Oxfordshire Safeguarding Children Board

Oxfordshire Serious Case Review

Child Q

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A. Why this case is being reviewed

1. Introduction

1.1 Child Q, 14 months old, died from an apparent drowning in the bathtub at her family home. At the time, Q and her 5-year old half-sister were both subjects of Child Protection (CP) Plans, under the category of Neglect.

1.2 The independent Chair of the Oxfordshire Safeguarding Children Board (OSCB) decided that the death of Child Q met the criteria required to carry out a Serious Case Review (SCR), as set out in *Working Together to Safeguard Children* (WT) (DfE, 2013):

> *(a) abuse or neglect of a child is known or suspected; and*
> *(b) (i) the child has died.*[1]

As a result the OSCB commissioned this report.

2. Succinct summary of case

2.1 Child Q was the younger of two children. She had an older half-sister who was living with both her and her mother at the time of Child Q's death.

Child Q's mother was only 17 when she had Child Q's half-sister, with her then boy friend. Child Q's half-sister was physically harmed in her parents' care, and her father was convicted of assault. As the mother's role in the abuse was initially unknown, Child Q's half-sister was removed into foster care for over a year (as an infant), and then, after extensive assessments during court proceedings, returned to her mother, under an Interim Care Order (ICO) and then a 12-months Supervision Order. Mother was required to adhere to a Written Agreement, which stipulated that she should provide adequate care and supervision to this child, and spelled out the (small) number of people with whom she could be left by her mother. This period preceded the scope of this review; however it may be considered relevant in relation to the mother's parenting skills.

2.2 Shortly after the Supervision Order ended, Q's mother met her new partner (Q's father) and became pregnant. Their relationship broke down during the pregnancy, but he was keen to share care of their child Q, who was born in 2013. He and his mother (Paternal Grandmother, PGM) began to look after Q on a regular basis – eventually half of every week – and occasionally had Q'S half-sister to stay overnight as well.

[1] *Working Together to Safeguard Children*, 2013, Chapter 4, Para 12; and *Local Safeguarding Children Boards Regulations*, 2006 (Regulation 5)

2.3 Q's mother is described as an immature and vulnerable young woman – a parent who loves her children, but who has struggled to prioritise their needs for consistent and safe care. As a result, the children were subject of Child in Need Plans (initially), and then CP Plans. Q'S mother engaged with many professionals, and wanted to 'show people' that she could be a good mum. There were, however, a number of negative factors affecting her efforts to change. She had an unhappy personal history, and apparently had no solid friendships, nor committed and positive family relationships, to support her. She suffered from periodic depression, and often became angry or distressed, with the inevitable impact on her parenting, as well as on other relationships. At times, she used alcohol irresponsibly.

2.4 When Q was about 9 months old, the family moved from one locality of Oxford, to another area. This left them more isolated, but Q's mother and the children were assisted to link into health, school and early help services in their new community. Because of the CP Plan, and the concerns from the network of professionals, the family were often seen two or three times a week by one or other of the workers involved. The death of Q at the age of 14 months was entirely unexpected.

2.5 Whilst this review was commissioned because of the death of Child Q, it was not possible to carry out the process without considering her as part of a wider family. During the review period (dating from Mother's pregnancy with Q), there were concerns regarding Q's care, but much of the agency contact with the family related to the parenting of her half-sister and the CP Plans for the children reflected this. The work of agencies with the whole family was therefore covered in the review.

3. Time frame

3.1 The timescale for this review is from October 2012 until Q's death in August 2014.

4. Family composition

Name in report	Relationship
	Mother
	Half-Sister
Q	Subject
	Q's father
PGM	Q's paternal grandmother
MGM	Maternal Grandmother

5. Organisational learning and improvement

5.1 Statutory guidance on the conduct of safeguarding children case reviews, including SCRs, states that

> 'Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice.

> LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.' (*WT*, 2013, p.66)

5.2 No case can be said to be 'typical'. However, the tasks in this case, in response to the circumstances and needs of this vulnerable family, were familiar ones and represent the 'core' roles and responsibilities of professionals and agencies, including the areas of early help, family support and safeguarding. The OSCB therefore saw that the SCR of this individual case would offer wider lessons for improvement, especially in dealing with cases of **Neglect** – already designated as their highest priority in the current year. The review was asked to address the following questions:

> What light does this case shed on the following areas:
>
> - How well our CP planning process is working to protect children
> - How well the inter-agency CP network responds to and works with children under 5 (*N.b*., the review did not compare or contrast the work with services for older children.)
> - How effective agencies are at working with mothers with problems of substance misuse
> - How well we work together in dealing with neglect of children

The **findings** section of this report addresses these questions by an appraisal of practice, and the proposal of general patterns, or systems, operating in Oxfordshire. Not surprisingly, some of these occur not only in Oxfordshire, but more widely in safeguarding networks across the country.

6. Reviewing expertise and independence

6.1 This review was led by two independent professionals, neither of whom has had a connection with Oxfordshire services before.

- Sally Trench is an accredited SCIE reviewer and experienced SCR Overview author and SCR Panel Chair, with a lengthy background in local authority social work (adult mental health, and children and families). Her qualifications include Diploma in Social Administration (University of London) and CQSW/MA in Social Work (University of East Anglia).

- Anne Morgan is an independent safeguarding consultant trained in SCIE methodology. She has contributed to numerous SCR and Domestic Homicide Review (DHR) reports and authored a SCR previously. She has a health background (acute and community) with extensive experience in safeguarding and multi-agency work including chairing an LSCB. Her qualifications include SRN/RSCN, HV Cert., MA Child Studies (Law Faculty Kings College London).

Both lead reviewers contributed to the writing of the report, with 'quality assurance' guidance from SCIE.

B. Findings

7. Introduction

7.1 The Findings – the main body of the report – begin with a synopsis of the **appraisal of practice**. This sets out the view of the Review Team about how timely and effective the interventions with Q and her family were, including good practice but also identifying where practice fell below expected standards. Where possible, it provides explanations for this practice, or indicates where these will be discussed more fully in the detailed findings.

7.2 **There is then a section to help the reader move from the case-specific detail to its more general relevance:** this section explains the ways in which features of this case are common to other work that professionals conduct with children and families, and therefore how they can provide useful organisational learning to underpin improvement ('a window on the system'[2]).

7.3 Finally, the report discusses in detail the **7 priority findings** that have emerged from the review. The findings explore how well local safeguarding systems are supporting individuals, teams and whole services to offer effective help to children and families. They also outline the evidence that indicates that these are not one-off issues, but underlying patterns – which have the potential to influence future practice in similar cases. We also consider what risks they may pose to the wider safeguarding of children.

8. Appraisal of Practice: a synopsis

<u>Introduction</u>

8.1 This case reflects the challenges faced by many professionals working with vulnerable families, where there is evidence of ongoing neglect, but the case does not meet the threshold for legal proceedings and where, with very high levels of support, the children are seen to be adequately cared for most of the time. One complexity is that such intensive support may inadvertently mask parenting deficits and the potential harm to children, particularly when professionals perceive the parent as attempting to do their best and as not malicious in their actions.

The parenting by Mother in this case was neglectful – as reflected in the fact that there were Child Protection Plans for both children and the children were identified

[2] Vincent, 2004

as being at risk of significant harm. There were a number of incidents that should have been treated more seriously (for example, when Q's half-sister was found in the garden at night), whilst the rest of the time the fact that the case went along without major mishap was due largely to a) the support provided by the paternal grandmother and Q's father, and b) being highly flexible, supportive and making up for gaps in the children's care.

8.2 The family – Mother and her two children Q (subject) and her half-sister – received comprehensive input from several services, and the children were seen on a regular basis, including routine use of unannounced visits at varying times. The children were regularly described in recordings (all agencies), indicating that they were appropriately held in mind by practitioners. Professionals generally (with some exceptions, noted below) communicated and worked well together, within Team around the Child, Child in Need, and Child Protection frameworks.

8.3 Practitioners saw the mother as a likeable but very immature young woman, functioning more as a teenager than a woman in her early twenties. She wanted the help of professionals to become a better parent, and was described as responsive to advice offered. At the same time, she was often 'found out' in keeping secrets about aspects of her life which she wanted to remain unknown to professionals. She could be volatile and challenging at times, but was generally seen as responding to clear boundaries and advice. Unfortunately, there was little sustained change in her parenting behaviour.

8.4 Paternal grandmother and baby Q's father provided shared care for Q, giving Mother the opportunity to focus on her older child, and some space for herself. Despite this informal 'respite' and considerable professional input, there continued to be instances when Mother's care fell below an acceptable standard, thus creating risks to the children. These risks included physical injuries, through accidents or possible assaults, exposure to unsuitable visitors to the family home, poor supervision of the children and persistent co-sleeping with the baby. These were not always followed up by professionals in a consistent and pro-active way, including spelling out for Mother the potential consequences of her actions.

8.5 The wish to support and engage vulnerable young parents is common to most people working in health, education and social care. For some services, this role is changing and becoming more complex: for example, Children's Centres now carry out more monitoring of parental behaviour, in line with their rising amount of CP work – a shift from the original 'open door' help provided in Family Centres. Reflective supervision and challenge are needed in all agencies to help workers carry out family support and CP roles simultaneously. This case review reflects how difficult this is in cases where neglectful parents are struggling to offer safe care to small children.

8.6 The following appraisal of practice outlines the Review Team's views about how well professionals carried out their roles and responsibilities in working with this family. It also provides a link to the analysis of why things happened as they did,

including the wider systems factors. It is these general findings which allow us to translate the learning from an individual case to the wider work of safeguarding agencies.

Appraisal

8.7 Mother wanted a new start and moved with her first daughter to location A about fifteen months prior to the commencement date of this review (September 2012). This period is outside of the dateline for the review, and therefore not commented upon – apart from noting that the family had had a previous, relatively recent move.

The social worker (SW1) who had been involved with the previous care proceedings for Q's older half-sister kept the case open until February 2013. However, all other professionals working with the family changed following this move, resulting in a break in the continuity of care; this change happened again when the family moved in April 2014. When families move, even where there are good handovers, there is an impact on planning and intervention and the risk of a "start again" response amongst professionals. This is explored further in **Finding 3.**

How the case was managed

8.8 The 'status' of the case changed a number of times: from allocation within CSC, to Team around the Child (TAC) under the Common Assessment Framework (CAF) process, then, after re-referral to CSC, to Child in Need and eventually CP frameworks. All of these involved multi-agency collaboration, with CSC only briefly absent from the network between February and April 2013 (when the case was managed as a TAC, and not allocated to a worker in CSC). Meetings were held regularly and attendance was good.

The Review Team noted that the timing of 'step down' to a TAC occurred when Mother was known to be pregnant again, with her new boy-friend. Q's half-sister's Supervision Order had only finished in September 2012. The decision to move the case to a TAC discounted the need for a pre-birth assessment, and minimised two recent incidents when the care of Q's half-sister was not appropriate (including Mother slapping her). The handling of this case throughout has examples of an acceptance of incidents without robust challenge or consequence, and this pattern is considered in **Finding 2.**

The TAC meetings produced appropriate plans for their work with Mother and the children. The Lead Professional was from her local Children's Centre (CC1), and this reflected its important role in supporting and monitoring Mother's parenting, comprising both outreach and centre-based activities. For a large part of the period reviewed, Mother used their services very regularly. Professionals saw her involvement with Children's Centres as absolutely vital, as she needed constant reminders and coaching in order to keep appointments and parent Q's half-sister adequately. Mother's immaturity, including her need for constant praise, and

professionals' responses to that behaviour, are consistent themes and are also discussed in **Finding 2**.

