KNOWSLEY SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW IN THE CASE OF CHILD O

Executive summary

The Knowsley Safeguarding Children Board (KSCB) has published the independent serious case review following the death of Child O.

In 2015 Child O was found deceased in a public place. Their body was discovered by a member of the public who called police to the scene. A post mortem confirmed the cause of death.

There were no suspicious circumstances surrounding Child O's death. Child O had left no note or indication that they intended to take their own life. At an inquest held in June 2015 the Coroner ruled a verdict of suicide.

KSCB commissioned a serious case review to be undertaken in accordance with Regulation 5 of the Local Safeguarding Children Board Regulations 2006.

The Local Safeguarding Children Board appointed a Lead Reviewer, Maureen Noble, to undertake the review using systems methodology.

The review used a systems based approach to analyse information and present the findings using recommended best practice in identifying improvement and learning.

The purpose of the review was to establish what lessons can be learned from the case to improve safeguarding in the future, to improve inter-agency working and to better safeguard and promote the welfare of children in the local area.

The panel agreed that the period under review would be from January 2012 to February 2015 on the basis that this encompassed significant contacts and practice and was sufficiently focused and recent timeframe within which to learn from practice and make meaningful recommendations.

The family had a long history of contact with agencies. The panel therefore decided that it was important to reflect the historical context of agency involvement with the children and to that end the author has included an overview of the family life and contact with agencies dating back to before Child O's birth.

The report identified eight key lessons from the serious case review and has made eight recommendations, which the board have accepted.

Background to the family

The family were known to services since 1998. Child O lived in the family home with both parents an older half sibling and a large sibling group.

Child O's parents had a difficult and volatile relationship with episodes of domestic abuse involving verbal and physical altercations for many years. The first domestic incident recorded in the chronology took place when Child O was a baby. Domestic violence reports indicated that father was sometimes intoxicated with alcohol during altercations.

Mother minimised and denied domestic abuse following incidents and told professionals on each occasion that father was no longer living in the family home. She said that she did not want to attend any specialist domestic abuse services. Mother reported to professionals that a more permanent separation from father had taken place in 2013.

There is evidence that Child O and their siblings witnessed many domestic abuse incidents. On more than one occasion Child O told staff at the primary school that their mother and father had argued and fought. On one occasion Child O rang police to say that their father had hit them in the face; although this was judged to have been an accident by professionals based on father's account of the incident.

All professionals who participated in the review were aware of neglectful parenting and those who entered the family home saw poor home conditions which were described by some professionals as at times being unacceptable and occasionally extremely unacceptable.

Family support was offered to the family and attempts were made by professionals to engage mother (as father was often absent.) However mother did not engage with professionals in any meaningful way and failed to consistently maintain any temporary improvements in home conditions.

Father was not seen with any frequency in the family home, the majority of professionals did not have much contact with him. He sometimes took the children to school and picked them up.

Father had been an offender in the past and during Child O's life he was arrested and charged with a number of offences.

For a period of approximately three years father's younger brother lived at the family home, he was a serial young offender and was arrested and charged with several offences during this time

Some professionals believed that mother was using drugs based on reports from the children and from their own observations.

There were complaints from neighbours about anti-social behaviour involving some of the children, including Child O. On several occasions the incidents involved the children intimidating other children who lived nearby.

The registered housing provider became involved in these complaints and warnings were issued to mother.

The older children attended the same primary school. At primary school Child O displayed some behavioural difficulties; Child O could be disruptive in the classroom and experienced outbursts of temper. Attendance at school was inconsistent and parental engagement with school was minimal.

During the period under review Child O changed to Secondary School and appeared to settle well. Child O quickly integrated into Secondary School and formed a small and close network of friends.

By the time Child O went into to Secondary School their parents were facing prosecution for non-school attendance (Level 4 action). Primary school was concerned that Child O would continue to experience difficulties in their daily school life and provided Secondary School with information to support their concerns.

In 2013 Child O was accepted onto a local mentoring scheme to give them an opportunity for personal development. Child O was assessed as meeting the criteria for inclusion in the scheme, although it was unusual for the scheme to take children of Child O's age. Child O was said to thrive at the project.

AGENCY INVOLVEMENT

During the period under review there was significant contact between the agencies and family concerning a range of issues, including school attendance, home living conditions, domestic violence, and substance misuse

FINDINGS

The review concluded that based on the information received by the review neither professionals, agencies or indeed Child O's family could have predicted or prevented Child O's tragic death.

However they identified a number of findings, where lessons can be learned across agencies on how we safeguard and promote the welfare of children in Knowsley.

The key findings of the review are summarised as follows;

1 – Responses to neglect and emotional abuse lacked shared understanding, consistency and multi-agency action.

Professionals in all agencies did not take sufficient action to address clear indicators of on-going neglect and emotional abuse of Child O and their siblings.[1]

The Review found that some professionals were over optimistic about parenting capacity and parental ability to maintain temporary improvements in home conditions or to change behaviours that put Child O and their siblings at risk (e.g. patterns of incidents of domestic abuse; lack of supervision; non-school attendance).

