Serious Case Review CN08

April 2014

Foreword

In 2011 the DSCB was among a number of Safeguarding Children's Boards across the country who undertook a pilot in using the Learning Together (Fish, Munro & Bairstow 2008) systems methodology developed by the Social Care Institute for Excellence (SCIE). The DSCB went on to use the systems methodology for two case reviews and then in 2012 the Board was given special dispensation from the Department of Education (DfE) to conduct a Serious Case Review (SCR) using the Learning together systems methodology. This was to be the first review nationally (using this methodology) to be conducted concurrently with the criminal investigation. In February 2013, when the case for this review was first considered, it was decided that the same process would be used and approval from the Department of Education was given. In March 2013 the new version of Working Together to Safeguard Children was published. In relation to conducting SCRs it states:

'SCRs and other case reviews should be conducted in a way which:

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

LSCB (Local Safeguarding Children's Board)'s may use any learning model which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro.'

The new Working Together to Safeguard Children sets out a number of principles which should be applied by LSCBs and their partner organisations to all reviews. Whilst the new guidance was not published at the time this particular review was instigated and planned due consideration has been given throughout to those principles and the guidance about reviews as a whole.

Two of the key principles in the guidance are that:

- *'there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;*

- *Improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.'*

The Learning Together methodology is designed to get professionals thinking about the systems that they work within and to challenge those systems and identify where weaknesses exist. The involvement of front line professionals, and family members, is the key to drawing out clear understanding of how things seemed at that time and why decisions were made. Those who have taken part in this SCR are clear that the learning begins as the review unfolds which is quite different to the historical method of conducting SCRs. It is intended that the energy, enthusiasm and reflective understanding which was a common theme throughout this review is adopted by the DSCB and its partner organisation in taking the findings forward and put in place lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm.

Translating the findings from reviews into programmes of action which lead to sustainable improvements has always been a challenge for LSCBs and their partner organisations but there is a clear expectation that the LSCBs takes on this challenge proactively, has ownership of review findings and acts positively in response to them.

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1. Introduction to the case

Why this case was chosen to be reviewed

1.1 On 19 January 2013, following a concern for the mother of the child and her admission that she had killed her child, the body of the male child was discovered at the home address. The child was just over 2 ½ years of age.

1.2 An immediate police investigation began and the mother was placed under arrest on suspicion of murder. The mother was subject of a mental health assessment when she was arrested and was considered fit to detain and interview. She was charged with murder on 20 January 2013 and later convicted of manslaughter and received a hospital order.

1.3 This case was considered by the DSCB SCR sub group on 11 February 2012. The sub group concluded that the criteria for a SCR had been met in that a 'child has died and abuse or neglect is known or suspected to be a factor in the death' (based on the guidance within Working Together to Safeguard Children 2010 Chapter 8, 8.9). The recommendation was confirmed by the Chair of the DSCB and notification was made to the Department of Education of the decision.

Succinct summary of case

1.4 Child A lived with his mother; the mother also had two adult children from previous relationships who were not living at the family home at the time of child A's death. She was estranged from the child's father, who lived nearby, with whom she had had an on-off relationship since 1996. Throughout the child's life there were incidents of domestic abuse involving the father which were reported to the police by the mother. A Restraining Order against the father preventing contact with the mother was issued on 8 April 2011 to last until 7 April 2013.

1.5 The mother had a mental health episode in March 2011 when she was detained under Section 2 of the Mental Health Act 1983. As a result, the child was initially accommodated by the Local Authority but then returned to the care of his half siblings who had returned to the family home. The case was closed to children's social work on 27 April 2011. Child A was not open to children's social work or any other specialist service at the time of death.

1.6 The mother was discharged from hospital in early April 2011 and received further contact from the Crisis Resolution Home Treatment Team (CRHT) until being discharged after two weeks.

1.7 In early November 2011 Adult A's mental health deteriorated and her GP made a referral to CRHT who completed a mental health assessment. As a result, the mother was placed on medication. She was assessed under the Mental Health Act 1983 but not found to be detainable. CRHT continued phone contact with the mother for a short time after the assessment and then there was no further involvement of mental health services with the mother.

Nature of findings

1.8 The Review has identified three main findings which will be explained in detail in section 5. The first finding is in relation to the lack of a system for monitoring the potential risk to a child when adult mental health services are no longer engaging with the parent, (page 17 & 18, 5.1 to 5.6). The second finding is about the standard and depth of assessments and decision making when considering the safety of a child, (page 20-22, 5.7 to 5.12). The third finding is also around assessments, specifically risk assessment processes within MASH (Multi-Agency Safeguarding Hub), (page 24 & 25, 5.13 to 5.16). There is a fourth finding, which is classified under longer term work, regarding MARAC (Multi Agency Risk Assessment Conference) processes (page 27, 5.17 to 5.21). In particular how to ensure that the safeguarding of children is robustly assessed at MARAC and also the challenges for MARACs in cross 'border' areas.

2. Introduction to the Review

Sources of data

Data from practitioners

2.1 The mentored Lead Reviewers conducted structured conversations with professionals in the following roles, who together formed the Case Group:

Medical

- General Practitioner for the child and the mother

Public Nursing Health Service

- Health Visitor for the child

Police

- Local Neighbourhood Beat Manager
- 121a (police notification form) evaluator within MASH (Multi-Agency Safeguarding Hub)

Children's Social Work

- Operations Manager MASH (formerly Practice Manager in MASH)

Devon Partnership Trust (Crisis Resolution Home Treatment Team (CRHT)

- Clinical Team Leader
- Senior Mental Health Practitioner

The conversations, with the permission of the professionals involved, were digitally recorded in order to assist the Lead Reviewers in data collection. In addition to the structured conversations a discussion was also held with the social worker who had briefly been involved with the child and the mother in March to April 2011.

Data from documentation

2.2 Information was sought from each agency which had involvement with the child, the mother and the father, and was compiled into a multi-agency chronology which was jointly reviewed by the Lead Reviewers and the Review Team. In addition some policy documentation from agencies and national research documents of relevance to the nature of the Review were consulted. The records used and documents consulted are listed in full at Appendix 3.

Data from family, friends and the community

2.3 The Lead Reviewers wanted to give the family the opportunity to contribute to the SCR. The Independent Chair of the DSCB wrote to the child's half siblings, and the father, to advise them about the SCR and the process. The letters also included an invitation for the family members to meet with the Lead Reviewers to talk about the family's view and in particular their thoughts about ways in which Services can be helped to improve the safeguarding of children. Similar letters were later sent to the maternal and

paternal grandparents. The allocated police Family Liaison Officer was advised about the letters and was available to explain the process and provide support to the family if required. Contact was also made with the victim support homicide service case worker, who is working with the child's half siblings, in order to help facilitate any future meetings with the family.

2.4 It was decided by Devon's Safeguarding Children's Board (DSCB), in consultation with the police investigation team, that whilst a conversation about the process would take place with family members, any deeper discussion about the family's experience should not take place until after the criminal process had concluded. This was due to the fact that some of the family members may be required as witnesses for any future court proceedings. At the time of writing this report there have been two responses from family members, the maternal grandmother and the child's half-sister, both have been contacted by telephone by one of the accredited lead reviewers. The maternal grandmother has declined further involvement in the Review and the child's half-sister has stated she will make contact if she feels able to in the future.

Parallel criminal investigation considerations

2.5 It was recognised by the DSCB and the Lead Reviewers that there are some inherent risks in undergoing two processes simultaneously. However it was recognised that to delay the SCR would not be in line with the priority of the DSCB that early learning should be gained and disseminated to ensure any failings in the safeguarding system are identified and rectified rapidly. To achieve the DSCB priority, whilst ensuring the integrity of the investigation was maintained, a liaison Detective Chief Inspector was appointed to work with the Lead Reviewers throughout the SCR process.