Professionals' responses to incidents

8.9 During the pregnancy with Q, the relationship with Q's father broke down, much to Mother's distress. In March 2013 both the Children's Centre (CC1) and the school (nursery) noted that Q's half-sister had a black eye. Mother gave staff different explanations for the injury, though they were not aware of these differences. The injury was not reported by either agency to CSC. This meant that there was a lack of ongoing identification of risk and Mother's ability to protect Q's half-sister.

8.10 On the 05.04.13 the police received information from members of the public who stated that a mother (no surname given) was seven months pregnant and taking class A drugs. She was also reported to have harmed her daughter. Initially, this referral was not shared with CSC – as it would normally have been. This was because a URN log[3] was not raised by the Police Community Support Officer. If this had been done, it would have enabled joint research by Police/CSC to identify the family and undertake a welfare check. This was not a typical response, and does not therefore lead to a finding about police practice more generally, although it does result in a recommendation from the police in their IMR in relation to organisational learning[4].

8.11 CSC received the same referral some days later, including the fact that there was a photograph of the bruising on the referrer's mobile phone. A visit was made on the same day by two Social Workers to investigate the concerns identified, and no bruising was found. The child was spoken to alone, which was good practice. A Strategy Meeting was held the next day and a single agency S47[5] was agreed. The police were not informed about the photograph of the bruises until 7 days after the strategy discussion, when this information was contained within the strategy discussion minutes. This should have been shared with them at the time of discovery; the fact that it wasn't appears to have been due to miscommunication between the two agencies. Had the Police known about the photograph, there would have been a joint investigation and possibly a better understanding of the risks to Q's half-sister.

8.12 The case was allocated within the Assessment Team, and a Core Assessment (CA) was commenced. This uncovered Mother's alcohol and cannabis use during pregnancy – something she had previously denied. This admission of wrongdoing, only when 'caught out', became a pattern in this case, as was non- or partial

[3] A URN is created when a new incident is reported to the police which requires police attendance/involvement using the Command and Control IT system.

[4] Thames Valley Police must instruct frontline staff that when dealing with information indicating a live Child Protection risk they must arrange attendance at the relevant address urgently as a first response. This would be through creation of a URN, to be followed up by a Child Protection report on Niche.
Thames Valley Police should review how they identify and record risk in Child Protection investigations, and other incidents, reflecting that there may be vulnerability and potential referrals for a number of parties. This should include a review of the training methods used for front-line practitioners.

[5] Child Protection investigation under S47 of the Children Act 1989

compliance with advice offered. The lack of any consequences when change did not occur, even when the children were on CP plans, resulted in little change in Mother's behaviour and her ability to parent. This is discussed in **Finding 1.**

The CA gave a good summary account of Mother's isolation and need for ongoing support, and noted her own disrupted experiences of being parented and her family relationships as a young adult; it described her desire to become a better parent and her engagement with services. This was a good balanced picture of the situation and one shared by all professionals working with Mother. The network reformed under Child in Need procedures.

8.13 Q was born in June 2013. Her health and development gave no cause for concern for the health visitor during her first months, and she was seen to be bonding well with her mother (a feature which continued until her death). In early July, the case moved from the Assessment Team to the Family Support Team, and was allocated to a Family Support Worker (FSW). The level of support for Mother during this summer was very good, and included not just a range of professionals, but also both grandmothers and Q's father. Mother was seen to be coping.

8.14 On the night of 10.08.13 the police received a referral from a neighbour, who had heard Q's half-sister screaming in the family's garden. Police visited and found Q's half-sister outside the house, and Mother inside, co-sleeping with Q. The house was unkempt, and Mother had been drinking and was very difficult to rouse. Police liaised with the CSC Emergency Duty Team, and both children were placed in emergency foster care under a Police Protection Order. This was an appropriate response, given the risk of significant harm to both children.

<u>Non-involvement of Father</u>

8.15 Q's father, who had Parental Responsibility (PR), was not contacted in relation to the PPO and not asked to provide support, despite the fact that at this time he and his mother generally cared for Q at weekends. He was not made aware of what had happened, or of the CP Plans, until several months later. This non-inclusion of Q's father at an important early stage reflected the professionals' wish to keep Mother on board and co-operative, thereby focusing on her, rather than the children's, needs. The degree to which fathers/male partners are involved in plans for children is discussed in more detail in **Finding 4**.

<u>Flawed information-sharing</u>

8.16 At a discussion on the morning of the 12.08.13, a decision was made for the children to return home, with the proviso that maternal grandmother (MGM) would stay in the family home for 6 weeks. An Initial CP Conference (ICPC) was agreed, to be held at the end of August. Later that same day, a paediatrician examined the children (CP Medicals) and noted bruising on Q's half-sister's back and abdomen. The report identified that some of the marks could have been finger-tip bruising; however, verbal feedback from CSC to police did not make this clear, and the police

did not become aware of this until much later – after they received minutes from the ICPC. This was another missed opportunity for a joint investigation to take place.

8.17 Strategy meetings at the time were commonly telephone discussions and did not include other professionals apart from the police and CSC. There were normally no minutes provided of these discussions. This review also learned of a routine problem with the timely distribution of CP conference minutes, CP plans and Core Group minutes (discussed in **Finding 6**). In this case, this had the effect of professionals going without the information they required to assess risk and make appropriate decisions relating to the children, as well as carrying out agreed plans.

CP framework

8.18 At the ICPC, both children were placed on a CP Plan, under the category of Neglect. This category covers many different kinds of parental neglect. Thus, in every case, the specific risks to the children need to be clearly named, alongside what is required to keep them safe, what the desired outcomes are, and the consequences of non-compliance. The absence of such clarity was a pattern throughout this case: an example of this was that at the ICPC, maternal grandmother announced that she could no longer stay with the family for the full 6 weeks (she had been there 2 weeks), but there were no consequences for losing what had been agreed as necessary protection for the children when they went home, after the PPO. The CP Plan identified that Mother needed – and was offered – emotional support, including referrals to drug and alcohol services; but there was no consequence when she continued to decline these.

It appears that neither Q's father nor Paternal Grandmother (PGM) was invited or made aware of this meeting and they were therefore unable to participate in the process at this time. Housing is not routinely invited to CP Conferences. This is identified in the section below on 'Additional Learning'.

8.19 Core Groups did not normally use a chronology or a list of significant events to help assess progress and compliance with the CP plan. Thus, patterns of behaviour – either demonstrating progress or the opposite – were harder to identify. Without a chronology of what had happened between Conferences or Core Groups, some information about incidents remained known only to certain agencies. An example of this is the Core Group on the 09.10.13 which was mainly taken up with Mother's angry reaction to Q's half-sister biting another child at school, whilst not mentioning Q's admission to hospital on the 8th September, which had raised concerns for the paediatrician and occurred only one month after the PPO for both children. At the Core Group meeting on the 06.11.13, Mother's debts, which were pressing for her, were discussed, but there was no mention of recent incidents (including 'shouting' at neighbours with children present) or the growing number of missed appointments/visits to the Children's Centre. The importance of chronologies, including multi-agency chronologies, for seeing patterns and tracking progress, as well as ensuring that critical incidents are shared, is discussed in **Finding 7**.

8.20 At the November Review CP Conference (RCPC), Mother said she planned to move house again, as she wanted to get away from personal/social problems in her area. Things were not going well for her at this time, and she appeared to have fallen out with a number of people, including her mother. Following the Conference, there were a number of worrying incidents which clearly indicated that Mother was struggling.

This RCPC was chaired by a different chair who had not met Mother before, and there was a new SW (SW3) for the family. There was, nonetheless, a continued positive and supportive stance towards Mother despite the fact that she was not complying with all aspects of the plan.

Lack of Strategy Meetings or Discussions

8.21 On the 24.11.13 (a Sunday) Q's father contacted the Emergency Duty Team in CSC, to say that he had visited the house and taken Q at Mother's request. The house was not in a fit state for a child and Mother had been drinking. He was worried about Q's half-sister and where she might be. Police responded by visiting the house and corroborated his description. When Mother returned, her presentation confirmed what had been reported. She had been assaulted and had a black eye. Q's half-sister was being looked after at MGM's boyfriend's house. This incident did not trigger a Strategy Meeting, despite both police and CSC involvement; this was a failure to comply with CP procedures. The seriousness of the situation was missed and the risks to the children not properly identified (see **Finding 2**). On the 26.11.13, when the Social Worker saw Mother, she admitted drinking and smoking cannabis when the children weren't there. The potential impact of these behaviours on her parenting was not given sufficient weight in the CP Plans.

During this critical period, the family's SW changed, and the family continued to receive an intensive service from the new worker, again with a mixture of support and challenge when Mother was making bad choices for herself and the children.

8.22 In late January 2014 Mother received two black eyes, and Q's half-sister also had a black eye. A Strategy Meeting or Discussion was again not held. Mother's descriptions (inconsistent) of how the injuries to herself and Q's half-sister happened were accepted, and not further explored. In the subsequent Core Group, it proved difficult to go beyond Mother's description of her collision with a high chair (and Q's half-sister 'knocking heads' with another child).

Similarly, when there was, on more than one occasion during the period reviewed, an allegation by Q's half-sister of being shut in a cupboard or shed, Mother's denial was accepted after an obvious cupboard could not be identified. The child was not asked to describe the cupboard or show anyone where it was.

There were no other kinds of professionals' meetings held without Mother, which might have offered a chance for all those in the network to receive the same

information about previous allegations and incidents. In addition, there was no request made for an opportunity to analyse or speculate together about what was going on in the family home – e.g., Mother's level of drug and alcohol misuse. The reluctance to hold meetings without parents present reflects general practice in terms of working with families, and is discussed in **Finding** 5.

8.23 Further concerns were identified on the 10th February 2014 when Mother spent the day in a pub with Q strapped in her buggy, showing a lack of understanding of Q's physical and developmental needs. Whilst this was dealt with by her SW appropriately at the time, this did not lead to any further "consequence" for Mother or the children – e.g., alteration to the CP plan or legal advice being sought. Legal action in relation to this incident on its own would not have been appropriate, but this was evidence of a lack of positive change. This was an example of how worrying incidents were not considered as patterns, and therefore did not build up an overall picture of the case.

Family move and changes of professionals

8.24 At the Core Group in February 2014, professionals were pessimistic about Mother's wish to move house again – seeking 'a new start'. They were concerned that she was planning to move to a village where she had no friends or contacts, and where all the services she needed would be 'new'. They therefore tried to talk her out of it. This was an accurate assessment of the situation.

At a home visit in early February 2014, there were more signs that Mother was not coping: the house, normally well kept, was very disorganised and unhygienic, and Q for the first time was described as 'moaning and hungry'. There had also been another incident of Mother's volatility towards other parents at the school. The CP Plan was not able to provide protection against the upsets that frequently characterised her life, and the effect these had on the children. The CP Plans increasingly had a 'cover-all' list of actions, but without clarity about desired outcomes and consequences for lack of change or progress. Such plans can lead to drift and lack of protection for the children. The challenge in creating effective CP Plans for Neglect is discussed in **Finding 1.**

8.25 In early April 2014 the family moved as part of a mutual housing exchange. There was good handover by many of the professionals involved, although school and the Children's Centre did not receive detailed or timely information. The RCPC, as a transfer-in Conference, was attended by both old and new professionals. This was good practice. The move however raised a different set of vulnerabilities because of the complete change of professionals and the challenge for them of gaining a full understanding of the family and its history. There is a risk in these situations, seen in this case, which professionals did their utmost to mitigate – i.e., that the family's 'new start' can be mirrored in the way professionals work with that family, not seeing previous patterns or having limited understanding of ongoing concerns (a pattern discussed in **Finding 3**). This can be a particular problem when working with neglectful families, who are given yet another opportunity to improve.

