Progress Report on the Findings from the Child Q Serious Case Review

1. Introduction

A Serious Case Review was undertaken into the tragic death of Child Q and this report demonstrates the multi-agency learning that has taken place as a consequence. It outlines the steps that have been taken to improve services, particularly in relation to supporting children and young people where neglect is a factor in their lives. It also evidences the impact of these improvements. Whilst significant progress has been made it is recognised that further work is required supported by strong leadership at the highest level across all partner agencies.

2. Our Strategic Approach

A multi-agency, senior-led Neglect Strategy Task and Finish Group has been established as a sub-group of Oxfordshire Safeguarding Children Board to elevate the profile of neglect to the highest level in all agencies and to ensure it is a top priority for all partners in the light of the high prevalence of neglect both nationally and locally and in response to the findings from the Serious Case Review on Child Q. This has secured a partnership commitment to addressing neglect and to further develop integrated family working and integrated local service delivery at all stages of a child`s journey from early help to statutory intervention. This work forms part of our strategic approach to early help and is one of the key priorities for the Oxfordshire Safeguarding Children Board.

The Neglect Strategy Task & Finish Group is supported by an Operational Group and a Learning and Development Group and is a two year work stream. Each group is co-chaired by senior managers from community health services and Children's Social Care to reinforce the joint strategic commitment to this work.

A pilot project working with families where neglect was of primary concern was undertaken in 2015 in the north of Oxfordshire. This sought to establish more effective ways of working to support better outcomes for children on Child Protection Plans for neglect. The pilot involved a wide range of practitioners from Children's Social Care, Early Intervention Services, health services, schools, police, adult and probation services. It enabled practitioners to refocus their attention on the issue of neglect, introduced valuable new ways of working and to forge stronger and more consistent multi-agency working. Practitioners reported the value of the initiatives and their impact on practice and outcomes for children and families. It has started to change practice, enable collective responsibility for child protection and provide tools and support for practitioners to make a real difference for children and families. The pilot also further underlined the joint effort that needs to be put into assessing and evidencing neglect to ensure that children and young people are sufficiently protected. A review of the longer term outcomes was undertaken in July 2016 which indicated a more joined up approach by professionals and has helped inform assessment, analysis and decision making.

Part of the role of the Neglect Strategy Task and Finish Group is to build on and strengthen the work already undertaken to roll out the learning from this pilot and the Serious Case Review on Child Q.

A neglect pathway has been developed to ensure that there is a consistent approach to managing neglect cases and this includes the types of assessment and tools that can be used at different stages, for example the Child Care and Development Checklist. This will be supported by the recently updated Early Support Assessment and Team Around the Family approach to provide early help for families. The Threshold of Need matrix has also been revised and approved by the OSCB to ensure a common understanding of concerns and risk across all agencies.
In addition a Think Family Co-ordinator has been appointed to embed the Think Family approach across the partnership as part of our Troubled Families work and will take a lead role within the Neglect Operational Group.

3. Our Response to the Findings

Finding 1: Child Protection plans for neglect do not consistently spell out 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.

Progress

A range of measures has been implemented to ensure that child protection plans are more specific and staff are confident about the action to be taken. Guidance has been issued to ensure child protection and child in need planning actions are specific, measureable, realistic and timely. Independent Chairs of Case Conferences are ensuring that this guidance is embedded within child protection case conferences and forms the basis of how effective core group working should take place so that a robust analysis of risk, based on the family's strengths and weaknesses, is undertaken.

In addition Independent Chairs take into account the NSPCC distinction in relation to neglect of emotional, physical and environmental aspects of neglect to inform effective outcome based child protection plans.

A learning summary for practitioners and managers has been produced to ensure that the learning from the serious case review is widely disseminated.
There are a number of ways in which the system is being tested to ensure these measures are being effective.

All agencies were required to report on their supervision arrangements through the Oxfordshire Safeguarding Children Board annual Section 11 self-assessment process. For 2015 nearly all returns gave a clear picture of the supervision arrangements within their agency and those that had not addressed this were subsequently challenged at the peer review and their supervision processes were clarified. All agencies are required to report on this again in the current 2016 self-assessment.

A multi-agency audit is being undertaken which will provide a baseline for demonstrating the effectiveness of child protection planning and intervention in cases of neglect and inform future developments.

Further work is planned through the Neglect Operational Group to produce a comprehensive single electronic guidance on all aspects of neglect to ensure that there is a shared understanding and agreed approach to neglect in relation to policy, processes, roles and tools that can be used across the core statutory agencies. It will also ensure that there is a clear response taken in relation to prevention and early intervention, assessment, risk assessment and recovery. It has been recognised that identification of neglect at an earlier stage is a priority for all partners. Further training for staff on neglect is also being planned through the Neglect Learning and Improvement Group.