2.6 The Detective Chief Inspector (DCI) attended the initial meeting and spoke to both the Review Team and the Case Group about his role and in particular how any potential disclosure issues should be handled. The CPS (Crown Prosecution Service) was aware of the SCR and was content from the outset that, with the oversight of the DCI, it would not adversely affect the criminal process.

2.7 It was decided that the involvement of family members, as previously discussed at 2.27, should be delayed until the conclusion of the criminal justice process. This was directly as a result of the family members being key

prosecution witnesses for the criminal case. As discussed at 2.21 there are plans to visit the family members who have responded.

3. The Review

Introduction

3.1 Once the SCR was instigated in March 2013 an early meeting was arranged between the Lead Reviewers (both accredited and mentored), the DSCB Chair at that time and the Children's Social Care senior manager assigned to assist the DSCB Chair in quality assurance, to discuss the SCR process. There was a decision made at this point that the time period the SCR should cover would be from the birth of the child until the date of death. This decision was reached primarily as an initial scoping of information held by agencies did not indicate any significant involvement with the mother, the half-brother or the half-sister before the birth of the child. In addition it was known that the SCIE systems methodology was generally more effective when considering more recent professional involvement.

3.2 The Lead Reviewers then considered the multi-agency chronology and, where appropriate, documentation (agency records and case files). The Lead Reviewers identified significant time periods of agency involvement with the child and their family from which provisional KPE's (key practice episodes) were drafted.

3.3 The provisional KPE's were shared with the Review Team at the first meeting and they were asked to review the multi-agency chronology themselves and encouraged to consider and challenge the appropriateness of the provisional KPE's and also to identify any further KPE's. As a result of the Review Team's involvement and input the KPE's were adjusted.

Timeline

The timeline presented in the table below provides a summary of ***key*** events, actions and decisions. It is not comprehensive but intended to provide sufficient detail of how the case developed, to provide the broader context for the illustrations used in the findings.

17 October 2010	Birth of the child.

30 January 2011	The father commits criminal damage outside the mother's home address.
19 February 2011 to 15 March 2011	Repeated reports by the mother to the police concerned about the father coming into the garden and trying to break into the house.
18 March 2011	The mother is arrested by the police and detained for assessment under the mental health act. The child is accommodated.
19 March 2011	The mother is detained under the mental health act and taken to hospital for treatment.
31 March 2011	The child is returned to the care of the half-sister and half-brother.
5 April 2011	The mother is discharged from hospital and returns home.
8 April 2011	The father is convicted of criminal damage. Restraining Order issued for 2 years. He also receives a supervision order and attends meetings with the Probation Trust over the next 12 months.
19 April 2011	The mother is discharged from CRHT.
27 April 2011	Case closed to children's social work.
18 May 2011	Case discussed at MARAC.
5 November 2011 to 16 November 2011	Concerns raised by police, family and GP about mother's mental health. Crisis Resolution Home Treatment Team (CRHT) involved from 09/11/11. The mother is assessed under the mental health act on 16/11/11 after several failed attempts in preceding days, she is not detainable.
21 December 2011	Final contact between CRHT and the mother. She stated she wanted no further contact from adult mental health services.
10 April 2012	Last contact between the father and the Probation Trust.
16 July 2012	The father breaches the Restraining Order by attending

	the mother's address, banging on the door and then using a knife he had brought with him to cut his wrists (superficial injuries). The father is arrested.
18 July 2012	Child's father pleads guilty and is convicted on 13/08/12 and sentenced to a suspended prison sentence and unpaid work.
7 September 2012	The child starts pre-school.
November to December 2012	The child was seen at the GP practice, diagnosed with viral upper respiratory tract infection. The child was absent from pre-school as result of virus until early December.
December 2012 to January 2013	The GP practice initially contacted the child's mother in late November to arrange a mental health review. On 07/12/12 she failed to attend mental health review. Appointment rearranged for 11/01/13 but was cancelled by her at the last minute.
18 January 2013	The child is collected from pre-school by mother.
19 January 2013	The mother is found by a member of the public and taken to local police station. The child was located deceased at the home address.

Key Practice Episodes (KPEs)

1. The first indication to any agency of a repeat of mother's mental health deterioration and the subsequent agency response (November 2011).

Mother's mental health declined in March 2011 resulting in a mental health assessment with her being detained under the Mental Health Act 1983, Section 2[1]. She remained in hospital for a short time (approximately 2 weeks) before returning home. The child was accommodated briefly by the Local Authority and then placed in the care of half-brother and half-sister prior to their mother's

[1] *Section 2 (s2) allows a person to be admitted to hospital for an assessment of their mental health and receive any necessary treatment.*

discharge. However it was the repeat of the mother's mental health deterioration in November 2011 which the Lead Reviewers and Review Team considered to be significant. It was felt that a second episode in a relatively short space of time represented a potentially higher level of risk for the child and therefore it was the agency response at this point which was of specific interest. The KPE was drafted as a starting point, as the SCR progressed it became increasingly more evident that the actions by organisations in March 2011 were crucial in understanding future decisions about the mother and child. The period of time from March 2011 to January 2012, when the mother disengaged with the Crisis Resolution Home Treatment Team (CRHT), was the most intensive period of professional interaction with the family and as a result has been a focus for much of this SCR.

2. The re-emergence of the domestic abuse towards the mother and the impact on her mental health, by her ex-partner, the father, and the breach of the Restraining Order in July 2012.

A review of the entire multi-agency chronology indicated that the deterioration in the mother's mental health was potentially linked with an increase in the occurrence of domestic abuse incidents. Between January 2012 and July 2012 there was a relatively inactive period of professional interaction with the mother. The breach of the Restraining Order was seen by the Lead Reviewers and Review Team as a very significant event for the mother and represented a clear opportunity for organisations to become re-involved with her and any risk to the child to be re-assessed. It was known that, due to an administrative error, the breach did not result in specialist domestic abuse officers (police) attempting to engage with the mother or a referral to MARAC (Multi Agency Risk Assessment Conference) or an IDVA (Independent Domestic Abuse Advisor), so it was essential to examine in detail this period.

3. The MASH (Multi Agency Safeguarding Hub) response and decision making process related to the subsequent 121A and the response from universal agencies (July 2012 onwards).

The Lead Reviewers and Review Team considered that, particularly in the context of a link between mental health and domestic abuse, there was a requirement to fully understand the rationale behind the decision making in the MASH. It was clear from the multi-agency chronology that there was only limited universal agency interaction with the mother and child from July 2012 to the child's death. There was a sense with the Review Team that the child became increasingly 'unseen' in the family

situation as time progressed and as such any risk to the child that might exist could not be properly assessed.

4. A summary judgement of how professionals responded to this family

- This section aims to judge how appropriate the way professionals handled the case was, given what was known and knowable at the time. This appraisal is made with reference to the available evidence base, professional standards and practice wisdom.
- Using a systems approach to learn from professional practice does not excuse poor practice.
- Where errors have been made, or professionals have failed to follow appropriate and expected processes it is important these are identified in a straightforward way.
- There is always the possibility that these may indicate disciplinary or capability issues related to the professionals concerned. These are not dealt with through the SCR process.
- The SCR focuses on understanding why people acted as they did. Adequate explanations are necessary to prevent similar types of poor practice reoccurring. The subsequent 'findings' section of the report focuses on explaining why people made the decisions they did.