8.26 After the move, there were some early improvements – e.g., in Q's half-sister's school attendance, which had dropped significantly at her previous school. However, following the Core Group in June, the situation changed. Mother's contact with the new Children's Centre and health visitor became markedly less frequent and in early July the SW received an anonymous referral about Q's half-sister having been hit, and Mother's friends coming round for drinking and possible drug-taking, while Q's half-sister was left in her bedroom. The referral didn't mention Q who was possibly with PGM. There was no Strategy Meeting or Discussion regarding this referral.

Mother denied the allegations. The SW saw Q's half-sister alone which was good practice. It was difficult to take this referral forward, as Q's half-sister denied being hit and there was no other evidence to support the allegation. The SW was concerned about the relationship between Mother and Q's half-sister, and made several visits in July, some of which were unannounced and at the beginning and end of the day. She had no such concerns in relation to Q, where maternal bonding was seen to be good.

An inconsistent picture was found, with Mother struggling at times to keep the household going, and sometimes on top of things. Q was described on one visit as being her 'normal happy self'. This pattern shows how important a chronology is in cases of neglect – ideally a multi-agency chronology – in order to review and assess risk, both in supervision sessions and meetings such as Conferences and Core Groups. As noted above, the use of chronologies/ Significant Event tables is discussed in **Finding 7.**

8.27 On 07.08.14, Q was taken to the GP practice, thought to have drowned in her bath. She was transferred to hospital where she was pronounced dead. Medical responses were appropriate and were immediately available.

9. Overview list

9.1 The findings in this case all relate in some manner to **working with Neglect**, and identify different types of systemic issues that make it more or less likely that such work is done in a timely and effective way. The first two findings are explicitly about patterns in how professionals respond to the challenges involved in this enterprise. The serious implications for children are well summarised by Marian Brandon and colleagues, in their review of Neglect and Serious Case Reviews[6], and are picked up in **Findings 1 and 2**:

> *'The fact that neglect is not only harmful but can also be fatal should be part of a practitioner's mindset as it would be with other kinds of maltreatment. This is not to be alarmist nor to suggest predicting or presuming that where neglect is found the child is at risk of death, but rather to suggest that practitioners and managers should recognize how easily the harm that can come from neglect can be*

[6] Brandon et al, 2013

minimised or downgraded. In the same way there should be recognition of the harm that arises when neglect cases drift. Practitioners need to have an open mind about the possibility of neglect having a fatal or very serious outcome for a child but deal with neglect cases in a confident, systematic and compassionate manner.'[7]

9.2 A list of the **findings** follows below, each showing a category in brackets, which names the type of systems finding it is, according to the SCIE list of categories (Appendix 2, Para. 5).

Finding 1: CP Plans for Neglect do not consistently spell out the specific risks to children and the consequences if the desired outcomes for their improved safety are not achieved. As a result, the professionals involved are less clear and confident about when to take protective action. (Communication and collaboration in longer-term work)
Finding 2: There is a pattern where professionals are not consistently and sufficiently pro-active in response to incidents and allegations regarding children on a current child protection plan, based on their perception that they 'don't have enough evidence' to pursue the incident. This stops them from following through with any further investigative or protective action, and the opportunity is then lost to investigate the experiences of neglected or ill-treated children. (Communication and collaboration in response to incidents)
Finding 3: There is a pattern of delayed and incomplete handover between some professional groups when families move, which can result in interruption of the knowledge about the family and the case, and lead to an unintended 'start again' for the new professionals, even with families where there has been no change or improvement for some time. (Communication and collaboration in longer-term work)
Finding 4: There is a pattern where the input and co-operation of one of the parents, normally the mother, is prioritised at the expense of not engaging the other parent (normally father) in the child protection process. This may result in the children not receiving care and appropriate involvement from one of the parents. (Professional-family interaction)
Finding 5: The commitment to working in partnership with parents in Oxfordshire has inadvertently led to an assumption that professionals cannot meet together, without parents being present, when they have concerns regarding case management. This jeopardises opportunities for joint discussion and supervision. (Management systems)
Finding 6: In Oxfordshire, there is insufficient capacity for the effective administration of invitations to CP Conferences, and

[7] Brandon et al, 2013, p.82

distribution of minutes and CP Plans. This leads to all the meetings of the CP system suffering from a lack of timely information-sharing and therefore of plans not being implemented in an effective way. (Management systems)
Finding 7: There is no agreed use of a multi-agency tool to capture a chronology of significant events, making it more difficult to assess risk to children and parental patterns which demonstrate poor capacity to change. (Tools)

10. What is it about this case that makes it act as a window on the practice more widely?

10.1 Neglect is a major concern for safeguarding children's networks, both within Oxfordshire and nationally. Locally, over half of Oxfordshire's CP Plans are under the category of Neglect; the total number of plans has increased 23% over the past 3 years.

10.2 Messages from research

10.2.1 For several years, research by Ruth Gardner[8], Brandon et al[9], and others have pointed to the challenges of working with neglect, including problems of identification and evidence, of erratic improvements in parenting, and the difficulty of deciding about interventions ('when is enough enough?'). All these were features reflected in this case.

> *'Neglect can be difficult to define because most definitions are based on personal perceptions of neglect. These include what constitutes "good enough" care and what a child's needs are. Lack of clarity around this has had serious implications for professionals in making clear and consistent decisions about children at risk from neglect.'* (NSPCC, 2012)

Added to this is the recognition that working with neglect is evidence that

> '*Neglect and emotional harm are some of the most highly stressful and demanding areas of work for individuals and groups of professionals.*' (Gardner, 2008, p.8)

10.2.2 There is also growing evidence from research about the long-term harm to children when neglect is a chronic feature of their lives. This is particularly true for

[8] Gardner, R., *Developing an effective response to neglect and emotional harm to children*, University of East Anglia and the National Society for the Prevention of Cruelty to Children, 2008

[9] Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C., and Black, J., *Understanding Serious Case Reviews and their Impact – A Biennial Analysis of Serious Case Reviews 2005-07*, 2009, DCSF

the under-5s, and under-1 year olds account for 50% of SCRs. Gardner's key findings included the following statements about the harm done to children:

- *Neglect is a major form of maltreatment that has not yet been effectively addressed.*
- *All forms of neglect (physical, emotional, environmental) are associated with measurable developmental damage, including to the child's emotional and social functioning. This can emerge at the pre-school stage and endure into adulthood.*
- *Without effective intervention, neglect can lead to active victimisation of the child both within and outside the family. In some cases this results in multiple abuse and death.'*[10]

These findings highlight the seriousness of the enterprise for LSCBs in trying to improve the lives of children who are being neglected in their families.

11. Findings in Detail

Finding 1: CP Plans for Neglect do not consistently spell out the specific risks to children and the consequences if the desired outcomes for their improved safety are not achieved. As a result, the professionals involved are less clear and confident about when to take protective action.

In this case, the review team were struck by the way that professionals seemed to be better at naming concerns and requiring changed behaviour from parents than at analysing and describing specific risks of harm to the children. Sometimes what seems obvious does need to be spelled out so that everyone has the same understanding of potential harm. Another linked point was that CP Plans did not consistently spell out what action would be taken, and when, if risks of harm to children were not lowered. This resulted in a lack of clarity about when/how and why to take more pro-active steps to protect the children.

How did the issue feature in this case?
The CP Plans for both children changed during the course of 2014, when a new template was developed which reflected a change in the way CP Conferences were managed and which underpinned the recording of the plans discussed in Core Groups. This new template was clearer about desired outcomes for the children (now the first column of the plan), and about time scales for action. But these 'aspirational' elements remained unbalanced without an explicit description of what the principal risks to the children were if Mother's parenting didn't become more consistently safe and child-focused, and 2) what the consequences would be if there were further incidents or not enough progress.

When allegations were made or incidents were reported, they were responded to, and Mother was normally admonished. As time went on, the CP Plans became

[10] Gardner, *ibid, p.7*

longer, and something of a 'cover-all', in order to address the concerning areas of the family's life. One result of this was the continuing high level of support being offered in response to Mother's and the children's needs. But this was not accompanied by robust analysis of the limited and inconsistent changes by Mother as parent, and the potential harm to the children from long term neglect.

The lack of progress was reflected by the persistent list of concerns which did not tend to diminish over time – e.g., that mother had unsuitable people and unfamiliar (new) men visiting her, on one occasion overnight. The concerns were expressed without making explicit their associated risks: in this example, that the children could be physically or sexually abused by a visitor, and that Mother might be distracted by visitors and fail to give adequate physical care and safety to the children. Without this linking of concerns with the impact on the children, there is less likely to be an alert child-centred approach.

What makes this an underlying issue?
Input from the Case Group members as part of this review process indicated that the thinking and CP Plans in this case were not atypical, and practitioners saw this case as one with a moderate to low level of neglect. The Review Team confirmed there are acknowledged problems locally about effectiveness of work done in neglect cases, and the challenge of constructing a consistent and effective response to potential short-term and longer-term harm.

Hitherto, the response to neglect cases has often been to increase the number of named actions in a CP Plan, without a 'grading' of risks which make it clear which are the most serious for the child/ren. Physical elements of a plan, such as clean and tidy children (or house), and school or nursery attendance, may be given more prominence than the emotional wellbeing of the children – something which is undeniably harder to assess and measure.

Against this background, the Oxfordshire SCB has recognised the need to focus on this form of abuse, and has therefore designated **Neglect** as their primary focus for improvement in 2015/16. There is a Neglect Pilot underway in North Oxfordshire, which has as part of its remit the testing out and evaluating of the use of the local 'Neglect toolkit' which is in use, but inconsistently around the county (for more details about the Neglect Pilot, see **Appendix 3**). The County Council has also requested involvement in an NSPCC pilot project to address neglect.

What is known about how widespread or prevalent the issue is?
The common difficulties of working effectively in cases involving neglect are not restricted to any particular team or area, but are considered by the OSCB to be county wide. Significant numbers of children are potentially affected given that half of Oxfordshire's CP Plans have a category of Neglect. Nationally, the picture reflects that in Oxfordshire. Neglect tends to feature more than any other category in CP Plans, and is the focus of the work with families in many Child in Need and Early Help cases as well.

For those higher level cases of neglect, practitioners elsewhere, and in all agencies, have struggled with making effective and timely interventions. Action for Children have identified that about a third of professionals nationally have felt powerless to intervene when they have concerns about child neglect and the same number felt that Government spending cuts have made it more difficult to intervene in cases of child neglect[11].

In their recent thematic survey of neglect cases in eleven local authorities, Ofsted noted that 'One third of long-term cases examined on this inspection were characterised by drift and delay, resulting in failure to protect children from continued neglect and poor planning in respect of their needs and future care.[12] (N.b., Oxfordshire was not part of this survey.)

What has been put in place in Oxfordshire since this review started which would lead the Review Team to believe that practice is different in Oxfordshire today?

The OSCB has identified working with Neglect as a priority in its 2015/16 Business Plan. As part of the action plan a pilot in the North area of Oxfordshire, running from January to May 2015, focused on how practitioners can work more effectively to support children, young people and families where there are issues of neglect. It worked specifically with a cohort of children on CP Plans for Neglect (see **Appendix 3**).

Early feedback on the pilot initiatives from both practitioners and families is positive. There are indications of better outcomes for some of the families. The pilot is being evaluated currently and once this is completed, recommendations will be taken forward in terms of improving/changing practice in relation to how practitioners in Oxfordshire work with families where Neglect is a feature.

