWS

Joint Recommendations from the Housing and Support Providers

1. It is recommended that a representative from the Registered Social Landlords operating within Wirral MBC becomes a member of the Serious Case Review Panel (as either an associate or full member).This nominated member will work in partnership with the LSCB to create some Good Practice Guidelines for RSL's involved in the SCR process.
It is recommended that this learning is shared at a National Level within the Housing Sector through the regulatory bodies.

2. It is recommended that a representative from the RSL's operating within Wirral MBC becomes a member of the LSCB on a permanent basis and this person assumes a responsibility to ensure that the work of the LSCB is disseminated to the RSL's within the Borough.

3. It is recommended that Housing Support staff are fully conversant with the Child Concern Model and understand the fluidity within the Team Around The Child Model. It is essential that RSL's and Housing related Support providers commit to ensuring their staff are trained within the model and that regular 'maintenance checks' are undertaken by managers to ensure staff are using the model as it is intended. This will avoid 'drift' and ensure that managers are accountable as well as individual workers.

4. It is recommended that ***all*** staff participating in the TAC meetings and process within Wirral MBC understand the role of the Housing representative and that the Housing representative behaves in a way that demonstrates their equality to those other members of the TAC.
It is essential that Housing workers feel able and are skilled enough to offer sufficient challenge to colleagues when they disagree with a possible outcome.
To this end it is recommended that all staff attending TAC meetings from a Housing provider or Housing related support provider have this issue included in their own personal development plans and are able to actively demonstrate their capacity through their supervision model. Whilst this is for individual Housing Organization's to take up it is recommended that the individuals involved in this SCR become the 'Champions' of this issue and attempt to ensure this is delivered.

5. It is recommended that all Housing related Support providers produce a 'who does what' style guide for practitioners to use and disseminate to other professionals. This information should document clearly the role and remit of workers within the Housing field. It should state clearly their boundaries and the referral and exit routes for Service Users.

6. It is recommended that when a service user faces potential eviction and has a child under 16 a referral will be made to Social Care Children's Services. The referral information should clearly state the contact made with the parent, when the child was last seen, any other potential address the family can seek accommodation, any arrears, the date of any potential eviction and any issues regarding the families' behaviors. Feedback should be requested by the Housing worker making the referral.

7. It is recommended that any potential challenging cases are transferred from one Housing provider to another there should be a case transfer discussion. Any potential risks/issues should be highlighted. This information will be shared with the Service User and recorded in accordance with the Policies and Procedures of the individual organizations.

Children's Centre

1. Review failure to gain access policy and procedure

2. Identify appropriate mental health training

3. It is recommended that a procedure is devised to ensure files are linked to previous files.

4. Practice guidance for record keeping to be developed.

5. Staff to receive regular record keeping training with random files to be audited every six months preferably by the Centre Manager and Family Support Coordinator

6. During the case load management discussions, the Family Support Coordinator should check, as a minimum that assessments have been completed appropriately and further appropriate action planned / taken.

7. Any amendments to policies / procedures to be highlighted to staff.

8. Respite policy / procedure to be reviewed and updated.

Wirral Hospital Trust and NHS Wirral

1. Wirral University Teaching Hospital needs to ensure that if feedback from Social Care referral is not received, the referrer must make contact with Central Advice and Duty Team and request an update.

2. NHS Wirral needs to ensure that there are systems in place for Health Visitors to meet regularly with GPs to share information about vulnerable families (i.e. Domestic Abuse situations, mental issues, substance misuse).

3. NHS Wirral must ensure that Health Visiting staff are trained and competent in the use of CAF when TAC meetings are taking place.

4. WUTH and NHS Wirral should review GP antenatal referral systems and supporting documentation so as to ensure that relevant medical and social information is shared.

5. The LSCB is requested by NHS Wirral to ensure that when there are TAC meetings, family General Practitioners are included in the distribution of any minutes and that there is effective liaison between the lead professional in the TAC process and the GP.