4.1. This case illustrates the very real difficulties experienced by a multi-agency system when faced with a vulnerable adult, with the care of a child, deemed to have the capacity to make decisions about her treatment, including withdrawing from it. Throughout this period the majority of the agencies involved in this case focussed their attention on the child's mother, and her needs, and were not sufficiently thinking about the potential risk to the child, should mother's mental health deteriorate again after the first episode of mental illness. The reasons behind this are explored in Finding One.

4.2 This case also embodies the complexities of adult and children's services working together in circumstances where there is a parent with mental health difficulties. Mental health difficulties affect a significant proportion of the adult population; it is estimated that as many as 9 million adults – 1 in 6

of the population – experience mental ill health at some time in their lives. Around 630,000 adults are estimated to be in contact with specialised mental health services. Data is not collected nationally about how many of the adults receiving specialised mental health services are parents or carers, but it is estimated that 30% of adults with mental ill health have dependent children.[2]

4.3 Nationally there is evidence that some parents with mental illness place their children at potential risk of harm. What is striking about this case is that, despite the number of agencies involved with the family, there was little communication between them which would have allowed for joint assessments of the risks to the child, either from the father or the mother.

4.4 There were some good examples of agencies working together initially, for example, the Neighbourhood Beat Manager and the Health Visitor both attended the ward round at the Glenbourne Unit when the mother was detained under the Mental Health Act, in March 2011. However, this led to the staff at the Crisis Resolution Home Treatment Team (CRHT) believing erroneously that they would be actively monitoring the mother's behaviour and would refer any concerns. Following the arrangement made by Children's Social Care for the mother's adult children to care for the child, the lack of joint working meant that no consideration was given as to what action should be taken were these protective factors to be removed in the event that the adult children left the home and the protection they provided was no longer available.

4.5 The Review Team felt that there were at least two occasions in which concerns were raised and action could have been taken to reassess whether the child was at risk. On neither occasion did this happen. In the absence of any of the agencies taking the Professional Lead in this case there was no obvious point of contact or conduit for concerns to be raised, logged and action taken. The reasons behind this form Finding Two.

4.6 Throughout this case the Review Team found evidence of 'silo working' with professionals making assessments based on very little information and knowledge other than that immediately being presented to them. Individuals did make some basic administrative errors in this case which did have some impact on the direction the case subsequently took, but this was within the

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[2] Families affected by parental mental health difficulties, Family Action; www.family-[2] D Meltzer, Inequalities in mental health: a systematic review action.org.uk/section.aspx?id=9054.

context of being both short-staffed and with high workloads. Staff under pressure are highly likely to make basic administrative mistakes and the Review Team has not given undue weight to these errors. Of far more significance are the wider operating systems which do not offer any opportunities for professionals working within their own 'silos' to routinely discuss vulnerable adults where they have concerns. The reasons behind this form Finding Three.

4.7 The significance of the breach of the Restraining Order and the effect of father's actions on mother and child was underestimated by all the agencies. The reasons behind this form Finding Four.

In what ways does this case provide a useful window on Devon's safeguarding systems?

4.8 Cases involving mothers who are vulnerable to the ebbs and flows of a mental health condition, together with other significant stress factors in their lives, such as domestic violence, need timely and effective help in order to avoid the 'sudden and unpredictable outburst' described by Lord Laming in his 2009 report *'The Protection of Children in England'*. This case presented the agencies involved with the family with a dilemma as currently there is no system for routinely monitoring adults with a history of mental illness when they care for a child, so how would the warning signs of deteriorating mental health be picked up?

4.9 Whilst this case has features which are unique to the individuals concerned and their particular circumstances, there are many other families which have similar characteristics and so this is a useful case to test how reliably our systems respond in such scenarios.

4.10 The case has provided a useful window on systems operating within multi-agency safeguarding teams such as the MASH and other multi-agency processes such as the MARAC. It is a useful test of whether the systems Devon has in place are sufficiently robust in their application to be safe.

What light has this case review shed on the reliability of our systems to keep children safe?

4.11 The Review Team identified four findings for the DSCB to consider.

4.12 In order to allow common themes to be readily identified across multiple case reviews, the Learning Together methodology expects underlining issues and findings from case reviews to **fall under six broad themes** :

1. **Response to incidents and crises**
2. **Longer term work**
3. **Cognitive and emotional crises**
4. **Family – Professional interaction**
5. **Tools**
6. **Management systems**

4.13 The Review Team are expected to present a clear account of:

- how the issue manifests itself in the particular case
- in what way it is an underlying issue – not a quirk of the particular individuals involved this time and in the particular constellation of the case
- any information they have gleaned about how general a problem this is perceived to be locally, or data about its prevalence nationally
- how the issue is framed for the DSCB to consider the risk and reliability of multi-agency systems and the relevance of this to the DSCB's overall aims and responsibilities.

4.14 The four findings from this case review are as follows:

RESPONSES TO INCIDENTS AND CRISES

1. Where adult mental health services withdraw services to a parent because they are not engaging, given they have mental capacity, there is currently no system in place in Devon to assess current or future risks to any children in the family and create an appropriate safety plan, leaving it to chance whether professionals are alerted to any deterioration or change that adversely affects the children's safety and welfare. (Response to incidents and crises)

2. Professionals are making assessments based largely on presenting information only and are not considering the wider implications for child safety. (Response to incidents and crises)

3. The system used to triage cases in the MASH does not adopt a clear risk assessment based process and is therefore susceptible to inconsistent application of thresholds. (Response to incidents and crises)

LONGER TERM WORK

4. The MARAC process focuses on adult, rather than child protection and this is reinforced by the agencies invited to attend the meetings. (Longer term work)

5. FINDINGS IN DETAIL

FINDING 1. Where adult mental health services withdraw services to a parent because they are not engaging, given they have mental capacity, there is currently no system in place in Devon to assess current or future risks to any children in the family and create an appropriate safety plan, leaving it to chance whether professionals are alerted to any deterioration or change that adversely affects the children's safety and welfare.

Illustration from the case
On 19th April 2011 the mother's case was closed to the Crisis Resolution Home Treatment Team and just over a week later, on 27 April 2011, the case was closed to Children's Social Care without any discussion between the two services. Whilst Social Care staff are normally invited to discharge meetings this is not always the case and there is no system in place to ensure it happens. The prevailing belief appears to be that if the parent is not 'sectionable' then they are not a risk and the CRHT do not inform the MASH when they are called out to make an assessment. Joint assessments between adult mental health services and Children's Social Care do take place sometimes but this is based on professional's view of the seriousness of the

case. In this case it meant that there was no system in place to ensure that the mother's mental health was being monitored and any escalation of risk addressed.

5.1. During the period between March 2011 and November 2011 there was significant agency involvement. The CRHT, Community Mental Health Team, Children's Social Care, Police, GP, Health Visitor and Devon & Cornwall Probation Trust were all involved but largely working independently of each other. Any possibility of agencies liaising with each other ended in May 2011 by which time the CRHT, Children's Social Care and the MARAC had all closed the case and therefore their involvement had ceased. Members of the Review Team confirmed that agencies do close cases independently of each other, without consulting on the possible impact of this, but expressed concern that this should be the case when dealing with vulnerable adults who have the care of children.