Changes to the way CP conferences are managed better have been further embedded; there is a better analysis of risk, which is based more on the family's strengths and weaknesses than previously. This approach is being audited regularly to assess improved outcomes for the children involved

Why does it matter?
A safer system is one where there is shared and agreed identification, and naming, of specific risks for children. Alongside this, there needs to be clarity about the outcomes which would demonstrate progress, and the consequences if these outcomes are not achieved. Without these elements of the work and the planning, professionals are left without a clear framework for protective action, and children are more likely to be exposed to the serious and long-lasting impact of chronic neglect: 'The perception of child neglect has changed significantly over time. It is

[11] Action for Children, 2013
[12] Ofsted, p. 4

now recognised as one of the most dangerous forms of abuse because of its harmful and sometimes fatal effects'.[13]

Finding 1: CP Plans for Neglect do not consistently spell out the specific risks to children and the consequences if the desired outcomes for their improved safety are not achieved. As a result, the professionals involved are less clear and confident about when to take protective action.
Children suffering from persistent neglect by their parents are known to be at serious risk of permanent harm. This is a challenging area for professionals, for the many reasons outlined above. Their responsibility to support and guide vulnerable parents needs to be balanced with a very clear analysis of the specific risks to the children, and a plan which stipulates what needs to change and by when, and what will happen if improvements do not happen. A lack of robust response by professionals to uneven or unsustained change will result in drift and further damage for children who are being neglected. **In responding to this finding, the Board may wish to consider the following areas:** • The outcomes from the Neglect Pilot in North Oxfordshire, particularly in relation to CP Plans for Neglect and the more consistent use of Signs of Safety for Conferences and Core Groups • An analysis of feedback from frontline staff across Board agencies about the difficulties in working with Neglect • Lessons from previous SCRs, case reviews and audits • An in-depth multi-agency audit of neglect cases timed to test whether the recommendations from this review and the Neglect Pilot have had an impact' • The outcomes for CP Plans for Neglect: length of time on Plan, incidence of re-Plans, and evidence of improved safeguarding • The degree to which CP Plans for Neglect are 'child-focused' • The impact of pressures within services on the effectiveness of practice in Neglect • The role of supervision and training in relation to Neglect, including challenges and best practice.

Finding 2: There is a pattern where professionals are not consistently and sufficiently pro-active in response to incidents and allegations regarding children on a current child protection plan, based on their perception that they 'don't have

[13] Turney and Tanner, 2005

enough evidence' to pursue the incident. This stops them from following through with any further investigative or protective action, and the opportunity is then lost to investigate the experiences of neglected or ill-treated children.

There seemed to be a contradiction in practitioners' responses to the family in this case. On the one hand many went above and beyond what was expected, yet various incidents and allegations of physical assault were not treated as seriously as the Review Team would have expected. It is not uncommon that it is difficult to get to the bottom of an alleged incident of maltreatment or neglect, and to see what role the parent may have played. There may be little physical evidence of harm to a child, and no reliable witnesses to behaviour which puts them at risk. For this reason, specific processes exist to enable as thorough an investigation as possible. However, in this case, there was a notable lack of use of such processes.

How did the issue feature in this case?

Professionals encountered difficulties in pursuing incidents/allegations, mainly regarding Q's half-sister: one was that allegations about physical abuse of Q's half sister sometimes came several weeks after the fact, when physical signs were no longer present. The other was that Mother had her explanations for Q's half-sister's bruises, and her account of what she had or hadn't done, and 'stuck to it', despite questioning or challenge by her workers. Overall, the associated level of concern regarding injuries or bruising meant that these instances were minimised. An example of this response to Mother is when she and Q's half-sister both had black eyes in January 2014 and her explanation was accepted, despite it being highly coincidental that two people would have this kind of injury at the same time. In addition, the history provided by Mother of how they were sustained was highly unlikely. This, linked with Mother's history of not telling the truth unless found out, was of concern to professionals, but was taken no further – e.g., by a medical examination of their injuries.

Professionals told the Review Team that they sometimes did not believe Mother's explanations, but did not feel they had enough evidence to do anything but carry on with the CP Plan as before. They felt they were nowhere near the threshold for a pre-court process. This was tautological. Without doing the appropriate investigations, they would not gain the necessary evidence. This was despite the fact that allegations were made from a variety of sources (including Q's half-sister herself) about her ill-treatment, including Mother slapping her and locking her in a cupboard. Mother herself eventually admitted other worrying behaviour – e.g., drinking and drug use during pregnancy. CSC discussed her daughter's allegations with Mother, but on a number of occasions (noted in the **Appraisal** above), they did not consider a Strategy Discussion or Meeting with Police colleagues.

Mother was seen as a likeable and very needy young mum who wanted to do well and to become a better parent. This was appreciated by professionals and may have contributed to a general approach of wishing to support and help her develop into a more responsible adult, whilst unconsciously providing a safety net for her at times of difficulty. The outcome of this was that risks to the children were not always

identified and analysed in a consistent way. Instead, workers gave her the benefit of the doubt – e.g., about the extent of her drinking and whether this happened when she was in charge of one or other of the children.

A view that this was a 'medium or low risk case' did not help, in that there was never a sense that these children would reach the threshold for pre-court or court proceedings. The children were already subject of CP Plans, and it seemed there were few other responses available, when Mother did not follow through on agreed actions. One example of this was when the Written Agreement for MGM to stay with the family for 6 weeks, as a protective factor (after the children were removed from home in August 2013) was breached, but no other measure was put in place to ensure the children's safety, despite the recent very risky incident.

What makes this an underlying issue?
When the response to incidents in this case was discussed with the Case Group and Review Team members, they were not surprised and did not regard this as unusual, pointing to common constraints about handling uncorroborated stories from parents. These were regarded as a normal aspect of the job: 'what more could you do if a parent denied X, and there was no obvious way to gather further evidence?' In such circumstances, professionals would expect to remain alert, but would not necessarily feel they could employ a different form of inquiry. Importantly, discussing this issue surfaced a misunderstanding on the part of practitioners that Strategy Meetings or Discussions do not need to be used for a child already on a CP Plan and are therefore rarely used for such children.

It is also common for allegations to come to the notice of agencies 'late', thus presenting evidential difficulties for an investigation, and the loss of 'urgency'. There was a view expressed within CSC that bruises, in particular, are very difficult to interpret. These are common circumstances in families, and have to be managed on a regular basis.

What is known about how widespread or prevalent the issue is?
A recently published SCR in Lambeth[14] contains a similar finding, suggesting the pattern can be found beyond Oxfordshire: '*When children are already on a child protection plan, there is a tendency for additional concerns not to be investigated through the correct child protection process. The assumption is that this will be addressed at the next child protection conference or core group'*. In fact, as the SCR authors make clear, children already on a CP Plan are among the most 'at risk' children known to agencies, and therefore more in need of the correct multi-agency procedures being used.

What has been put in place in Oxfordshire since this review started which would lead the Review Team to believe that practice is different in Oxfordshire today?

[14] Lambeth SCR Child I

It has been made clearer to workers in CSC that Strategy Meetings/Discussions should be used as required when deciding how to investigate a CP referral, including for children who are subject of a CP Plan.

Why does it matter?
A safer system is one where all agencies deal appropriately with incidents and allegations of maltreatment or neglect, following national CP guidance (*WT*, 2013); where all such investigations focus on the child, and where Laming's model of 'respectful uncertainty' is maintained by professionals throughout.

Ruth Gardner's research (2008) noted the tendency for professionals to stand back in relation to a series of alerts or incidents which signalled Neglect:

> '*Professionals were unanimous in feeling that best practice should mean a sensitive but prompt and pre-emptive response to early signs of child neglect (i.e. if in doubt, respond), rather than the current prevalent "wait and see" approach, which was at best potentially damaging and at worst dangerous.'* (p. 7)

Finding 2: There is a pattern where professionals are not consistently and sufficiently pro-active in response to incidents and allegations regarding children on a current child protection plan, based on their perception that they 'don't have enough evidence' to pursue the incident. This stops them from following through with any further investigative or protective action, and the opportunity is then lost to investigate the experiences of neglected or ill-treated children.
A major part of CP work involves dealing with incidents and allegations about harm to children, often of an uncertain or unclear nature. Professionals need to work together, using all their exploratory powers**,** to ensure that reports about harm to children are shared and thoroughly dealt with, and that patterns of the same allegations (as in this case) are recognised as of significance. The work must be led by a child-centred approach, which involves alertness, challenge, and robust explorations of alleged harm. There is some evidence in Oxfordshire that this approach is constrained by a perceived 'lack of evidence', and therefore no further action is taken in such cases. This is tautological, as it closes the possibility of identifying available evidence, and therefore increases the level of potential harm, which has not been properly understood and responded to. **In responding to this finding, the Board may wish to consider the following areas:** • The understanding of all who work directly with children of the nature of harm in Neglect cases, including incidents of physical abuse or accidents caused by neglect • The use of Strategy Meetings/Discussions, including for children

on CP Plans, and the inclusion of Health in these
- The skills of workers in agencies in agencies to respond in a more child-centred way to incidents/allegations
- The kind of input which would be needed (and achievable) to improve their skills
- The role of supervision in supporting and challenging workers in Neglect cases
- The challenges of investigating allegations about physical harm which are a few weeks old

Finding 3: There is a pattern of delayed and incomplete handover between some professional groups when families move, which can result in interruption of the knowledge about the family and the case, and lead to an unintended 'start again' for the new professionals, even with families where there has been no change or improvement for some time.

Changes in professionals working with families are a fact of life, and not only because families move. What this case has highlighted is the vulnerabilities that these transfers carry with them, and the need to be aware of what may be lost at points of transfer when working with complex and difficult cases.

How did the issue feature in this case?
During the time period covered by this review, the family, who had moved only just over a year previously, moved once again, and the following changes occurred:

- Three different CP chairs
- Three Social Workers
- Involvement by a 2nd and a 3rd Children's Centre
- Two Health Visitors
- At least two GPs

This resulted in some information between professionals being lost, especially after the family's second move. For all new professionals, continuity and a perspective which viewed the case over time had been interrupted; there was an inevitable 'start again' for their work, which often comes with picking up the reins of a case already in progress.

Some good handovers were made, including 'old' and 'new' professionals being present at the transfer-in Review CP Conference after the family's move in spring 2014, an in-person meeting of the Social Workers, and a telephone call between Health Visitors. In contrast, there was minimal information passed from one Children's Centre to another, and no CP Plan provided from CSC. Q's half-sister's school also didn't receive information about the CP Plan in a timely manner. These two key agencies, who had the most frequent and regular contact with Mother and

the children, began their work with little knowledge or understanding of the concerns and risks, and the overall purpose of the CP Plan.

What makes this an underlying issue?
Discussing how different agencies respond to these moves with the Case Group and Review Team revealed that the systems for transferring information include sending records, and sometimes direct contact between outgoing and new workers. These systems vary across services, and can often be erratic in terms of timeliness and completeness. Face-to-face handovers are regarded as best practice, and can sometimes be achieved, but are vulnerable to pressures of large caseloads and insufficient capacity in teams.

Transfer summaries within CSC have not been used consistently in Oxfordshire and this misses the opportunity to pass on a critical analysis of the risks, patterns to be aware of, and the worker's and supervisor's views of how the case might progress.

The Review Team agreed that there is a tendency for workers to 'give the family time to settle', to see what happens in the new situation: in other words, perhaps inadvertently, to mirror the 'fresh start' which the family may be seeking and contributing to a period of drift.