Private Nursery

1. That the Nursery makes the provision of the statement of needs a condition of accepting a referred child in the spirit of multi-agency working.
2. That the Nursery reviews the policy for managing children's records, particularly to ensure staff understand the importance of signing and dating diary entries.

3. That the Nursery actively seeks confirmation of receipt of communications sent to agencies, where the agencies do not themselves acknowledge receipt. To include confirmation that the appropriate person has received the communication

Merseyside Probation Trust

1. Merseyside Probation Trust (MPT) should undertake an audit of OM5's caseload to satisfy itself that the guidance which is in place to determine whether a case should be subject to MAPPA is being implemented as expected.

2. MPT should undertake an audit across the Trust to confirm that Spousal Assault Risk Assessments (SARA) are being completed in line with Trust Policy.

3. MPT should ensure that when the Safeguarding Policy is reviewed there is specific reference to referrals to Children's Services/Social care being timely and confirmed in writing regardless of whether Social Workers are already involved in the case.

4. MPT should remind staff of the need to gather intelligence from other agencies in relation to previous partners and their children of men who are convicted of domestic abuse and ensure this information is recorded on the SARA.

Merseyside Police

1. Additional Training in "Protect" for Family Crime Investigation Unit staff with emphasis on correctly inputting children's details.

2. Area staff to be reminded to complete form VPRF/1 emailed to the Family Crime Investigation Unit when there are any issues involving children regardless of previous Social Care involvement.

3. Family Crime Investigation Unit draw up a service level agreement with Wirral Social Care in deciding which Domestic abuse cases brought to Police attention where a child is resident are referred over.

4. Control Room Supervisors to ensure that details of Officer completing form VPRF/1 are entered on the Altaris log in child welfare incidents

Wirral Social Care

1. Social Care should satisfy itself that where offenders who are seen as being a risk to children are developing relationships that could put children at risk, that a Section 47 investigation is undertaken. These situations should not be dealt with through simply sending letters reminding parents of their responsibilities to protect their own children.

2. Social Care should ensure that information received in respect of domestic violence affecting women who are pregnant or have children is appropriately communicated to other agencies, and an initial assessment is undertaken to determine risks.

3. Social Care should carry out an audit of referrals to ensure that current Policy and practice guidance in relation to Domestic Violence is being followed and there is a shared understanding of thresholds for intervention with partner agencies

4. Social Care should audit the quality of initial and core assessments to ensure that these assessments have considered the appropriate elements of the Assessment Framework.

5. Social Care should audit the Children In Need planning process to ensure that the plans being developed are clear, specific, have timescales and contingencies in place if not achieved, and that the planning and review process is a robust multi-agency one. This should include a review of the process for cases moving out of Children In Need to TAC.

6. Social Care should consider the training needs of Children's Social Care staff in relation to Adult Mental Health and the impact of Domestic Violence on Adult Victims.

7. Social Care to ensure that the Consultation process provided by Area Team Social Workers is appropriately recorded, supervised by a suitably qualified Social Work Manager, filed and a database of consultation is maintained that can be accessed by Social Workers and Managers. In providing consultations Area Team Social Workers should access ICS for any history of previous involvement prior to giving advice.

8. Social Care to ensure that all correspondence, communications with and referrals to either CADT and District Offices are traceable, recorded, brought to the attention of the appropriate staff and are maintained as part of the Social Care record.

9. Social Care should consider the impact of case transfers on individuals receiving services and should have a clear rationale for transferring cases that is for the benefit of service users. The implications of case transfer should be particularly considered in the case of service users who are hard to engage.

10. A joint protocol to be developed to provide guidance for staff on joint working across Children's/Adult Social Care, in cases were there are concerns about an adult parents/carers mental health and its impact on parenting capacity should be developed.

Cheshire & Wirral Partnership NHS Foundation Trust

1. That where there are concerns for a child of a parent with mental health needs under the age of 5, Health visitors should always be consulted about any safeguarding concerns as a matter of course.