5.2 This tendency to work in isolation was highlighted in the recent Ofsted report *'What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems'* March 2013. In that report they found that 'in assessments where there were issues of parent or carer mental ill health, professionals did not routinely approach the assessment as a shared activity between children's social workers and adult mental health practitioners, in which each professional drew on the other's expertise. As a result, the majority of assessments did not provide a comprehensive and reflective analysis of the impact on the child of living with a parent or carer with mental health difficulties.' The Ofsted Report noted that in most cases they reviewed when parents had been admitted to hospital, joint working was poor in ensuring that plans for discharge took the children's needs into account

5.3 It might be regarded as good practice that the Neighbourhood Beat Manager and the Health Visitor attended a ward round when the mother was an in-patient at the local mental health Unit (this is very unusual). However, this led to an assumption by the CRHT that the mother would be receiving ongoing support and monitoring when discharged and that any deterioration in her mental health would be observed and action taken. This was particularly important because, following the mother's discharge from the local mental health unit, she was receiving no further support from adult mental health services.

5.4 Following the discharge of mother from the mental health unit GPs received a discharge summary but health visitors were not copied into

this. Health Visitors are further marginalised by not routinely being involved in decision making around potential foster placements and are not informed about Police Powers of Protection or other notification routes when children are taken into care.

5.5 From our conversations it became evident that individual professionals do not fully understand each other's roles and responsibilities and some assumptions are made, including the level of knowledge and training about mental illness. Because professionals don't fully understand each other's roles they lack the confidence to challenge other agencies/professionals and their decisions. For example, in this case the GP expressed surprise that the child's mother did not receive support following discharge from hospital, feeling that a Community Psychiatric Nurse should have been allocated, but he did not challenge this decision.

5.6 Even when concerns were expressed, firstly by the multi- disciplinary meeting held on 14th November 2011, and then by the Neighbourhood Beat Manager on 4 January 2012, there was no system for systematically logging these concerns and making a fresh risk assessment. The Review Team discussed the possibility of setting up local practitioner groups to discuss such cases but, with agencies stretched, it is unlikely that membership of all the agencies likely to be involved in individual cases could be sustained. In addition, it was felt that if the current systems worked better there should be no need for another process.

FINDING 1. Where adult mental health services withdraw services to a parent because they are not engaging, given they have mental capacity, there is currently no system in place in Devon to assess current or future risks to any children in the family and create an appropriate safety plan, leaving it to chance whether professionals are alerted to any deterioration or change that adversely affects the children's safety and welfare. (Response to incidents and crises)

Child protection and mental health services tread a difficult and sensitive line between being proactive to safeguard children and not unnecessarily infringing on the rights of parents, to privacy amongst other rights. This case has drawn attention to the way in which current arrangements in relation to parents with mental health issues disproportionately favour the adult's rights over those of their children. Where adult mental health services withdraw services to a parent because they are not engaging, there are currently no systems in place in Devon that create safeguards for the children in the future. There is no risk assessment or safety and contingency planning at the point of withdrawal. From the child's perspective, it is left to chance whether the professional network is alerted to deteriorations in the parent's mental

health or other changes that increase the risk of harm to children even though such recurrences are often more rather than less likely to happen.

There are some professionals who would be well placed to monitor, assess and respond to early indicators of potential mental ill health and the attendant risk to children but these professionals may not have sufficient information, knowledge or training to undertake this role.

Mental health services work within a framework in which adults who are deemed to have the capacity to make decisions cannot be forced to undergo treatment or receive support. This is the case whether or not they have the care of children. If, at the time of discharge from in-patient care an assessment is made that the adult does not pose a risk to children there is no system in place to ensure that this is a joint or multi-agency assessment, with a system of review built in.

In the absence of a system to continually assess the risk to children, universal services are best placed to raise concerns. This case has illustrated that in order to perform a child protection role effectively universal services need to be fully informed of the family 'history'. However, data protection legislation and concerns about information sharing is leading to anxiety and confusion about when information can be shared, and with whom, with or without consent. The culture of patient confidentiality in some organisations, such as those working within 'health', means that the focus tends to be on protecting this right rather than on the safety of children.

ISSUES FOR CONSIDERATION BY THE DSCB

- Do DSCB members think that the current arrangements for information sharing are appropriate for children of parents with mental health problems?
- Is there consensus on how agencies should respond in cases of vulnerable parents with children refusing treatment and/or support? For example, should guidance be issued to adult mental health practitioners and Children's Social Care stressing the need to work together to agree effective discharge/action plans and the closure of cases?
- What are the cost-benefits of different options?
- What are the real and imagined barriers to a more pro-active response by professionals?

FINDING 2. Professionals are making assessments based on presenting information only and are not considering the wider implications for child safety.

Illustration from the case
On Monday 16th July 2012 the child's mother called the police to state that her ex-partner was outside shouting through the letterbox. Police attended and he was found nearby in possession of a kitchen knife which he had used to self harm by cutting his wrists. He was arrested and later charged with possession of a knife in a public place and breach of the Restraining Order. He was convicted at court on 13th August 2012 and the Probation Service completed a Fast Delivery report for the Court with a recommendation that the ex-partner complete an Unpaid Work Order. Fast Delivery Reports have a three hour time allowance which covers an interview with the offender and writing the report. This only allows for limited further enquiries and in this case there is no indication that the report writer requested any information from Children's Services.

5.7 A key episode in this case was the re-emergence of the domestic abuse towards the child's mother by her ex-partner and the breach of the Restraining Order which was dealt with by the Court in July 2012, and the possible impact this had on the mother's mental health. Information from the CRHT who looked after her when she was first sectioned in March 2011 was that issues around the Restraining Order had a significant impact on her stress levels. This information does not appear to have been shared with other professionals. The apparent lack of information sharing meant that none of the other agencies understood the possible link between the Restraining Order being in place and the mother's mental health. Discussions with the case group uncovered the fact that none of them properly understood what a Restraining Order is and the implications or significance of the breach. There is also no system in place for supporting domestic abuse victims when Restraining Orders are reaching their end.

5.8 The Probation Service undertook a Fast Delivery Report in July 2012, based on the fact that they did not regard this to be a serious offence (only high risk, complex cases are dealt with by the preparation of Standard Delivery Pre-Sentence Reports). They had previously assessed the father as posing a medium risk of harm to the mother, through their attendance at the MARAC and previous supervision of him. The Senior Probation Officer on the Review Team explained that staff are under pressure by the courts and the Probation Service to complete as many reports as they can as quickly as

possible, so Oral Reports and Fast Delivery Reports are now used widely for all but the most serious offences. Fast Delivery Reports have a time allowance of three hours leaving the Probation Officer little time for making enquiries with other agencies (such as Children's Services) and without making a full risk assessment. However, in this case, a full risk assessment had been completed within the previous four months and information was available from the police domestic violence unit.

5.9 The Probation Service systems and processes means that, as in this case, it is not unusual for an officer from one team to be in court and deal with a case up to adjournment for reports and then an officer from a different team be allocated to prepare the report. This non-alignment with the courts is a structural issue which impacts not only upon the system of allocating and preparing reports but also the communication chain across and between agencies.

5.10 In this case the report in July 2012 was based largely upon the presenting facts and information in the case and the potential risk to the child appears not to have been addressed. As the offender was not living at the home address of the adult victim he was assessed as low risk of harm and the previous spousal risk assessment suggested that his participation in the 'Building Better Relationships' Programme was not warranted. His non-compliance with the Restraining Order and bail conditions appear to have gone unremarked. Despite the mother's wish that the Restraining Order be extended, it is not clear who would be responsible for ensuring that her wishes were acted upon and there is no system in place to deal with issues arising from Restraining Orders coming to an end.