What is known about how widespread or prevalent the issue is?
In Oxfordshire and elsewhere across the country, work with children and families is increasingly characterised by periodic changes in the professionals involved. The reasons for this are usually inevitable: children get older and move from nursery to school, workers change jobs, agencies make new arrangements for allocation of work and lose capacity, etc. Families also move house, sometimes for very good reasons, but sometimes to avoid concerns raised within their neighbourhood and the scrutiny of professionals working with them. This mobility of vulnerable families has been highlighted in a number of SCRs nationally.

What has been put in place in Oxfordshire since this review started which would lead the Review Team to believe that practice is different in Oxfordshire today?

Oxfordshire already has a system which supports the Independent Chair of CP Conferences remaining with a case after a move within the county.

It is now routine for transfers between Children's Centres to have an in-person handover.

The Early Intervention Service (EIS) is now represented at all Initial CP Conferences (including transfer-in Conferences), thus ensuring they have the opportunity to receive essential information about the family and offer additional support to help family and practitioners achieve goals as set out in the child protection plan.

There has been a drive in CSC to block transfers of cases where there is no transfer summary provided – the aim being to embed the consistent use of transfer summaries.

A number of changes to electronic recording systems are underway in different agencies. A move to new IT system MOSAIC in CSC will allow CSC and the EIS (Early Intervention Service) to share the same system. Health professionals in the MASH have access to the CSC system, but only when they are working there.

What are the implications for the reliability of the multi-agency child protection system?

There are few ways to prevent change in the personnel who work with children and families, given the myriad reasons for these changes. Therefore, services need to be alert and prepared for the risks in handling cases when they move from one worker, and/or from one setting, to another: these are the vulnerabilities in the transfer of appropriate and full information in a timely way, and in the potential for a 'new start, or settling-in' period after transfer, resulting in less pro-active work with the CP Plan.

Finding 3: There is a pattern of delayed and incomplete handover between some professional groups when families move, which can result in interruption of the knowledge about the family and the case, and lead to an unintended 'start again' for the new professionals, even with families where there has been no change or improvement for some time.
There is an inevitability about changes in personnel who work with children and families, for all the reasons outlined above. The need to transfer cases and information, and to get to know new families, is a routine aspect of the work of professionals. This review found some evidence of good transfer between some but not all professional groups which provided for the potential for information to get lost, and historical risk not fully appreciated. **In responding to this finding, the Board may wish to consider the following areas:** • The multi-agency guidelines outlining best practice when transferring cases across areas • The use of electronic recording systems within agencies, and potentially across agencies, for sharing information • A system for retaining the same Independent Chair of CP Conferences for a family • Flexibilities which could be used to retain the same worker across boundaries • A template for transfer summaries, particularly in CSC, which could be shared across agencies. This could include a clear description of risks, especially for children on CP Plans (in line

with **Finding 1**).

- The impact on families of having a change in workers, and managing this change

Finding 4: There is a pattern where the input and co-operation of one of the parents, normally the mother, is prioritised at the expense of not engaging the other parent (normally father) in the child protection process. This may result in the children not receiving care and appropriate involvement from one of the parents.

It is important, when undertaking assessments and implementing plans of support and/or protection of children, that there is professional engagement with both parents/carers and extended family. *Working Together* 2013 clearly identified this as a priority, unless to do so would put the children at risk, as do OSCB Procedures for Initial CP Conferences[15]. And yet in a critical period, this case showed a stark lack of communication, assessment and collaboration with the father, in contrast to the mother. Whilst this is appropriate where the man is considered a risk to family members it is not appropriate in other situations and results in the parent not being able to act as a responsible parent and the children not benefitting from their input[16].

How did the issue feature in this case?

Neither father was consistently involved in this case, although both had parental responsibility (PR) and their details were known to CSC: Q's half-sister's father due to CSC's previous involvement and Q's father because he was living with Mother when Q's half-sister returned home to her mother in 2011. Q's father was not involved in the Core Assessment in 2013 following the first Strategy Meeting prior to Q's birth as he and Q's mother had separated. Q's half-sister and Q (once born) were identified as Children in Need and Mother was assessed as a lone parent reporting no contact and support from Q's father, even though he and his mother were in fact caring for Q frequently.

When Q and her half-sister were placed under Police Protective powers, Q's father was not informed and not asked whether he could provide safe care for Q. Whilst this was understandable in the very short term – it being the middle of the night and a weekend – he should have been made aware and included in the assessment of risk in relation to Q's future care. He was subsequently not told about the ICPC which followed from this incident in August 2013, although the CP minutes would suggest that he and his mother had given their apologies. This was not in line with OSCB CP Conference Procedures which state that anyone with parental responsibility should

[15] OSCB Procedures for Initial CP Conferences, Section 7

[16] Scourfield, J. (2006) The challenge of engaging fathers in the child protection process. Critical Social Policy, special issue on gender and child welfare, 26, 2: pp. 440-449Scourfield, pp. 440-449.

be invited verbally by the SW and an invitation followed up in writing. Where required, the Independent Chair should identify the reason for parental non-attendance at the Conference and the non-attending parent's input and views should be included in the social worker's report. Non-attending parents should also receive CP Conference minutes. Q's father and paternal grandmother were not made aware of the CP Plan until after the first RCPC in November, to which they were also not invited.

Case Group members explained that Mother did not want Q's father to be involved or to know about the CP issues. On balance, they took the view that, in order to keep her engaged, they needed to work towards getting her to talk to Q's father about these matters, rather than their informing and involving him directly.

Eventually, Q's father and his mother were included in the CP process, and PGM attended most Core Group meetings and Conferences. They increased their care of Q and at the time of her death were caring for her for half of every week. Professionals reported that they felt that Q was safe and well cared for when with her father and PGM.

What makes this an underlying issue?

Social Policy has until recently reflected a view that child care is a woman's role, and men have tended to be excluded from discussions around care, as well as, in many instances, seen as an actual or perceived risk to children[17]. Whilst this attitude is changing and men are becoming more involved in their children's care, the inclusion of men often becomes more complex when the parents are living apart and there is a level of animosity between them, as there was in this case.

Some of the Case Group felt that at the time of the Core Assessment and the ICPC (i.e., 2013), this was a not untypical picture, and that fathers could be 'left out' in situations where the mother's engagement and co-operation was prioritised over the father's. However, there was a countervailing view that this approach has steadily diminished, and there are now many measures in place to promote awareness of and adherence to the CP Procedures regarding inclusion of fathers.

The Review Team reported on a small number of complaints from fathers in relation to them not being involved in their child's care. These complaints were from fathers who wanted to be involved, and may therefore reflect a larger number of other men who were not included, for a variety of reasons. It has not been possible to measure the incidence in Oxfordshire of similar actions as occurred in this case, which is why the finding is posed as a question. However, the fact that this practice was accepted and not challenged by all the professionals involved would suggest that, at least at that time, it was an underlying issue.

The need for improved working with fathers was a health recommendation in a recent OSCB SCR published in 2014[18]. Both the Case Group and the Review Team felt that whilst this had been an area of concern, it was now being addressed and less likely to occur in the future.

[17] Scourfield, pp. 440-449
[18] OSCB SCR Child N 2014

What is known about how widespread or prevalent the issue is?
The SCR mentioned above highlighted the lack of involvement by fathers in early midwifery and health visitor intervention. Whilst there are no data available to identify how widespread this is in Oxfordshire amongst other agencies, it is a problem that has been highlighted nationally, and government policy has introduced a number of initiatives to improve fathers' participation.

What has been put in place in Oxfordshire since this review started which would lead the Review Team to believe that practice is different in Oxfordshire today?

An OSCB audit took place in 2013 to analyse how well fathers were included in formal CP processes. The Children and Young People's Board held a parents/carers' Sounding Board which was well-attended by fathers and men in parental roles. The learning from this was disseminated across all agencies. In 2013, Children's Social Care included a workshop on involving fathers at its large scale 'Celebrating Social Work' event. Good practice from the Family Nurse Partnership project was presented to approximately 50 social care practitioners.
Practice is believed to have improved, and there have been fewer complaints from fathers/male partners about being excluded.

The following actions address inclusion of fathers more generally, rather than specifically during CP procedures:

As a result of a previous SCR all booking appointments for maternity services ask for father as well as mother to attend and all health visiting "First contact" visits request father's attendance. OUH has taken action to ensure that information about both parents is collected in maternity services.

Health Visiting has conducted an audit of the involvement of fathers at key contact points (e.g., New Birth Visit), and this has shown an increase of health visitor involvement with fathers.

The Teenage Pregnancy Log book of preparation for birth and early parenting is designed to include fathers as well as mothers (information from the Teen-age Pregnancy Midwife).

A key performance indicator for Children Centres is to increase the numbers of targeted groups accessing services from the centres, and fathers are one of these groups. Outreach to fathers by Children Centres in Oxfordshire has increased over the last year but it is acknowledged that there is still more to do.

The introduction of a Multi-agency Safeguarding Hub has enabled agencies more easily to share information they have which would include information on fathers.

The current CP Conference methodology is being used increasingly by CSC and partner agencies, and this involves looking at both parents separately.

OSCB multi-agency training on improving work with young men and boys, commenced in 2014. It covers understanding behaviours, support services and resources so that professionals can work to their best effect.

Why does it matter?
If fathers are not involved in the CP process and not included in any of the assessments carried out, professionals will proceed without adequate information about either the risks that they represent, or indeed the protective factors they and their family may provide to the child/children involved. This will impact on decisions made and may not necessarily be in the best interest of the child.

Finding 4: There is a pattern where the input and co-operation of one of the parents, normally the mother, is prioritised at the expense of not engaging the other parent (normally father) in the child protection process. This may result in the children not receiving care and appropriate involvement from one of the parents.
It is important when working with families, as part of assessment and implementation of plans to provide support and/or protect the children, that there is professional engagement with parents and extended family. *Working Together* 2013 clearly identified this as a priority unless to do so would put the children at risk, as does OSCB Procedures for Initial CP Conferences[19]. And yet this case showed an initial lack of communication, assessment and collaboration with the father, in contrast to the mother. Whilst this is appropriate where the man is considered a risk to family members, it is not so in other situations. The outcome for the child may be that he/she does not benefit from support and input from the paternal side of their family.[20] **In responding to this finding, the Board may wish to consider the following areas:** • The routine capturing of details about fathers in agencies working with women and children in Oxfordshire – including Early Intervention services and in assessments for Child in Need and CP processes – and any increased improvement in outcomes for children since the routine recording of fathers by health visitors • Lessons from previous SCRs, case reviews and audits in relation to inclusion of fathers/partners • Lessons from other local authorities and LSCBs, as well as from

[19] OSCB Procedures for Initial CP Conferences; Section 7
[20] Scourfield, J. (2006) The challenge of engaging fathers in the child protection process. Critical Social Policy, special issue on gender and child welfare, 26, 2: 440-449.

research, about what works well in including fathers or the partners of mothers
- The role of Strategy Meetings, Conferences and Core Groups in improving practice – in a safe way for mothers and children
- The possible use of consultation exercises to assist with this issue

Finding 5: The commitment to working in partnership with parents in Oxfordshire has inadvertently led to an assumption that professionals cannot meet together, without parents being present, when they have concerns regarding case management. This jeopardises opportunities for joint discussion, challenge and supervision.

Working in Partnership with parents is now the expected norm with them being aware of concerns professionals may have and what is needed to address those concerns. However, there are occasions when it is beneficial for professionals to meet together to address such issues as network functioning, 'stuck' cases, etc. In such circumstances, a professionals meeting, peer-supervision or a facilitated network meeting may be required. The usefulness of such meetings, and when they are justified, needs to be understood and agreed among agencies.