What difference has this made?
There is greater awareness of the impact of neglect on children and of the importance of engaging families in order to enable change**.** Child protection plans are more robust with measurable outcomes**.** Multi-agency co-ordination and core group function to effectively support and challenge families to make and sustain change has been strengthened.

Case study
This case study relates to a family (mother and father) who have two young children. There were concerns about parental substance misuse, domestic abuse and poor parenting and non-engagement with health services. There were also concerns about the children's developmental progress and poor weight gain.

A Think Family approach was essential due to the complexity of the situation and range of needs within the family. Different professionals took on defined roles with the family. A Team Around The Family (TAF) was initiated and the family were supported by a health visitor and Children's Centre for the children to attend nursery. There was liaison with medical teams to assess reasons for the poor weight gain. As there were increasing concerns about the family a neglect tool kit was completed. A domestic abuse incident that was witnessed by the children initiated a referral to Children's Social Care. A social work assessment was completed and an initial child protection conference was held. Both children became subject to child protection plans.

Outcome
Over time the health practitioner was able to develop a therapeutic relationship with the family which led to the parents engaging with different services. The parents were able to see the impact their behaviour was having on their children. There have been no further incidents of domestic abuse. Both children have made significant developmental progress. The children are no longer subject of a child protection plan and have been stepped down to a TAF to ensure ongoing support and to ensure that change is sustained. The family have appreciated the work that has been undertaken and valued the support of all agencies.

Finding 2: There is a pattern where professionals are not consistently and sufficiently pro-active in response to incidents/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.

Progress

A rolling programme of workshops for Children's Social Care staff commenced in 2016 which has included guidance about the management of incidents on open cases and strategy meetings. This will be repeated across all services in Children's Social Care when the current restructure of children's services within the county council has been finalised in March 2017.

The learning from Child Q Serious Case Review was communicated to staff within Children's Social Care via the internal 'In the Loop' newsletter in early 2016.
The Neglect Learning and Improvement Group has been tasked with ensuring that the workforce development issues identified in the Serious Case Review on Child Q and the North pilot are fully implemented.

Within Childrens Social Care, it is proposed that a task and finish group is being set up to look at the interface between the Assessment Teams and the case holding social work team in terms of roles and responsibilities on open cases. This will result in the case holding team having responsibility for managing some strategy discussions on open cases. This will all be rolled out to the teams by June 2017. The protocol for how issues on open cases are being dealt with is being updated. Within this there will be specific guidance on the recording of decision making
The Escalation processes are now included in training material.

What difference has this made?

There is a greater awareness of the importance and function of escalation at different stages of a case. This has been evidenced by the fact that in the 2015/16 Complex Case Panel Annual Report there had been four young children presented to the panel where there were issues of long term neglect and difficulty planning for their future. The Complex Case Panel is a senior-led multi-agency panel which addresses risk management and case planning for our most worrying children and young people. This is a strong indication that escalation processes are working effectively.

Finding 3: There is a pattern of delayed and incomplete handovers 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 for some time.

Progress
A chronology is now being provided by social workers and is used by core group members. This also forms part of the information provided when cases are being transferred. In addition, the north area of the county has used the neglect pilot to develop a 'transitions' meeting which is a forum where all cases transferring between Children's Social Care teams are discussed. This has been considered within the new structure for Children's Social Care.

The effectiveness of handovers is being monitored by Independent Chairs of case conferences and core groups and any concerns escalated through established internal management processes.

Sovereign Housing Association has amended its Mutual Exchange Application form. Applicants are now requested to complete a section about whether there is Children's Social Care involvement, which triggers housing officers to contact Children's Social Care for further information.

Universal services within Oxford Health NHS Foundation Trust have developed a Transfer Out Form that is completed by the outgoing practitioner. This contains a 'Summary of Concerns' and 'Current Health Involvement' and establishes if liaison with the new Health Visitor/School Health Nurse has been completed.

What difference has this made?
These measures enable professionals who are new to a case to ascertain easily the concerns and have a greater understanding of the family history and underlying factors and level of risk. They will be more able to consider what support and interventions will help protect against further harm and vulnerability and to identify what progress/lack of progress has been made.

Case Study
This family has been known to Children's Social Care since birth. There was a parental history of poor mental health, aggression and learning disability. There were concerns about the children as a result of a history of poor supervision, unexplained bruising, an inability to access appropriate medical care, poor presentation and significant behaviour problems. Whilst there were periods of stability in the family home and the mother was able to make changes to improve her children's care, she was unable to sustain this. Concerns were expressed by a neighbouring authority regarding an adult who may pose a risk to children who had moved into the family home.