5.11 Both the GP and the Health Visitor had contact with the mother around the time of the Court proceedings. Neither appreciated the impact of the domestic abuse and instead made assessments based on the presenting issues. GPs do not receive 121As so would have been unaware of the notification and the Health Visitor appears not to have recognised the potential significance of the information contained within it. Ironically, her focus was almost exclusively on the child's physical wellbeing and emotional presentation rather than on considering any wider implications of the domestic abuse on the mother's mental health and assessing risk.

5.12 Cases assessed as high risk should be referred to the MARAC and actions agreed with relevant agencies. When the breach of the Restraining Order was input by the Central Data Input Bureau (CDIB) a domestic violence code should have been included in the electronic record but this was

omitted. This code is used by the Domestic Abuse Unit (DAU) to search for incidents in their area. There was consequently no involvement by DAU and no referral to MARAC or IDVA. In Devon there is no 'back-up' system in place to ensure that the DAU is alerted to incidents so is totally reliant upon an administrative process being followed in every case. The absence of a MARAC referral meant that the child's mother was not offered support by the IDVA and a potential means of monitoring any deterioration in her mental health was lost. Furthermore, police involvement and support was not reinstated.

FINDING 2. Professionals are making assessments based on presenting information only and are not considering the wider implications for child safety.

Research cited in this report clearly shows that adult mental health services and children's services must work together to be able to meet the needs of families. The SCIE Guide entitled 'Think Child, think parent, think family: a guide to parental mental health and child welfare'(1) describes how the current organisational context and separate legal frameworks leading to separate guidance on policy and practice has led to a specialisation of knowledge and management structures in different departments. This has led to agencies being accused of 'silo' working and not communicating with each other sufficiently.

Services who work exclusively with adults are at risk of losing sight of the child and failing to take into account the impact of the adult's behaviour on children. Increasingly, time and other organisational constraints are placed on frontline staff and this can lead to assessments and decisions being made on limited information or understanding. The tendency is for adult services to consider the needs and well-being of adults rather than undertake full assessments of risk to children, including any protective factors which might mitigate the risks. This is why a system of joint working with Children's Services is vital if children are to be adequately protected.

During a time of significant budgetary pressures services are almost bound to enter a period of retrenchment. Combine this with a lack of recognition of the impact of adult mental ill health on children and there is then a serious risk of practitioners not engaging with other services in order to understand the wider child protection concerns. Although adult mental health services are expected to consider child protection there are no national requirements to gather information and report on children whose parents or carers have serious mental health difficulties. This lack of accountability increases the likelihood that these services give insufficient attention to the risk of harm to children.

ISSUES FOR CONSIDERATION BY THE DSCB

- How can communication and joint ownership of risk assessments between adult services and children's services be improved?
- How can the meaning/ implication of Orders, such as Restraining Orders, be disseminated across a wide and complex workforce?
- How can the DSCB ensure that financial constraints do not compromise children's safety?

FINDING 3. The system used to triage cases in the MASH does not adopt a clear risk assessment based process and is therefore susceptible to inconsistent application of thresholds.

Devon's Multi Agency Safeguarding Hub (MASH) is a partnership between Devon County Council Children's Social Care, Education and Youth services; Devon and Cornwall Police, Health and the Probation Service, Youth Offending Team (YOT), Early Years Childcare Services (EYCS) and Domestic Violence Services (DVS). Information can be received into the MASH through enquiries from both professionals and the public; following such enquiries relevant information will be sought from partner agencies within the MASH which will then inform decisions about whether the child is at risk of significant harm or may benefit from support from other services. All referrals are subject of triage at point of receipt and not all will be passed into the MASH process.

Illustration from the case
In this case the breach of the Restraining Order on 16th July 2012 was dealt with by the police who completed a 121A (police notification form of contact with a child) on 17th July 2012. This form was evaluated by one of the police **e**valuators who work alongside MASH on 19th July. The form was sent (electronically) to MASH for triage

where it was first seen by the triage social worker who provided initial MASH analysis and then the Practice Manager. The decision by the social worker and signed off by the Practice Manager, was that it would not go into MASH with a request for information from all other agencies and was therefore classed as information only. Whilst there are published thresholds, this decision was not based on all the available information and, given the history of mental illness and domestic violence, should have triggered a different response. The 121A was sent to Health (not the GP) and the Education Welfare Service (who do not deal with children below compulsory school age).

5.13 The process by which this 121A form, following the Breach of the Restraining Order, was RAG rated and then sent to the MASH with the words 'For Information Only' was a cut and paste error by the police evaluator. At the time the team of police **e**valuators were not at full strength so were behind with the work. During such periods reduced background research is undertaken in order to keep on top of the workload. The information on the police form passed to MASH did not include the DASH (Domestic Abuse Stalking Harassment) risk assessment or MARAC information. The decision to take no further action (made by a Social Worker and signed off by the Practice Manager) was made on just police historical information and previous children's services information. The rationale for the decision was based on an inaccurate interpretation of the information provided and the reassurance that the father was not living in his child's home. This 121A was then sent to health and education, with the potentially misleading message still attached to it. This system of marking 121As 'for information only' ceased at the end of 2012.

5.14 The decision to take no further action did not adequately take into account the presence of the 'toxic trio' of domestic abuse, adult mental illness and alleged drug taking. At the time the MASH were running a pilot with adult mental health services (from June-September 2012) in which a worker was based in the MASH, contributing to the information gathering and providing advice. Prior to the decision to take no further action this worker was not asked to either gather further information, or provide advice to guide the assessment. The success or otherwise of this pilot has not been formally reviewed.

5.15 The assessment by the Social Worker who triaged the referral was fundamentally flawed as it simply focussed on the potential risk posed by the father. It was based on limited information and therefore did not

consider the possibility that mother's mental health may in itself be a risk to her child. The Review Team were concerned that there is too much scope in the MASH operating system for variable and inconsistent decision making based purely on a social worker's professional judgement with no consistently applied risk analysis or threshold.

5.16 The workers from adult mental health services expressed the view in the case group discussion that referrals made to the MASH by them are not given sufficient weight and this perception was echoed by other case group members. Given that referrals from adult mental health services are relatively infrequent it seems surprising that this should be the case. The Ofsted Report on joint working between adult and children's services, referred to earlier in this review, found that in some cases adult practitioners had to make repeated referrals before Children's Social Care took any action and that adult services practitioners did not challenge Children's Social Care when they were not satisfied with the response to a referral. This reflects a culture of giving concerns from adult services practitioners insufficient weight (although it may be the case that the level of concern is not always clearly expressed and evidenced). The Review Team felt that the current MASH system has a bias towards **Children's** Social Care which takes insufficient account of the knowledge and understanding of other agencies who may bring a different perspective to the decision making process.

FINDING 3. The system used to triage cases in the MASH does not adopt a clear risk assessment based process and is therefore susceptible to inconsistent application of thresholds.

Almost all Local Authorities have now adopted some form of Multi-Agency Safeguarding Hub. In Devon the decision was taken to get the MASH up and running and then resolve all the issues that would inevitably arise, including those around governance, over time. This approach is not without its risks.

The Ofsted Inspection of Devon's arrangements for the protection of children in April 2013 highlighted serious weaknesses in the MASH system, stating that 'professional judgements made by social care managers are of variable quality and are not subject to effective quality assurance arrangements'. Inspectors found inconsistent decision-making in the application of child protection thresholds. The report states that 'in some cases, risks are not being sufficiently identified resulting in decisions which failed to provide timely and appropriate

protection to children'.

This case confirms the weaknesses identified by Ofsted. Whilst the Review Team felt that in this case the outcome would still have been 'no further action', it raises systemic concerns. These need to be addressed in order for all the partner agencies to be reassured that children are being caught by the safety net created by the MASH process.