2. That all staff should be reminded through briefing and training events of their obligation to complete the form 'Children in the family home' whether electronically or hard copy. That we explore the feasibility of making the completion of this electronic page mandatory before assessment can be completed.

3. In all cases of a parent/s presenting to any mental health team in Wirral consideration/discussion of their children's needs should take place including whether to refer to the team around the child (Cheshire Common Assessment Framework CAF).

4. That key staff in Wirral Mental Health teams are engaged in the review of NPSA Rapid Response Report, Preventing Harm to children of parents with mental health needs.

5. That when a Parent (mother or father) presents with symptoms that indicate possible early features of a Serious Mental Illness, especially if they are a lone parent consideration should be made of their parenting ability or their need for support to provide appropriate care to their child/ren.

Connexions Greater Merseyside

1. That Information Sharing Agreements with schools are reviewed and refreshed as part of the Partnership Agreement process by the end of November 2009.

2. Safeguarding training for all Connexions staff in Wirral will be updated as part of a refresh process by the end of December 2009.

3. That a series of staff briefings (and reiterated via supervision sessions) reference GMCP policy and procedures and the PA code of conduct in the light of this case particularly in relation to vulnerable/homeless young people requiring maximum support to ensure that professional practice guidelines are understood and adhered to at all times.

4. That on call practice and procedure is reviewed.

5. That procedure in relation to the archiving of records and potential Safeguarding Investigations such as SCR's are reviewed and aligned.

6. That procedure for the retention of Incident Report forms is reviewed and robust procedures for retention are confirmed with all staff.

7. That inter-centre communication and document transfer processes are reviewed (within the context of the support provided for B and C) alongside case loading practice to seek to maximise support for vulnerable young people.

8. That an investigation takes place into the practice of PA2 (F) who accommodated B at her home

13. RECOMMENDATIONS FROM OVERVIEW REPORT

1. Training and Awareness

The LSCB should review the existing training on parental mental health and the impact on children and ensure that all relevant practitioners are able to recognise and respond appropriately in cases where there are parental mental health problems.

2. Community Mental Health Support Services

The LSCB should initiate a debate with all key agencies about support services for adult service users with mental health problems who have children. This should include GP representatives.

As part of this process the LSCB should ask Wirral and Cheshire Partnership NHS Foundation Trust to audit the quality of mental health assessments in cases where those adults being assessed have children. A working multi agency protocol should be developed from these debates.

3. Family Support Interventions
The LSCB should review the effectiveness of family support interventions, particularly in relation to "hard to access" service users. This Review should encompass the Team Around the Child (TAC interventions) and also the effectiveness of the lead professional role.

4. Quality of Assessments
The LSCB should undertake an audit of the quality of multi agency assessments being undertaken. This should include core assessments, initial assessments and CAF. Training for professionals on undertaking assessments should be reviewed.

5. Information Sharing and Case Closure
The LSCB should develop an introduce a Protocol to ensure that any agency withdrawing their involvement from a case or closing a case where there is a child in need, should discuss the implications with the other agencies prior to withdrawal of services/ case closure.

6. Challenges to Decision Making
The LSCB should review auditing and quality assurance systems in order to ensure that all agencies understand their role in challenging decision making in individual cases and are able to make appropriate challenges.

7. Housing Related Issues
The LSCB should ask Housing providers to produce regular reports on progress being made in developing joint protocols and shared good practice in providing services for young parents.

8. Listening to families
The LSCB should ensure that the views of family members are taken very seriously in undertaking assessments and planning services for children and their carers. This will require an audit in order to ensure that standards for the involvement of family members are at an acceptable level.

Acknowledgements

Members of the Wirral Local Safeguarding Children Board wish to extend their sincere thanks to the family of A and B, in spite of their grief, met with the independent author of this report and shared their experiences, views and feelings about the services offered to them in the period under review.

Thanks are due to those professionals in relevant local agencies who committed their time and energy to a critical examination of the services provided.