How did the issue feature in this case?
There was good attendance at CP conferences and Core Groups, and professionals reported that they worked well together and challenged Q's mother. However this case review process has highlighted that some information was not shared in meetings with Mother and some incidents were not discussed in Core Groups (e.g. the trip to hospital in 2013 and the allegation of ill-treatment of Q's half-sister in 2014). This may have been because of a wish not to upset Mother and keep her on board. The result was that not all professionals held the same set of information.

Meetings with service users present do not generally allow for analytical or speculative discussion (e.g. about the level of Mother's keeping secrets, or what was known about her alcohol misuse), or for robust professional challenge of each other within the professional network. Challenging Mother in meetings also proved difficult. An example of this is when she had two black eyes and Q's half-sister had one. The Core Group meeting was unable to get beyond her explanation of the causes, despite the fact that her injuries were physically unlikely to have occurred in that way and the likelihood of her and Q's half-sister having injuries at the same time highly improbable (see link to Finding 2).

Another time when a professionals meeting would have been beneficial was at the time of the move in 2014, when not all professionals (in particular school and the Children's Centre staff) had all the information required to carry out the work expected of them (see also Finding 3).

What makes this an underlying issue?

Both the Case Group and the Review Team felt that this was not an isolated case, and that it would be unusual for professionals to meet to discuss a case without parents being present, even when it might be useful. There was a clear culture of openness with parents which some Review Team members felt would be threatened by having any meetings without parents (although currently, this is true for Strategy Meetings).

A member of the Review Team described how a health practitioner's request for a professionals meeting had been discouraged by CSC, apparently on the grounds that this would not fit with the principles of transparency. Currently, there is no clear guidance nor agreed criteria for deviating from the important principle of openness and working in partnership with parents. This is unlikely to change unless such criteria can be agreed, for when a professionals meeting can be agreed.

What is known about how widespread or prevalent the issue is?
The Children Act 1989 and Working Together 2013 both identify the need to work openly and in partnership with parents unless to do so would put a child at further risk of harm. The Review Team and Case Group were in many ways typical of the wider professional respect for these principles. There is a legitimate concern expressed widely in children and families work not to lose the improvements made from a time when parents were regularly left out of decision-making meetings.

Social policy has reflected and promoted this view. However, in some cases such as this one, this has resulted in a lost opportunity to share information and provide clarity about the level of risk.

The consequences from not holding professionals meetings have been picked up in other SCRs, including the Gloucestershire SCR into the neglect of Abigail and her siblings Bobbie, Charlie and Daisy[21], and also identified by the research carried out in Improving Child and Family Assessments in 2011.[22]

What has been put in place in Oxfordshire since this review started which would lead the Review Team to believe that practice is different in Oxfordshire today?

Nothing specific has yet been put in place but both the Case Group and the Review Team felt that this was an area requiring further work.

The Review Team were told about the regular use of 'case mapping' (usually at the TAC level), when there is a concern about the work in a case being effective.

Why does it matter?

[21] Gloucestershire SCB SCRs 2014
[22] Selwyn, J., Farmer, E., Turney, D., Platt, D.: Improving Child and Family Assessments: Turning Research into Practice; Jessica Kingsley Press, 2011

When cases are drifting, or there is multi-agency professional disagreement or the need for peer supervision/facilitation, it may be helpful for professionals to meet without parents, to debate and analyse what would achieve better outcomes and to agree a way forward. This would also support supervision provided within a professional's own agency and would provide a space for free thinking, analysis and clarity of vision required in complex cases.

Finding 5. The commitment to working in partnership with parents in Oxfordshire has inadvertently led to an assumption that professionals cannot meet together, without parents being present, when they have concerns regarding case management. This jeopardises opportunities for joint discussion, challenge and supervision.
A safe system enables partnership with parents and adequate support to professionals. This finding has highlighted a norm which provides the former at the expense of the latter. Where there is no progress in a case, and by extension no improved outcomes for children, there should be the possibility for the network to meet separately to look together at the effectiveness of their work. **In responding to this finding, the Board may wish to consider the following areas:** • The perceived barriers to holding such meetings • The possibility of agreed criteria, or terms of reference, for holding a 'professionals only' meeting • The balance needed with the principle of transparency of working with parents • The role of the Board's escalation policy when professionals are unable to agree a way forward • The resources and skills needed for skilled chairing or independent facilitation (when required) of such meetings

Finding 6: In Oxfordshire, there is insufficient capacity for the effective administration of invitations to CP Conferences, and distribution of minutes and CP Plans. This leads to meetings in the CP system suffering from a lack of timely information-sharing and therefore of plans not being implemented in an effective way.

Elsewhere in this report, we have written about the need to follow national guidance for multi-agency CP work (Finding 2, above), which includes the operation of the CP Conference system. This review has highlighted that locally this system is not functioning efficiently, especially in sending out minutes and plans. This leaves

partner agencies with lowered confidence about what they can expect in relation to accurate and timely information-sharing.

How did the issue feature in this case?
There was delay in timely and consistent sharing of CP Plans and minutes for professionals in this case; for example the minutes of the ICPC were not available for the first Core Group meeting.

What makes this an underlying issue?
This review heard that this is regarded as typical of what is now experienced from the CP Conference system. The message from both Review Team members and Case Group members was that there are almost always lengthy **delays** in receiving CP Plans and minutes, sometimes of several weeks. This is particularly problematic for people who have been invited to a Conference, but who were unable to attend. They can be left with no information about risks to the children for a period in which they may be working with the family.

The Review Team also commented that agencies generally assume minutes will not arrive in a timely way, and resort to finding ways around this.

It is unclear whether colleagues are aware of the minimum standards for these to be distributed – in the Oxfordshire Child Protection Procedures (updated June 2013).

- CP decisions/plans should be distributed within **1 working day**.
- CP Conference minutes should be circulated within **28 days**.

Neither of these targets is being met on a regular basis, and Case Group members said that CP decisions/plans do not arrive in advance of the minutes, which take much longer to be completed. The use of a separate document for the CP decisions/plan, which should be sent out separately and in advance of the minutes, is apparently not in place.

There were also complaints about the production of Strategy Meeting minutes, and some colleagues (the Police, in particular) said they do not expect ever to receive Strategy Meeting minutes from CSC. They understand that the chair of the Strategy Meeting also has to minute the meeting; normally has several meetings in one day; and therefore has no capacity to produce minutes in a timely way.

There are clearly some systems which are obstacles to efficiency. Until recently, there were insufficient numbers of administrative staff to operate to the expected standards.

All records (invitations, minutes, etc.) are sent out by paper copy and using second-class post. This is because of concerns about the security of Email. Unfortunately, this can add delays to the receipt of invitations and minutes.

What is known about how widespread or prevalent the issue is?

In Oxfordshire this was known to be a problem due to a lack of administrative support for CP conferences. It was exacerbated by the increase in children with a CP plan, where numbers increased over the time of the review and have continued to increase to date. Numbers of children with a CP plan in 2012 were 364, numbers in March 2013 were 430 and in 2015 they were 632, a steep increase over a three year period and one which continues currently. Numbers are lower than the national average but higher than statistical neighbours.

There has not been an audit in relation to the timeliness of getting conference minutes to family and professionals involved, but it is clearly a known and acknowledged problem. The problem is exacerbated by the use of second class post rather than electronic distribution due to concerns relating to data protection.
It is likely that many of the same challenges are experienced in every local authority, where CP work is increasing in volume. Everywhere, the same standards are required, and many of the same pressures on staffing resources are bound to apply. It is not known whether there are more efficient systems in use elsewhere from which Oxfordshire could benefit.

What has been put in place in Oxfordshire since this review started which would lead the Review Team to believe that practice is different in Oxfordshire today?
The concerns expressed above have been escalated to the Deputy Director for Safeguarding (CSC), who is addressing the problems outlined in this finding.

There has been an increase in the number of administrative posts working with CP Conferences, but it is not yet known whether this has had an impact on the finding.

The more regular use of Egress, a secure email tool, in CSC (since 2014, and for their providers from May 2015) for sending communications safely is now in place, for the different processes involved in the formal CP framework.

What are the implications for the reliability of the multi-agency child protection system?
The period which follows the ICPC (and possibly, a transfer-in Conference), in particular, represents an opportunity to work with families in a focused and more intensive mode, at a time when families may be ready to listen to the combined concerns of the professional network. Where there is a delay in receiving the plan there is a reduced opportunity for agencies to consider their roles and what they can offer, in preparation time for the first Core Group meeting (within 10 days). The effectiveness of the work during this period and at the Core Groups is reliant on having the skeleton CP Plan and developing it in partnership with the family and key partners.

Finding 6: In Oxfordshire, there is insufficient capacity for the effective administration of invitations to CP Conferences, and distribution of minutes and CP Plans. This leads to meetings in the CP system suffering from a lack of timely information-sharing and therefore of plans not being implemented in an effective way.

The reliable operation of the CP Conference system, including other meetings within the CP framework (such as Strategy Meetings), is essential to support the work of professionals with families, and with each other. The CP Plan is the building block to guide the work with families, and a baseline for review against progress. Not to produce or share the plan in a timely way brings considerable problems: that concerns about the children and the purpose of the work remain unclear, and may even minimise the perception of risks.

In responding to this finding, the Board may wish to consider the following areas:

- Feedback and positive criticism needed from partner agencies to identify problems regarding invitations and minutes
- Capacity issues (number of staff; skills of staff, etc.), and the systems issues (the need to maintain security, the templates/tools available, etc.)
- The organisational responsibility for CP Conferences and distribution of minutes
- The method of sending invitations and minutes
- Lessons from other local authorities about how to achieve the national minimum standards required for sharing CP Plans and minutes

Finding 7: There is no agreed use of a multi-agency tool to capture a chronology of significant events, making it more difficult to assess risk to children and parental patterns which demonstrate poor capacity to change.

The usefulness of a multi-agency chronology of significant events has been underlined by numerous SCRs, by the Victoria Climbie Inquiry Report, and in other research. In order to assess risk accurately, a tool is required that will identify both past and present concerns, patterns of behaviour, and what interventions haven't worked in the past. An agreed tool to enable this to occur, such as a significant events form or a chronology, provides professionals with the information which will enable them to do this.

How did the issue feature in this case?

There were a number of worrying incidents of various kinds that continued to occur in the family/to the children. These were dealt with by different agencies (normally by the SW), and were not always shared in a timely way with inter-agency colleagues. This seemed to make it harder for colleagues to identify a 'cluster' of events which might show that mother was going through a particularly low period or difficult time in terms of coping with the children or her own emotional struggles.

Integrated chronologies of significant events were not used routinely for CP Conferences or Core Groups as a means of tracking progress (or otherwise). This meant that not all incidents were reported to these meetings, and repeated patterns, e.g., of Mother not telling the truth until 'found out', were not always picked up.

What makes this an underlying issue?
Review Team members acknowledged the importance of chronologies for working with families. Within agencies, these are vital for reviewing progress and identifying incidents and patterns, so that workers and their managers can reflect on what is or isn't making a difference for the children. Across agencies, they offer a tool for identifying and tracking, so that partners are similarly able to analyse what is going on in a case and what progress has been made.

All the agencies involved in this case have a chronology template which is meant to be maintained and used for analysis and review of the work – e.g., in supervision. However, the usefulness of sharing or integrating a chronology with partner agencies is not currently on the table. Even doing so for CP Conference reports and minutes is regarded as not easily achieved.