ISSUES FOR CONSIDERATION BY THE DSCB

- What actions do DSCB consider necessary to ensure that MASH is a robust safeguarding hub?

  - Should professionals from other agencies be part of the risk assessment and decision making processes in the MASH?

  - What are the cost-benefits of different options?

Longer Term Work

FINDING 4. The MARAC process focuses on adult, rather than child, protection and this is reinforced by the agencies invited to attend the meetings.

5.17 The Review Team found that once both adult mental health services and children's services had closed the case the one remaining opportunity to put in place safeguards for the child was the MARAC, which met on 18 May 2011. The focus of the MARAC is not on protecting children but on the perpetrator of domestic abuse and the principal victim (usually the ex-partner). Any risk to children is discussed within the context of the risk posed by the perpetrator and not the potential risk posed by the victim. Reviews by Ofsted of SCRs from April 2007 to March 2011 highlighted repeated examples of the risks resulting from the parents' own needs being underestimated – including when parents had mental health difficulties and/or drug and alcohol problems.

5.18 As far as could be ascertained from the brief Minutes of the MARAC meeting, there were no actions specifically aimed at supporting the child.

5.19 These meetings generally include representatives from both adult and children's services but, in the absence of clear indications of significant harm to children, the process does not facilitate the protection of children being given top priority. The Review Team felt that risks to children should be given at least as much consideration in the MARAC process given that it is a multi-agency meeting and therefore an ideal opportunity for professionals from adult and children's services to share information and concerns.

5.20 Whilst it was not a particular issue in this case, the Review Team were aware that attendance at MARAC meetings can be compromised when families live close to the borders between different Local Authorities and may be receiving services from both. Individual agency representatives are not inclined to attend more than one MARAC and this can compromise effective information sharing.

5.21 In this case an administrative error by the police meant that the case was not referred back to the MARAC following the breach of the Restraining Order. This oversight meant that the opportunity was lost to put in place an action plan in the months leading up to the child's death. It also meant that the mother was not supported during a period when it is very likely that she was becoming increasingly anxious about the Restraining Order coming to an end.

FINDING 4. The MARAC process focuses on adult, rather than child, protection and this is reinforced by the agencies invited to attend the meetings.

The number of domestic homicides has been a national issue for some time. In response to this a number of police forces, including Devon & Cornwall, alongside ADVA (Against Domestic Violence and Abuse), introduced a system of holding MARACs in high risk domestic abuse cases. This was originally conceived by the police as a way of identifying high risk (adult) victims and supporting them in order to reduce the number of domestic homicides. The MARAC process is therefore led

by the police and this has had the unintended consequence of the referrals into the MARAC being made overwhelmingly by the police with the process continuing to have the adult victim as the principal focus. Given that research shows that children are present in at least 30% of domestic violence incidents and approximately half of all child protection cases contain an element of domestic abuse, placing children at the heart of the system would empower professionals from all agencies to consider the particular impact and risks to children living with either perpetrators or victims of domestic abuse.

This case demonstrates the inadequacies in a system which defines one adult as the perpetrator and one as the victim, with insufficient attention focussed on the risk to children posed by either adult.

If all agencies were better engaged with domestic abuse risk assessments and referral to MARAC the system would not be almost totally reliant upon the police making the referrals. This would help to shift the culture away from it being an adult perpetrator/victim focussed process towards becoming more holistic in approach, considering the impact of domestic abuse on all family members.

ISSUES FOR CONSIDERATION BY THE DSCB

- How could the MARAC process be used more effectively to protect children from harm?
- Is there a need for a review of the MARAC system and processes?
- How can we encourage professionals with concerns to refer these to the MARAC?

TOOLS

What has been learnt about the tools and their use by professionals?

5.22 In conducting this review the Review Team found that front-line practitioners are not always best served by the systems they use, often on a daily basis.

5.23 GP practices now use electronic patient records, often with a flag system to alert GPs to specific conditions or issues. However, these flags (denoting

child protection or domestic violence for example), in the words of the GP in the case group, don't always 'scream at you'. In a system where patients may be seen by a variety of GPs within the practice this is a system risk. Having an electronic patient records system means that although important information, such as discharge letters from the CRHT, are sent to GP practices and may be scanned into the patient's records, they are not necessarily easily accessible to other healthcare professionals such as the health visitor.

5.24 Both the GP practice for this case and another GP practice for a different case, (previous local SCR) have, as a result of what happened, recognised the importance of sharing concerns about patients with each other and are taking greater ownership for the receipt of letters and test results. Similar systems may not be in place across other GP practices in Devon.

5.25 A number of services and teams continue to use paper based recording systems which cannot be integrated with other records. A previous SCR in Devon highlighted the shortcomings of using a paper based system in terms of the out of hours GP services. It also means that there is a barrier to sharing information even within GP practices.

5.26 The Single Point of Access (SPOC) system for the distribution of 121As, introduced in 2009, needs urgent review. The Probation Service and GPs do not receive 121As so neither are aware of incidents/concerns involving children. The Review Team heard that even those services which do receive the 121As do not always have effective systems for their onward transmission, leading to delays for all those who would benefit from knowing the information contained within them.

Ownership and action – DSCB and member agencies responsibilities

During the process of completing this SCR the Review Team and Case Group identified a number of practice improvements which have already been implemented. Listed below are some of these improvements:

5.27 The GP practice is now holding weekly meetings to discuss vulnerable patients and the ownership of letters and test results is much clearer. (GP Practice)

5.28 The Mental Health unit are planning to produce leaflets for carers, including the signs and symptoms of mental illness. It will include details of

how to contact them in an emergency. (Crisis Resolution Home Assessment Team)

5.29 The practice of putting 'For Information Only' on 121As has been stopped. The police are considering which other agencies might benefit from receiving these notifications. (121A Evaluators)

Conclusion

Whilst this review has identified a number of issues for agencies to resolve and so improve the safeguarding of vulnerable children in Devon, the opinion of the reviewers is that the tragic death of this child, was unexpected and could not have been predicted and so prevented.

Recommendations

1. All services engaged primarily with adults to develop practice tools that will assist staff to identify the risks that adults may pose to their children. All agencies working with adults must make their own assessment of risk to children and should not rely on whether or not the child is known to Children's Social Care as the basis for this assessment.

2. Where there is a risk of further illness in the parent that is likely to have an effect on the child/children, a multi-agency meeting should be called. The purpose of this meeting is to jointly assess the potential impact on the child/children and agree a contingency plan should protective factors be removed. The plan must be communicated to other agencies that may have contact with the family.

3. GP practices need to find ways to receive and respond to indicators of risk to children, including incidents of domestic violence. A nominated Senior person within every GP practice is to ensure that there is a recognised and effective system within their practice to flag up incidents (including domestic violence) and fulfil their safeguarding responsibilities.

4. A process should be commissioned to enable GP practices to receive police 121A's.

5. The findings from this Serious Case Review relating to the MASH should be referred to the current MASH review/MASH Board.

6. An appropriate representative from all agencies who are signed up to the MARAC operating protocol should ensure regular and effective attendance at all MARAC meetings. Alongside the assessment of risk to the adult victim, the risk to children should be specifically considered in every case. The chair of the MARAC is responsible for ensuring that risks to children are thoroughly considered.

7. The DSCB will receive an annual report from MARAC with specific reference to the identification of risk to children and the appropriate referral of children to the MASH in incidents where the risk meet the threshold for social care intervention.