The neglectful home conditions were viewed differently by different groups of professionals this resulted in an inconsistent approach to addressing the neglect that the children were experiencing.

2 – Reponses to domestic abuse need to be strengthened to ensure that the needs of children who live with domestic abuse and the impact that this has on their emotional wellbeing is understood and responded to by all professionals.

All agencies and professionals were aware of the frequent domestic abuse incidents between mother and father and attempts were made to encourage mother to seek specialist support. However, the impact of on-going domestic abuse on Child O and their siblings was not fully addressed by services. Professionals identified a lack of integrated responses to domestic abuse and a reduction in services to meet the needs of victims and

3 – Parental substance misuse impacted the lives of Child O and their siblings however some agencies were unaware of the concerns in relation to drug use, there was a lack of follow up to referrals and plans to escalate the case to child protection were not followed through.

Parental substance misuse both suspected by some professionals and known CSC professionals. Despite this knowledge mother's use of cocaine was not fully addressed as a risk factor to the children. In addition father's alcohol misuse appears to have gone unchallenged by professionals. Mother was asked to self-refer to the drug service which she did, although she subsequently failed to attend appointments. Neither CSC nor any other agency took action to escalate the case to child protection despite warning mother that this would happen if she failed to address her drug use.

4 – Housing and anti-social behaviour services did not give sufficient consideration to safeguarding in their involvement with the family.

Responses to anti-social behaviour and neighbour nuisance lacked a focus on the safety and wellbeing of the children. Responses were not integrated and there were no referrals made to CSC regarding reported incidents of the children being unsupervised and vulnerable

5 - Many agencies were involved with the family over the timeline of the review however there was a lack of case leadership and no clear 'lead professional' co-ordinating activity and responses.

6 - None of the agencies involved in the review used the local escalation policy to address concerns when the case did not meet thresholds for statutory intervention.

7 – Listening to and acting on the voice of the child

Efforts to seek and listen to Child O's voice did not take place across all agencies. This resulted in a lack of understanding of Child O's needs and views and a lack of professional insight into the quality of Child O's daily lived experience. Single and multi-agency interventions (other than those in the primary school and the mentoring programme) were therefore often adult focused and driven and not child centred.

8 - There was a lack of engagement by Child O's family with CIN

Child O's family did not engage with CIN or early help services and processes, this lack of engagement persisted over many years without review or escalation or triggering consideration of statutory intervention.

RECOMMENDATIONS

The review has made a number of recommendations to the LSCB to address their findings;

Recommendation 1

The LSCB should be assured that the local strategy to tackle neglect is up to date and informed by this review. This should include assurance that all professionals have a clear understanding of neglect and emotional abuse and adopt a child centred approach to their assessments in this regard.

The LSCB should be assured that the professionals are skilled in assertive practice and models of change when working with resistant parents.

The LSCB should be assured that the graded care profile is understood and adopted by all relevant agencies and that there is multi-agency agreement on the application and interpretation.

The LSCB should ensure that there is regular graded care profile training and training for professionals in terms of drug misuse and working with resistant families.

The LSCB should put in place a mechanism to audit use of the graded care profile by professionals and analyse the results to ensure compliance with the requirement to use this tool.

Recommendation 2

That the LSCB strengthen the domestic abuse/family pathway against evidenced based effective interventions and map the provision and availability of services to domestic abuse victims and their families.

That professionals working with children and families understand the on-going impact of domestic abuse on child development and are equipped to assess and refer children to appropriate services.

Recommendation 3:

That the LSCB are assured that a mechanism is in place to track referrals to substance misuse services and that these are followed up by the practitioner making the referral.

That the LSCB are assured that substance misuse services have robust policies and practice in relation to safeguarding children.

Recommendation 4

That the LSCB are assured that housing and anti-social behaviour services continue to develop and implement revised policy and practice in integrating responses to anti-social behaviour, neighbour nuisance and safeguarding and that these are monitored.

Recommendation 5

That the LSCB ensure that the role of the lead professional is enshrined in early help and targeted services policy and practice and that there are mechanisms in place to ensure that all cases have a nominated lead professional.

That all agencies understand and act on their responsibilities in relation to enabling staff to adopt the role of lead professional and that any reticence amongst agencies or individual practitioners to adopt the role of lead professional is addressed through training and support.

Recommendation 6

That the LSCB continues to monitor use of the escalation policy and procedures and that these are understood and acted upon by all agencies and individual practitioners.

Recommendation 7

The LSCB should be assured that work to strengthen local policy and practice on ensuring that the voice of the child drives practice is taking place.

Performance management information via the use of multi-agency audits should be provided to the LSCB as part of its quality assurance programme.

Recommendation 8

The LSCB should refresh guidance to all agencies regarding persistent non engagement with CAF and CIN and other forms of early help service. The thresholds for escalation of concerns should be considered and agreed upon in the initial or planning phase in CAF reviews

The board accepts the findings of the review and is committed to learn the lessons, which are identified in the report