The value of chronologies is agreed, but Review Team members described a number of barriers to making them used more reliably:

- The introduction of chronologies in ICS was not successful. Social workers found the tools difficult to use, and more recent adaptations (e.g., Frameworki in CSC) are still inflexible, too lengthy, and do not allow the identification of 'key' events.
- In Oxfordshire, there are different models in use, even within agencies such as Health, and a number of new tools are currently being developed. This suggests there will be a period before these changes are bedded in and being used consistently and confidently.
- There are major caseload and time pressures on workers, leading to a culture which does not prioritise, or insist upon, the maintenance of a chronology – due to the amount of time required and the difficulties described here. This may particularly apply to those cases below the threshold for court proceedings (where a chronology must be produced).
- One of the drivers for the change in conduct of CP Conferences was the emphasis placed on the family's strengths and resilience as well as their weaknesses thus engaging the family with the process. Some of the Review Team felt the use of chronologies did not fit well with this model and therefore the same importance was not placed on using them.

What is known about how widespread or prevalent the issue is?
Within Oxfordshire a chronology is prepared by the social worker for CP Conferences but not distributed with the minutes. This is felt to be too unwieldy to share on a regular basis. Recently, the OSCB have agreed to share and integrate chronologies

to cover a short period of time when they feel to do so may provide professionals with a broader picture on what's happening in a case.

Nationally, the requirement to maintain chronologies in CSC has been in place since Lord Laming's inquiry into the death of Victoria Climbie, and his finding that professionals had failed to recognise patterns in the child's history. He therefore made the recommendation that

> *Within six months of the publication of the report, directors of social services had to ensure every child's case file had, on the inside of the front cover, a "properly maintained chronology"*[23].

Long before that, in 1973, the equally seminal inquiry into the death of Maria Colwell concluded that it was essential to keep chronological records of significant events in a case – in order to provide a picture of a child's history, including risks of harm. But a review of the use of chronologies in *Community Care,* noted that

> *'…more than 30 years after Maria's death it seems chronologies are still not always managed properly and key opportunities to intervene are being missed.'*[24]

There is clear evidence that the value of chronologies is endorsed, and that attention is being given to how to achieve better practice, including meeting Laming's recommendation. No doubt some areas are proving better at this than others. But it is likely that the barriers outlined above continue to challenge local authorities and all agencies in the safeguarding children network.

What has been put in place in Oxfordshire since this review started which would lead the Review Team to believe that practice is different in Oxfordshire today?

Children's Centres now use chronologies routinely and have done for the last twelve to eighteen months. They are reviewed regularly to assess progress.

The OSCB have also agreed a process which has been put in place to carry out a short-term integrated chronology for complex cases.

What are the implications for the reliability of the multi-agency child protection system?

'Abuse and neglect are infinitely more preventable when good chronologies are kept.' 'Patterns in social history and behaviour can be detected and something which might appear insignificant in isolation can be identified as a key warning sign in context.'[25]

[23] Lord Laming, The Victoria Climbie Inquiry Report, 2003, Recommendation 58

[24] Camilla Pemberton, 'Danger signs that lay in a timeline. How social workers should use case chronologies', *Community Care*, September 27, 2010

[25] Quotation from T. Palmer, in Camilla Pemberton, 'Danger signs that lay in a timeline. How social workers should use case chronologies', *Community Care*, September 27, 2010

A child protection system needs to be able to have a reliably accurate picture of the present in the context of the past for all children. Relying on the narrative of records and the personal memories of practitioners is fallible and risky. A safer system is one where chronologies are expected and relied upon as a tool for case analysis, planning and review. As multi-agency chronologies, they provide a far stronger and more effective vehicle for sharing information within the safeguarding children network. They can also assist in preventing a 'start again' mind-set, when they are available to new professionals joining a case (see link to **Finding 3**).

Finding 7: There is no agreed use of a multi-agency tool to capture a chronology of significant events, making it more difficult to assess risk to children and parental patterns which demonstrate poor capacity to change.
To assess risk accurately a tool is required that will identify both past and present concerns. An agreed tool to enable this to occur such as a significant events form or a chronology provides professionals with the information which will enable them to do this. **In responding to this finding, the Board may wish to consider the following areas:** • The current use of chronologies in constituent agencies • An agreed multi-agency policy on chronologies • Guidance on how to construct and use a chronology • Auditing their use, via internal audits and inspections of services • Constraints and obstacles for using a chronology in safeguarding cases • The possibility of achieving an **integrated chronology** for CP Conference reports, using an agreed template

12. Additional Learning

12.1 Misleading records in relation to participants in CP Conferences

This review has highlighted a routine mistake in CP Conference minutes, in relation to those who were invited to the Conference.

Father and PGM were not informed about the Initial CP Conference, and were not invited. However, in the minutes their names were listed under 'apologies' – thus wrongly suggesting that they had been invited but sent their apologies. This would have been misleading for the professionals attending; had they known the true situation, they might have objected to the exclusion of father, who had parental responsibility.

Some members of the Case Group confirmed that they had noticed this happening to themselves: when they received minutes, their names were listed as having given apologies, but they had never received an invitation.

An accurate system is needed which reflects who was invited/who attended/who gave apologies/who did not attend and did not give apologies.

12.2 Enabling wider participation in CP Conferences and Strategy Meetings

The Review Team suggested that, given modern technology, there could be greater flexibility in how to conduct certain meetings, including CP Conferences and Strategy Meetings. Video or audio conferencing would perhaps enable Police Officers, GPs and other health professionals to participate more readily, whilst currently time and distance pressures mean they often cannot attend.

12.3. Housing Involvement in the CP process

Housing are not routinely involved or made aware by CSC of children with a CP plan. Housing have already amended their paperwork so that once made aware they can record whether families who move into social housing have children with a CP plan. They will also be agreeing a process with CSC which will enable them to provide input into CP conferences which may include the routinely being asked for a report and provided with minutes.

13. Conclusion

13.1 This systems review has had two principal aims: to report and learn from what happened, and why, in a particular child or family's story; and to consider what this tells us about the wider safeguarding of children in Oxfordshire, and how this might be improved.

13.2 Overall, the review has highlighted the complexity of working with Neglect. It explored the initial four "research questions" in relation to multi-agency working in Oxfordshire, and identified findings in relation to three of them. The question regarding substance misuse did not result in a finding, as there was no evidence available to suggest that Mother had an addiction to drugs or alcohol.

The findings have focused on the learning for Oxfordshire which will improve agencies' response to Neglect. There were no findings, nor any data captured in the review process, that suggested that any agency's actions (by commission or omission) could have prevented Q's death.

13.3 Mother's care of the children was characterised by workers as 'low to medium' neglect, and as such little different from many other families known to agencies in Oxfordshire. All the information available and observations by workers suggested that there was good attachment between Mother and Q. While this did not

necessarily mean that Q was not at risk, professionals were understandably more worried about her half-sister, where there was some evidence of emotional abuse and possible physical abuse.

13.4 The contents of this report have been the product of the Review Team and Case Group, who contributed their knowledge and experience in relation to this case, as well as their wider understanding of how safeguarding systems operate in Oxfordshire and elsewhere. They participated in the analytical process with a clear desire to make things work better in future. This was enhanced by the additional information provided by Q's father and paternal grandmother.

It is hoped that this review will support learning and improvement across the safeguarding network, and will lead to better outcomes for children at risk of harm.

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APPENDIX 1

Review methodology

1. Methodology

1.1 Statutory guidance requires SCRs to be conducted in such 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 data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings. (WT, 2013, p.67)

1.2 It also requires that the following principles should be applied by LSCBs and their partner organisations to all reviews:

- 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;
- the approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are **independent** (see section 8 below) of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process. (WT, 2013, pp. 66-67)

1.3 The OSCB wished to try out a new systems approach for SCRs: the Learning Together model (Fish, Munro & Bairstow, 2009), developed within the Social Care Institute for Excellence (SCIE). This model meets the expectation in WT 2013 for SCRs, and other learning reviews, to demonstrate 'systems principles' in seeking to capture 'what happened and why'. The model involves the use of a Review Team of senior managers and a Case Group made up of the professionals involved with the family, who work together with the Lead Reviewers to collect and analyse data about the case and the context for the work carried out. The aim is to identify

whether local systems are supporting good multi-agency practice and better outcomes for safeguarding children. As a result, most Learning Together findings tend to focus on systems which operate across agencies.

The Learning Together model also includes the views of any family members able to participate in the process.

A full account of the Learning Together methodology, and the process used for this SCR, is provided in **Appendix 2**.

2. Reviewing expertise and independence

2.1 The model relies on reviewing expertise and independence, in the same way that WT 2013 requires independence in at least one lead reviewer for Serious Case Reviews.

3. Methodological comment and limitations

3.1 The Lead Reviewers and Review Team gathered data from all the professionals/agencies involved with the family in Case Group meetings and in individual conversations, 22 in total from five different agencies. These activities yielded a large amount of rich data to support systems learning. There was good attendance at the follow-up meetings and professionals involved participated very positively in the process, reflecting and sharing on their experience.

The Lead Reviewers and Review Team members were conscious that this participation was initially very distressing for workers, particularly those who had known the family over time, and had worked with Q very recently. Nonetheless, their feedback was that they valued the opportunity to contribute to learning from a tragic event. We are very grateful to them for doing so.

3.2 The use of documentation, including an integrated timeline and key records from agencies, provided a necessary starting point and context for the case discussions at the workshops. (Details of documentation are given in Appendix 2, Para 10.4.)

3.3 Oxfordshire has carried out a number of SCRs in the recent past and this review provided an opportunity not only to explore a different methodology but to provide some of the Review Team (listed in Appendix 2) with the experience of participating at this level. This was successful, and the feedback from the Review Team was that they, in common with their Case Group members, found the experience a positive one, albeit requiring an intensive input of work from them. They especially valued its collaborative, multi-agency nature. The opportunity for practitioners to appraise their practice collectively was new, and they appreciated the chance to analyse the work done across agencies with the family.

The Review Team, of which some members had never been part of a SCR at this level before, experienced some unavoidable absences and changes in membership, and

not all members had received training on the SCIE methodology, so that they had to learn while doing the review.

Despite all the challenges, the Review Team demonstrated a high level of commitment and a willingness to challenge themselves and each other, in order to generate the learning from this case.

3.4 One of the social workers involved in the case had left the department and was therefore not available to be a part of the process. Her team manager was still in post and able to provide a lot of background information.

3.5 The Review Team were unable to answer the research question in relation to substance misuse. This was because there was no evidence to suggest that Mother had a problem of addiction, although there were concerns at times about her irresponsible use of alcohol and cannabis.

3.6 The police completed their own Individual Management Review (IMR) which was shared with the Review Team. Their officers were not available for the one-to-one conversations which were held with other professionals, but they did attend the Case Group introduction and follow-up meetings as active participants.

3.7 The Lead Reviewers were unable to meet with the Mother because of an ongoing criminal investigation, which means that her views were not available for the review. It is hoped that at some future point, she will be able to contribute in some way and to add to the insights into this case.

A conversation was held with Paternal Grandmother and Q's father. Their participation at such a difficult time was a testament to their commitment to both children and their information provided some insight into what life was like for Q and her half-sister.

APPENDIX 2

Learning Together Methodology and Process

1. This review has used the SCIE Learning Together model – a 'systems' approach which provides a theory and method for understanding why good and poor practice occur, in order to identify effective supports and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and CP work (Munro, 2005; Fish et al, 2009). National guidance in the 2013 revision of *WT* 2013 now requires all SCRs to adopt a systems methodology.

2. The model is distinctive in its approach to understanding professional practice in context; it does this by identifying the factors in the system that influence the nature and quality of work with families. Solutions then focus on redesigning the system to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.

3. Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.