6. Glossary

- **Case Group:** Staff directly involved in the case from all agencies
- **Findings:** What has been learnt from the particular case about the general functioning of the local multi-agency child protection system
- **First follow-on meeting:** Discussion meetings held where staff directly involved in the case are asked to check, correct and amplify the analysis of the Review Team to-date
- **KPEs (Key Practice Episodes):** Episodes in the case that have been highlighted for detailed analysis
- **Lead Reviewers:** The pair who lead the case review process
- **Review Team:** Group of senior representatives from the involved agencies who conduct the case review. Generally the expectation is that they should have had no direct decision making role in relation to the case
- **SCIE (Social Care Institute for Excellence):** SCIE is an independent charity and, working with Professor Munro, has been developing the Learning Together systems methodology for case reviews and SCRs since 2006.
- **Second follow-on meeting:** Discussion meetings held where staff directly involved in the case are asked to compare their handling of the particular case with their ways of working in other cases and more generally
- **Window on the system:** The phrase has been coined by a health academic called Charles Vincent to capture the goal of a case review

Appendix 1

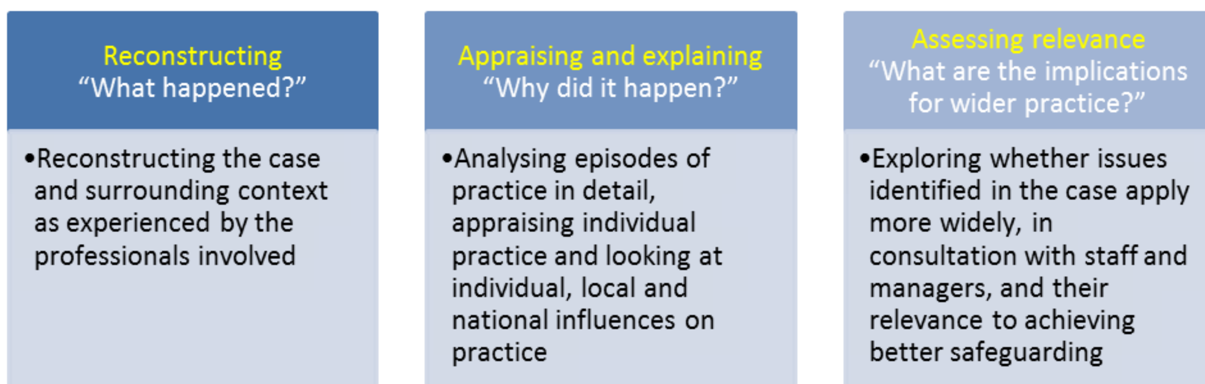
SCIE methodology and special dispensations/conditions adopted by the DSCB

1. SCIE methodology

1.1 The focus of a SCR using a systems approach is on the multi-agency professional practice. The methodology allows the reviewers to go beyond the case specifics, and explore what happened and why, identifying underlying issues influencing practice more widely. This 'deeper' exploration identifies generic patterns that constitute 'findings' or 'lessons' about the system which move it from the case specific to a systems wide analysis.

1.2 The key advantage of the SCIE methodology is the emphasis on the 'learning together' principle which runs through the entire process. It is the active engagement of professionals that provides real understanding of how things are in practice and therefore what can be improved in the 'systems' to help professional consistently achieve good practice. It is also a way of providing professionals emotionally affected by the case to start to come to terms with what happened and why and allows them to see that positives outcomes from such a tragic case can be achieved. Another key observation is the creativity of thinking, often directly from the involvement of frontline professionals, that is captured which directly leads to the development of potential solutions to the findings from the review. There is also evidence that simply the involvement in the process leads to more immediate changes in practice to improve safeguarding.

1.3 The analytic heart of the Learning Together model involves three essential aspects.



The 'systems' model helps identify which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely. It supports an analysis that goes beyond identifying what happened to explain why it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative model for case reviews – those directly involved in the case are centrally and actively involved in the analysis and development of recommendations. This is a key difference from the historical SCR method of using Agency's Individual Management Reviews (IMRs) to inform the Overview report.

1.4 For further information about the SCIE Learning Together systems approach for case reviews the full report by authors Dr Sheila Fish, Dr Eileen Munro and Sue Baristow can be seen by following the link below.

http://www.scie.org.uk/publications/reports/report19.pdf

Alternatively the ***key*** messages from the full report can be viewed by following this next link.

http://www.scie.org.uk/publications/reports/report19.asp

2. Dispensations and conditions

2.1 These were:

Conditions:

- All members of the DSCB must support the use of the SCIE model for this SCR.

- The DSCB will confirm that the Chief Executive and Lead Member of Devon County Council support the DSCB's plan to use the SCIE methodology for the SCR.

- The SCR will be conducted by reviewers who are fully accredited to use the SCIE model.

- The DSCB will provide the DfE with updates when required on the progress of the SCR which should include

    - the projected timescale for completion;
    - nature of the learning achieved and how this is being disseminated;
    - feedback from agencies and practitioners on the process followed;
    - the extent to which transparency is achieved in the process;
    - family involvement; and,
    - how issues of accountability are being tackled.

- The DSCB will aim to complete the SCR by September 2013

- The DSCB will put in place arrangements for evaluating the learning outcomes from the SCR.

- The DSCB will agree to share the learning about the process used in relation to the SCR with the DfE, professionals and relevant organisations including those outside its own areas.

- The DSCB must publish a full report of the findings of the SCR.

- The DSCB will use its best endeavours to involve relevant family members in the review in order to ascertain their views and wishes.

Dispensations:

- When conducting a review using the SCIE model, the DSCB will not be able to meet all the requirements of the statutory guidance for SCR set out in Chapter 8 of Working Together, in particular the guidance contained in:

- Paragraph 8.20 on determining the scope and terms of reference of the review;
- Paragraphs 8.29 – 8.31 and 8.34 – 8.39 on individual management reviews and health overview reports;
- Paragraphs 8.27, 8.32 8.33 and 8.40 on the overview report (but bearing in mind the need for the pilot to result in a report which is suitable for publication);
- Paragraph 8.41 on the SCR panel's responsibilities for the overview report;

- Paragraph 8.42 on the executive summary; and
- Paragraphs 8.43 – 8.46 about action to be taken on completion of the review, including evaluation by Ofsted.

The DSCB will be expected to follow statutory guidance in all other respects.

Appendix 2

<u>The Review Team for CN08</u>

- Accredited Lead Reviewers – Maria Kasprzyk (Professional Lead for Social Work Devon County Council), Helen Hyland (Designated Nurse for Child Protection NHS Devon).
- Mentored Lead Reviewers – Beverley Dubash (Portfolio Lead for Learner Support & Safeguarding Lead for Education, Babcock LDP), Sophie Creed (Serious Case Review officer for Devon and Cornwall Police).
- Nicola Jones – Commissioning Lead for Primary and Community Care (Clinical Commissioning Group (CCG) for NEW Devon).
- Neil Welock – Senior Probation Officer (Devon and Cornwall Probation Trust).
- Karen Hayes – Operations Manager, Children and Young People Services (Devon County Council).
- Deborah Wardknott – Child Protection Lead Eastern Area (Integrated Children's Services (ICS) Virgin Care).
- Nigel Wheaton – Team Leader Devon Partnership Trust (Adult mental health services).
- Julia Slingsbury – Public Health Nurse Lead /Service Manager Southern Area (Virgin Care).
- Chloe Webber – Domestic Abuse Strategic Officer (Devon and Cornwall Police).
- Rachel Martin – ADVA (Against Domestic Violence and Abuse) Manager (Devon County Council).

