Board Response to the Serious Care Review: Child K

1.0 Background

Working Together to Safeguard Children (WTSC) 2015 is clear that serious case reviews are a part of the learning and improvement framework that all local safeguarding children boards must have in place to identify learning from child deaths and serious incidents in order that local and national practice to safeguard children can continuously improve.

Reviews therefore must seek to:

- Identify precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Understand practice from the point of view of the individuals and organisations involved at the time rather than using hindsight;
- Be transparent about the way information is collected and analysed; and
- Make use of relevant research and case evidence to inform the findings.

2.0 Methodology

WTSC 2015 allows Local Safeguarding Children Boards (LSCBs) to use any learning model consistent with the principles in the guidance; Calderdale LSCB decided that this case warranted a participative review with the emphasis upon professional and family involvement.

The Calderdale LSCB set up a serious case review panel of local senior managers who were all independent of the family and casework. The role of the panel was to assist the lead reviewer in terms of planning the process, consider the evidence and to quality assure the overview report. The panel developed terms of reference for the review, which are included in the published report.

Barry Raynes, a non-executive director from Reconstruct Ltd was appointed by the Calderdale LSCB serious case review panel to write the overview report. Barry has thirty-five years experience of child protection social work. He has been involved in over 30 serious case reviews since 2007 – either overseeing the work of Reconstruct's consultants or producing overview reports.

Each agency involved with the family was asked to provide a chronology and this was formed into a joint chronology by the Calderdale LSCB secretariat. Each agency was asked to consider any lessons and recommendations that related to multi or single agency working. Single agency learning was included in the resulting action plan.

The lead reviewer and author of this report considered the joint chronology, requested actual records where appropriate, met with staff who had been involved with the family and with family members to create a narrative. This was shared with staff who were then asked to consider additional lessons that could be learned.

The lead reviewer continued to communicate directly with staff either in face-to-face meetings or via email. He developed a series of questions that this report addressed. Staff were invited to consider their own questions (which were added) and asked to contribute to the analysis,

conclusions and recommendations. Staff had sight of this report at the narrative and analytical stage of production.

The Case Review sub group quality assured the work of the serious case review panel once the panel had agreed the final draft of the report. The final report was presented to the Calderdale LSCB by the author. The LSCB participated in a robust dialogue of challenge and questioning to ensure the report met the standards that the LSCB had in place in the Serious Case Review Framework. The LSCB accepted the report on the 19th September 2014. The report has had a deferred publication date due to criminal proceedings and the family's request for the publication date not to clash with anniversaries.

3.0 Key Learning

The Serious Case Review overview report, its learning and recommendations have been considered, quality assured and accepted by the serious case review panel, the Independent Chair of the CSCB and by the Calderdale LSCB. There are two main areas of learning that arise from this report:

- **Practice should be focused upon children's needs and not those of parents, and;**
- **Some guidance in place in Calderdale hinders rather than promotes good practice**

The report also identifies a number of recommendations for the Calderdale LSCB and for its partners/members. The Case Review sub group focussed on the impact and outcomes from the recommendations. The sub group reports on the progress of each area of learning through the action plan.

3.1 SCR Recommendations

1. The LSCB to develop a child focused risk assessment framework, which considers the family (drawn from current child protection practice) for use in all assessments for children in levels 2-5 in their continuum of need document.

2. The LSCB to review guidance regarding information sharing and thresholds to ensure that said guidance is correct, unambiguous, short and helpful for practitioners.

3. The LSCB, within its Learning and Improvement framework to develop and implement a quality assurance system for plans for children, from levels 2-3, to ensure that said plans contain child focused outcomes that are measured and reviewed.

4. The LSCB to require member agencies to consider the issue of challenge to parents (in any ways appropriate to that agency) to determine whether their staff are struggling to maintain the balance between keeping families engaged whilst also challenging behaviour they believe to be inappropriate.

5. The LSCB to identify the relevant professionals to receive the existing local SMART planning training and the named organisations to ensure these staff attend.

6. Member agencies to ensure that all practitioners and aware of the ability to access advice and support from the Learning Disability team, as covered by the learning disability protocol.

7. The LSCB to continue to ask partners to provide information to raise awareness in the community regarding adults under the influence of drugs or alcohol co-sleeping with infants on a sofa. Partner agencies to strengthen what has been promoted and actively assess and discuss sleeping arrangements when unclear.

3.2 Outcomes and Impact

There have been a number of high-level outcomes as a result of acting on the recommendations, these include:

- Risk assessments for vulnerable children across the continuum of need are in place and focus directly on individual children using SMART actions
- The rigorous auditing demonstrated at tiers 4 and 5 has been replicated with those working with families at tiers 2 and 3
- Practitioners are attending training focussed on challenging parenting which is not good enough and disguised compliance
- Policies, procedures, guidance and tools have been revised, updated and clarified
- Continuous learning from regular auditing across the continuum of need is driving forward the Learning and Improvement Framework to establish safer practice

The CSCB is measuring the impact through the Performance Management and Quality Assurance Framework. Part of this impact evaluation will come through challenge events for front line practitioners to assess the impact the changes have made.

4.0 Dissemination, implementation and monitoring of impact of learning

A culture of continuous learning and improvement in Calderdale across organisations that work together will be complimented by regular monitoring and review. This is outlined in the Learning and Improvement Framework however some examples of how the learning from this review have been promoted and embedded are:

a) Publication on website
b) Policy and procedure updates
c) Action Plans: Translation of recommendations into SMART programme of action that lead to sustainable improvements in practice which have been monitored, implemented and updated through the Calderdale LSCB Case Review Sub Group and Business Group.
d) Challenge events for front line practitioners to 'test' out the learning
e) Training, briefings and practice reviews
f) Newsletters, briefing papers and learning lessons for front line practitioners
g) Quality assurance through audit
h) Performance management of indicators outlining practice improvements or need for development

5.0 Independent Chair's Summary

The death of a child has a lasting impact on all those who were close to and knew the child. It is important that through this review we are as assured as possible that if things could have been done differently they will be in future. It is also important to recognise that when looking back we are able to see things that were not always possible to see at the time, so we have to be measured in the conclusions we draw as a result of review.

The report and the contribution of the family, the professionals who worked with them, the leaders of the organisations they worked for, the LSCB partners and staff, and the independent reviewer set out an understanding of what happened and why. The review report highlights that all concerned acted in the best interests of the child and family and that although there may have been with hindsight some opportunities to do things differently this would have been unlikely to have changed the course of events.

As Independent Chair of the LSCB I am responsible for deciding when reviews take place, how they are conducted and that they result in as open, objective and helpful outcome as possible. Board members and I are responsible for ensuring that those concerned act on the learning and actions identified by the review and that as a partnership we hold ourselves to account for making sure that these result in measurable change.

The review identifies some significant learning for a number of organisations and professionals as well as for the LSCB itself, and these are highlighted in this Board response and will be further evidenced through Board meeting minutes, special reports and the LSCB Annual Report.

This review like others reminds us of how important it is and how hard it can be to make sure that lots of different people are able to focus on children, their needs and any risks they face and be able to share information that results in a consistent response. Understanding any family is always challenging especially when sometimes the adults have particular needs, and we learn from this review that it is important that when these are there, they are better understood. There is also a wider message that although much has been done to raise awareness and provide advice and support, too many children continue to die in circumstances such as these.

The Board have endorsed the findings and recommendations from the review and have acted to implement them, and in publishing the report wish to further demonstrate their commitment to improving the quality of joint working arrangements.

Richard Burrows BA, MBA Dip SW
Independent Chair
Calderdale Local Children Safeguarding Board