4. The basic principles – the 'methodological heart' of the Learning Together model – are in line with the systems principles outlined in *WT* 2013:

a. **Avoid hindsight bias** – understand what it was like for workers and managers who were working with the family at the time (the 'view from the tunnel'). What was influencing and guiding their work?

b. **Provide adequate explanations** – appraise and explain decisions, actions, in-actions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it

c. **Move from individual instance to the general significance** – provide a 'window on the system' that illuminates what bolsters and what hinders the reliability of the multi-agency CP system.

d. **Produce findings and questions for the Board to consider**. Pre-set recommendations may be suitable for problems for which the solutions are known, but are less helpful for puzzles that present more difficult conundrums.

e. **Analytical rigour**: use of qualitative research techniques to underpin rigour and reliability.

5. Typology of underlying patterns: To identify the findings, the Review Team has used the SCIE typology of underlying patterns of interaction in the way that local child protection systems are functioning. Do they support good quality work or make it less likely that individual professionals and their agencies can work together effectively?

They are presented in six broad categories of underlying issues:

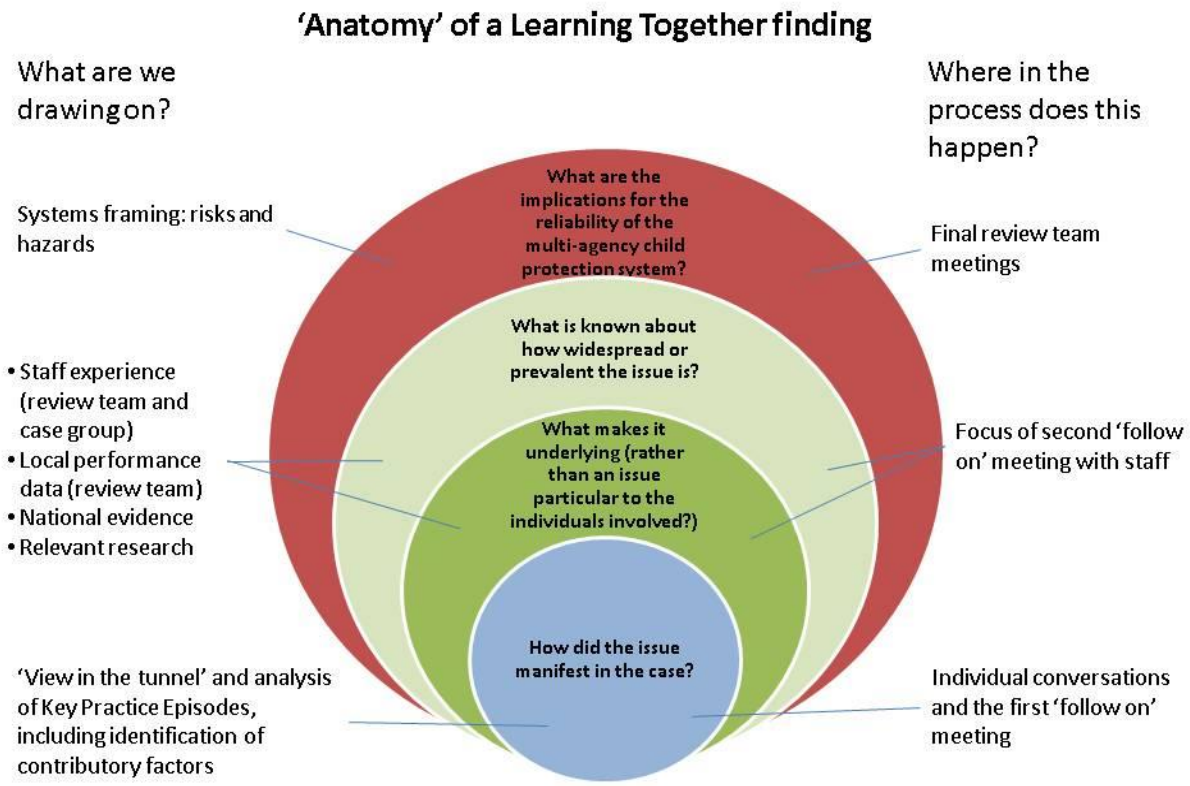
1. Multi-agency working in response to incidents and crises
2. Multi-agency working in longer term work
3. Human reasoning: cognitive and emotional biases
4. Family – Professional interaction
5. Tools
6. Management systems

Each finding is assigned its appropriate category, although some could potentially fit under more than one category.

6. Anatomy of a finding: For each finding, the report is structured to present a clear account of:

- How did the issue feature in the particular case?
- How do we know it is not peculiar to this case (not a quirk of the particular individuals involved this time and in the particular constellation of the case)?
- What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?
- What are the implications for the reliability of the multi-agency child protection system?

These 'layers' of each finding are illustrated in the Anatomy of a Learning Together Finding (below).



7. Review Team and Case Group

7. 1 Review Team

The Review Team comprises senior managers from the agencies involved in the case, who have had no direct part in the conduct of the case. Led by at least one and often two independent Lead Reviewers, they act as a panel working together throughout the review, gathering and analysing data, and reaching conclusions about general patterns and findings. They are also a source of data about the services they represent: their strategic policies, procedures, standards, and the organisational context relating to particular issues or circumstances such as resource constraints, changes in structure, and so on.

The Review Team members also have responsibility for supporting and enabling members of their agency to take part in the case review.

	Agency
	OSCB Business Manager (SCIE Champion)
	Specialist Investigator Thames Valley Police
	SCIE Independent Lead Reviewer
	SCIE Independent Lead Reviewer
	DCI Thames Valley Police
	Senior Manager Action for Children/ Practice

	Improvement Manager Action for Children
	Early Intervention Manager Oxfordshire Clinical Commissioning Group
	Safeguarding Practitioner Oxfordshire Clinical Commissioning Group
	Named Nurse Safeguarding Children, Oxford Health NHS FT
	Corporate Secretariat Manager Oxfordshire County Council
	Safeguarding Children Lead and Patient Experience, Oxford University Hospitals
	Senior Named Nurse Oxford Health
	Joint Commissioning Manager for Drugs and Alcohol , Public Health
	Principal Social Worker Children's Social Care Oxfordshire County Council

7.2 Case Group

The Case Group are the professionals who were directly involved with the family. The Learning Together model offers a high level of inclusion and collaboration with these workers/managers, who are asked to describe their 'view from the tunnel' – about their work with the family at the time and what was affecting this.

In this case review, the Review Team carried out individual conversations with 20 Case Group professionals, and two family members. Case Group members were invited to an Introduction Meeting (to explain the Learning Together model and the SCR process) and later to an all-day workshop and two follow on meetings.

Health: GP (2) Consultant Paediatrician (1) Midwife (1) Health Visitor (2)
CSC: Team Manager (3) Social Worker (3)
Early Years and Education: Head Teacher, Primary School (2) SENCO (1) Teacher (1) Children's Centre Worker (3)
Conference and Review Service: Independent Chair of CP Conference (1)
Thames Valley Police: PC (5)
Housing:

Housing Officer (2)

8. Structure of the review process: A Learning Together case review reflects the fact that this is an iterative process of information-gathering, analysis, checking and re-checking, to ensure that the accumulating evidence and interpretation of data are correct and reasonable.

The Review Team form the 'engine' of the process, working in collaboration with Case Group members. The Review Team held an introductory meeting for the Case Group at the beginning of the process, to explain the Learning Together model and the process they would be part of. Case Group members were then involved via individual conversations, and in two multi-agency Workshops, where they were asked to give feedback on interim/draft reports.

The Review Team were involved in collecting and reading data, including a multi-agency chronology and key documents. Together with the Lead Reviewers, they met to analyse the material (5 meetings) and contribute to the findings.

9. Scope and terms of reference

9.1 Taking a systems approach encourages reviewers to begin with an open enquiry rather than a pre-determined set of questions from terms of reference. In this review, we noted and explored the questions (Para 5.2 of the report) which the OSCB had posed as of particular interest.

10. Sources of data

10.1 Data from practitioners

Workshop Days were held at which members of the Case Group responded to the analysis of the case and gave feedback about accuracy and fair representation of the material presented. In relation to the emerging findings, the Case Group were asked to comment on whether these were underlying and widespread/prevalent. In other words, could we draw conclusions about whether, and in what way, this case provided a 'window on the system'?

10.2 Key Practice Episodes and Contributory Factors

Following on from individual conversations, the first Workshop Day aimed to piece together the practitioners' 'view from the tunnel' and a selection of Key Practice Episodes (KPEs). These KPEs are significant points or periods in relation to how the case was handled or how it developed. Case Group members are also an invaluable source of information about the why questions – an exploration of the Contributory Factors which were affecting their practice and decision-making at the time.

10.3 Participation

The Learning Together model relies on professionals contributing very actively to the review and the resultant learning, as it is their unique experiences which help us understand what happened and why.

We know that participation in a case review can raise anxieties and sometimes distress about what has happened to children, and may prompt self-questioning about 'could I have done something differently?'. In this context, the Lead Reviewers and the Review Team are especially grateful for the willingness of the professionals to reflect on their own work, and to engage openly and thoughtfully in the review.

10.4 Data from documentation

The Lead Reviewers and members of the Review Team were given access to the following documentation:

- The records of the agencies in the case, which were then translated into an integrated chronology
- Referrals and Assessments
- Reports for CP Conferences
- Minutes of meetings: CP Conferences, Core Groups, Strategy discussion
- CP Plans
- Information relating to the North Oxfordshire Neglect Pilot.
- OSCB Child N 2014

10.5 Data from family, friends and community

The Learning Together model aims to include the views and perspectives of family members as a valuable element in understanding the case and the work of agencies.

In this review paternal grandmother and R's father were able to participate. R's mother was not able to due to the ongoing police investigation.

APPENDIX 3: The Neglect Pilot (North Oxfordshire)

The North Pilot, which was developed and led by practitioners from multiple agencies and services, was composed of the following workstreams:

- Strengthening the core group function
- Providing intensive support to families at critical points
- Developing tools to support practitioners and evidence neglect
- 'Think Family' to support and enable parents/carers
- A needs analysis to estimate the extent of neglect in Oxfordshire

Within core groups, the pilot trialled initiatives to clarify and share responsibilities for delivering the action plan across the group and to focus on making actions smarter and achievable. Joint visits by practitioners to the family home were encouraged to improve observation and demonstrate to families practitioner and service joint working. To support practitioners, case mapping exercises to understand family situations and reflective core group sessions to resolve differences between professionals or to agree a plan for a 'drifting' case were completed. Feedback from practitioners was that this was helpful joint problem solving and more co-ordinated joint working helped to move cases forward.

A group of families with very complex needs were offered very intensive family support to help them achieve the actions identified on the child protection plan and to help practitioners and families assess capacity for change. Closer working between Early Intervention and children's social care was really positive and enabled services to engage with families that have been traditionally hard to engage and support them to make changes. This way of working did achieve positive outcomes for families. A number of the children within these families experienced difficulties around transitions within education settings. A Transitions coordinator and a checklist which was developed to be used at Conferences around educational issues increased the focus on moves into different education settings, ensured that school applications had been made which then helped to ensure that right support was accessed at the new setting from the start.

Briefings for practitioners on core groups and has been positively responded to, as has spreading understanding of the case mapping approach to other agencies. The focus of the pilot on neglect has raised the profile of neglect and opportunities, such as briefings and facilitated sessions, has provided space for practitioners to discuss approaches to neglect.

To ensure and support a 'Think Family' approach, link workers were established in adult services to provide advice and consultation to children's practitioners, facilitating referrals and assessments of support to meet the needs of parents/carers. Similarly, to support and enable parents/carers to change their family situations and improve outcomes for their children employment support was available from the Thriving Families programme for these families, along with the employment support already provided by Children's Centres.

Further evidence on the value of the Graded Care Profile assessment tool is being sought through an application to be part of the NSPCC national trial of their updated version.