Appendix 3

Documentation

Agency records reviewed

- Public Health Nursing Records (Health Visiting)
- GP records for mother and child
- Social work electronic record
- Multi-Agency Safeguarding Hub (MASH) “referral information gathering form”
- Police records and description of contact (including MARAC (Multi-Agency Risk Assessment Conference) involvement)
- The Probation Trust records of involvement with the father of the child
- Devon Partnership Trust records
- South West Ambulance patient clinical records
- Community Health Care (CRHT)
- Pre-school records
- Children centre records

Additional data sources considered

- The Probation Trust pre-sentence report
- Restraining Order
- MARAC minutes
- 121a records
- 121a evaluation working practice
- MASH referral document
- CRHT discharge summary
- The Probation Trust supervision order contact records
- Children’s social work initial assessment and Emergency Duty Team record

National documents

- ‘What about the children?’ Ofsted and the Care Quality Commission thematic inspection report March 2013.
- ‘Think child, think parent, think family’ SCIE final evaluation report March 2012.

Appendix 4

Structure & publication of the report

- The main section of the report contains the findings of the SCR but it will not detail all of the 'workings out' of the Lead Reviewers and the Review Team in reaching the findings and as a result detailed documents such as the chronology are not included with the final report. However, as a result of learning from the SCR conducted in 2012, a précis of the chronology and decision making process in identifying the key practice episodes will be included to assure DSCB members that the methodology has been robust.

- This report is laid out using the SCIE report template and SCIE terminology.

- The report, in accordance with CPS advice, will not be published before the conclusion of any possible prosecution. In the meantime, DSCB are working on improvements that draw on the findings of this SCR and will report on these actions and resulting improvements at the time of publication of this SCR.

Methodology

- The DSCB had previously participated in the SCIE *'Learning Together to Safeguard Children'* pilot, trialling the systems methodology for SCRs and had completed a pilot review of a case in Devon in 2011. In 2012 the DSCB was one of three LSCBs nationally to use the systems methodology for a SCR.

- As the new Working Together to Safeguard Children had not been published at this time the 2010 Working Together was used to decide if the case reached the criteria for a SCR. The DfE, whilst not expressly giving special dispensation to use the systems methodology were content that the DSCB had sufficient experience from recent reviews to make an informed decision and therefore did not object to the use of the SCIE methodology. On the 18 February 2013 the DSCB advised the DfE that a SCR had formally been instigated and that the learning together SCIE systems approach would be used.

Although there was no official special dispensation given by the DfE the DSCB decided that it would be prudent to adopt similar conditions and dispensations that had been used for the previous SCR in 2012. These are described in detail in Appendix 1 with this report.

Learning Together systems methodology

- The key points of a systems approach are listed below; however Appendix 1 with this report provides a more detailed description of the process.
- The analysis is not only confined to the specific case but the case is used as a means to assess how multi agency systems are functioning.
- The ‘systems’ model helps identify which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely.
- It is a collaborative model for case reviews – front line practitioners directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

The Review Team

- The DSCB appointed two Lead Reviewers who had previously participated in the SCIE pilot and had then led the SCR in 2012. The Lead Reviewers had also been accredited through the SCIE accreditation process since the 2012 review. However in a change from the previous SCR the DSCB felt it would be prudent to have two additional unaccredited but carefully selected Lead Reviewers who could be mentored through the process. The intention being that the availability of additional, trained and accredited Lead Reviewers from different professional backgrounds would provide resilience to the DSCB for future case reviews, audits and SCRs.

- The Review team and the Lead Reviewers have collectively undertaken the role of data collection and analysis, the Lead Reviewers have been the authors of the final report but consultation and reflection with the Review Team has been made during the report writing stage. Ownership of the final report lies with the DSCB as commissioner of the SCR.

- The Review Team was made up of senior representatives from different agencies, for full details of the Review Team members please see Appendix 2.

Governance

- There was an expectation from the DfE that the DSCB would seek peer review for the SCR to provide a form of quality assurance and challenge throughout the review process. Whilst attempts were made to engage neighbouring LSCBs this was difficult to achieve so the previous chair of the DSCB agreed to act as the independent SCR chair to provide quality assurance, with the support of an experienced children's social work senior manager who had extensive experience in SCRs and had no involvement in the case.

- The Lead Reviewers were also able to access SCIE for advice and support and through this SCIE were considered to have provided methodological oversight and quality assurance for the process.

Structure of the review process

- The Learning Together review model developed by SCIE has a clearly staged process but as a result of the experience of the DSCB in conducting reviews using this methodology a slight deviation from the process has been developed which has been found to be extremely successful.

- In the DSCB method the multi-agency chronology and the formal records and case files from each agency are initially scrutinised by the Lead Reviewers to identify, at an earlier stage in the process than the pure SCIE model dictates, key time periods and therefore provisional key practice episodes. A key practice episode (KPE) is identified through its significance in the time period in terms of the role it plays in the overall history and the opportunity it may have presented for professional involvement.

- The first introductory meeting for the Review Team was a combination of explaining the SCIE systems methodology and an opportunity for the Review Team to come together to consider the multi-agency chronology and review the proposed time periods of specific interest.

- The Case Group joined the Review Team in the afternoon of the first meeting to be both introduced to the SCIE systems methodology, with a detailed explanation of the conversation process[3], and also provide an initial opportunity to share some first thoughts about their involvement with the

[3] Term used to describe the individual meetings held with front line practitioners

family. The Case Group was also invited to comment on the provisional KPE's identified.

- The final meeting to present the report and its findings to both the Review Team and the Case Group is scheduled for October 2013.

- The table below shows the schedule of meetings held for this SCR:

Dates of Meetings:

25 February	Scoping meeting with Lead Reviewers, Chair of the DSCB and senior manager from children's social work.
5 March	Document reading – Lead Reviewers
26 March	Document (chronology) reading– Lead Reviewers
2, 5 and 22 April	Planning meetings – Lead Reviewers
25 April	Introduction meeting to Review Team and Case Group
30 April	Individual conversations with Case Group members – Lead Reviewers
2 May	Individual conversations with Case Group members – Lead Reviewers
14 May	1st Analysis and Follow-On meeting Review Team and Case Group
23 July	Consideration of draft report with Review Team
4 October	Final meeting - Review Team and Case Group

- In between these meetings the Lead Reviewers evaluated the information from both the Review Team and the Case Group and began to draft the final report.

- The mentored Lead Reviewers received supervision, support and guidance from the accredited Lead Reviewers throughout the process to ensure the robustness of the review and compliance with the SCIE systems methodology.

Engagement of professionals

- The Lead Reviewers found that both the Review Team and the Case Group members were committed to the process throughout and were very supportive of the SCIE systems methodology. Only one member of the Review Team had a previous understanding of the SCIE systems methodology having completed the SCIE Learning Together foundation course. The open and reflective discussions by both the Review Team and Case Group members has led to a greater understanding of agency and professional practice in a multi-agency context.

Structure & publication of the report

- The main section of the report contains the findings of the SCR but it will not detail all of the 'workings out' of the Lead Reviewers and the Review Team in reaching the findings and as a result detailed documents such as the chronology are not included with the final report. However, as a result of learning from the SCR conducted in 2012, a précis of the chronology and decision making process in identifying the key practice episodes will be included to assure DSCB members that the methodology has been robust. This will be described in the introduction within the Findings section at 3.1.

- This report is laid out using the SCIE report template and SCIE terminology.

- The report, in accordance with CPS advice, will not be published before the conclusion of any possible prosecution. In the meantime, DSCB are working on improvements that draw on the findings of this SCR and will report on these actions and resulting improvements at the time of publication of this SCR.

- Improvements already implemented as a direct result of the review process are included in Section 5.

- A glossary of terms used in the Learning Together methodology is included in Section 6.