Outcome
The family history, concerns and level of risk were reviewed and a child protection conference was convened. A child protection plan was put in place and the adult of concern left the family home. The current plan is described as stable but there remains uncertainty about whether the parents will be able to continue to prioritise their children's needs and so there continues to be close monitoring.

Finding 4: There is a pattern where the input and co-operation of one parent, 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.

Progress
A number of actions have been taken to address this issue including the development of a good practice guide which has been circulated within Children's Social Care. Attendance at conferences by fathers is reported by Independent Chairs of Case Conferences to be at an higher levels. This is also evidenced by a family within the Neglect Pilot where the father was increasingly engaged with professionals and subsequently became part of the core group.

A learning summary about working with fathers and male care givers has been produced and focuses on the importance of the involvement of fathers and male carers as part of child protection work.

Health visitors routinely record information relating to a child's father at a Primary Birth Visit. This practice is evidenced by Health Visitor Documentation Audit that was undertaken during 2015.

Training is provided by the OSCB to improve the skills that are required to work with young men and boys. The course explores a variety of topics including masculinity and role theory, key issues affecting young men, factors that increase risky behaviour and positive approaches to working with young men and boys.

What difference has this made?
Fathers are routinely included within the child protection process; this means risks and protective factors that a father brings to his child`s life are considered.
There is a clearer understanding of the role of a non-resident parent.
Professionals have a greater understanding of the role that fathers and male care givers play in a child's life.

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 about case management. This jeopardises opportunities for joint discussion and supervision.

Progress
Procedures have been completed that set out the reasons and circumstances in which professionals only meetings can be held and the roles of supervisors, managers and designated leads in ensuring they are used appropriately.

These procedures will be taken forward by Neglect Operational Group to ensure they are embedded in practice.

What difference has this made?
Children's Social Care professionals have been 'given permission' to meet without families in certain circumstances where this is in the best interests of the child or young person.

Finding 6: In Oxfordshire, there is insufficient capacity for the effective administration of invitations to Child Protection Conferences, and 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.

Progress
There has been an overall improvement in the timely distribution of minutes and invitations to conference with performance reaching high levels at 80%. However, recent budgetary pressures and a reduction in administrative staff, alongside increased numbers of conferences, have impacted upon this in terms of consistently maintaining the improvement. This is under continual review and is monitored at a senior level.

What difference has this made?
There is improved multi-agency co-ordination and awareness of issues across all agencies supporting the family to ensure swift responses and effective communication about concerns and progress.

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 risks to children and parental patterns which demonstrate poor capacity to change.

Progress
Evidence from the neglect pilot in the north demonstrated there was improved assessment and evidence regarding neglect. There was multi-agency co-ordination and strengthening of core group function. Signs of Safety mapping were routinely used to amend the child protection plan around specific areas of concern. This multiagency approach helped inform analysis of risk and care planning.

A chronology template has been developed that sets out to assess progress and compliance with a child protection plan. This template will be distributed to core group members at the initial case conferences so that staff can complete individually and bring to core group meetings in order to ascertain a shared understanding of progress. This will be communicated and implemented via the Neglect Learning and Development Group over the next six months.

What difference has this made?
Use of tools like Signs of Safety mapping and the Child Care and Development Checklist ensure that there is appropriate support at critical points in the child's journey and in assessing and evidencing neglect. This was evidenced in the findings on the cases targeted for intensive support in the Neglect North Pilot.

Case study
This case relates to a mother with a 10 year old child. There were long standing concerns about the impact of neglect on the child, which included poor boundaries and routines, poor school attendance, poor social skills and challenging behaviour. The mother had significant health problems which meant she had little energy or motivation to make and sustain change. It was established the father did not have any involvement with the child`s care and support.

The core group used signs of safety mapping to refocus the care plan. Intensive support was provided for both mother and child whilst maintaining a focus on the child`s health, wellbeing and development. This included work around relationships, routines, medication and exercise.

Outcome
The mother`s confidence improved; she participated in a parenting programme and challenging behaviours course. The child`s school attendance improved together with his behaviour and he developed friendship groups. The plan was stepped down from a child protection plan to a child in need plan.

4. Conclusion
Our strategic approach demonstrates our drive to secure collective commitment to addressing neglect consistently across all partner agencies in Oxfordshire. Whilst we recognise there is still work to be done we have a strong foundation in place on which to build and ensure we improve the recognition, assessment and timely response to children and young people living in neglectful situations in Oxfordshire.

Glossary
OSCB – Oxfordshire Safeguarding Children Board
NSPCC – National Society for the Prevention of Cruelty to Children
CP – Child Protection