Redcar and Cleveland Safeguarding Children Board

Independent Overview Report of the Serious Case Review Concerning

'EMMA'

This report has been commissioned and prepared on behalf of Redcar and Cleveland Local Safeguarding Children Board (RCSCB) and will be available for publication once it has been finalised.

Until publication this report is confidential and must not be shared with non-relevant parties. References relating to the subject child have been anonymised.

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INTRODUCTION

PURPOSE OF THE SERIOUS CASE REVIEW

1. This Serious Case Review (henceforth referred to as a SCR) was commissioned by the Redcar and Cleveland Safeguarding Children Board (henceforth, the RCSCB) on the 04.04.14 in accordance with the HM Government statutory guidance 'Working Together to Safeguard Children' 2013. This states[1] that where a child has died or suffered serious harm and abuse or neglect is either known or suspected; and in the latter case, there is cause for concern as to the way in which the (local) authority, their Board partners or other relevant partners have worked together to safeguard the child, the Local Safeguarding Children Board is required to undertake a SCR.

2. The overall purpose of a SCR is to:

' Look at what happened in the case, and why, and what action will be taken to learn from the review findings, so that, action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and

there is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final report of the SCR with the Public' (Working Together, 2013, page 65)

REASONS FOR THE SCR AND BRIEF CASE BACKGROUND

3. The subject of this SCR is Emma which is not her real name but anonymised to protect her identity. She was born at the end of 2011 and is the younger sister to Sarah; both are the children to Lisa (mother) and Lee (father). She and her family are of White British heritage whose only language is English. It is not known what, if any, their religious background is. The parents had been supported to care for Sarah through a multi-agency Child in Need (CiN) plan in 2011. Their relationship was conflictual and they split up in the spring of that year, albeit with the father having regular contact with Sarah.

4. Professional concerns mounted through 2011 around aspects of Lisa's lifestyle, reports of anti-social behaviour, suggestions of substance misuse, Lee's violence and missed health appointments for Sarah. Following Emma's birth in late 2011 she and Sarah were made the subjects of multi-agency child protection plans in January 2012 under the category of Neglect. The plans were ended in May 2013 and the children became subject to Child in Need plans, continuing to be cared for by their mother and her new partner, Tom.

5. Emma, aged almost two, suffered serious non–accidental injuries in October 2013 whilst in the care of her mother and Tom. She was taken to a local hospital for treatment and made the subject of Police protection. She and her sister were placed in foster care by the local

[1] As per Regulation 5 of the Local Safeguarding Children Board Regulations 2006 (see page 68 of ' Working Together to Safeguard Children, 2013, page 68)

authority under section 20 of the Children Act 1989, with the consent of their mother. Care proceedings were started shortly after and were concluded in March 2014 when both children were placed in long term care of a member of the extended family.

6. Cleveland Police started a criminal investigation into the incident which resulted in Lisa being charged in October 2014 with neglect. She stood trial in late 2015 and was given a custodial sentence.

7. The care proceedings in March 2014 made several findings of fact relevant to this SCR. Firstly, that Emma sustained serious non-accidental bruising to her face and other parts of her body. Secondly, that both Lisa and Tom had been in the house in the days leading up to Emma's hospital admission and therefore neither of them could be excluded from causing the injuries. Thirdly, that both adults failed to protect Emma and that there was some considerable delay in getting medical help for her. Finally, the court found that Emma had suffered significant harm whilst in the care of her mother which was attributable to that care.

8. The serious harm suffered by Emma and aspects of the multi-agency intervention with the child and her family therefore met the criteria for a SCR.

TIMESCALE OF THE REVIEW

9. The Review is from the 08.07.10 to the 31.10.13. This covers the period from when Lisa informed the midwife that she was pregnant with her first child, Sarah, to the point where care proceedings were started by the local authority on the children in response to the injuries to Emma in October 2013.

TERMS OF REFERENCE

10. In addition to the overall purpose of the SCR, four case specific terms of reference (ToRs) were identified. These were,

1. How effective was the child protection plan and reviewing process in safeguarding and promoting the welfare of Emma?
2. How well did agencies engage with individual members of the family including the extended family and significant others?
3. To what extent did agencies understand the risks presented to Emma in respect of the violent behaviour of the individual members of the family, including the extended family and significant others?
4. Was the work in this case consistent with each organisation's and the RCSCB policy and procedures for safeguarding and promoting the welfare of children and within wider professional standards?

METHODOLOGY AND PANEL

11. The SCR Panel (henceforth known as the Panel) comprised senior agency representatives who considered the information obtained from agency chronologies, Individual Management Reviews, the Learning Event and Court documents. The Panel was independently chaired by Mr Bruce Dickie (MSc) who is an Independent Management Consultant (est. 2011), having worked in the NHS for 25 years, the last 6 of which were as Director of Children & Young People's service in a Trust in the north east. He has been a member of several children's and adult safeguarding boards. He has had no previous connection to Redcar & Cleveland Council nor any of its partners prior to this SCR.

12. The Lead Reviewer was Mr Paul Sharkey (MPA)[2] who has wide experience of both writing and chairing Serious Case Reviews since 2002. He is presently an independent safeguarding consultant with over thirty years background in both statutory and third sector child protection agencies. He completed the Department of Education/ NSPCC/ Action for Children/ 'Improving Serious Case Reviews' course in July 2013 and is on the Association of Independent Chairs of LSCBs register for independent SCR Chairs and Lead Reviewers. He has had no previous involvement with the RCSCB or any of its partner agencies prior to this SCR.

13. The Panel included senior representatives from the following agencies;

- Designated Nurse Safeguarding Children-South Tees Clinical Commissioning Group
- Lead Nurse Safeguarding- South Tees Hospitals NHS Foundation Trust
- Associate Director of Nursing and Governance- Tees, Esk and Wear Valleys NHS Foundation Trust
- Service Manager- Redcar and Cleveland People Services-Children's Social Care
- Detective Superintendent-Cleveland Police
- Head of Independent Living Services, Coast and Country Housing, Redcar
- Business Manager, Redcar and Cleveland Safeguarding Children Board (RCSCB)

14. The Panel met on the following dates;

- 6 May 2014, included IMR author's briefing with Lead Reviewer and Chair
- 9 July 2014, included meeting with IMR authors
- 20 August 2014, included meeting with IMR authors
- 4 September 2014, Learning Event that included all IMR authors and front line managers and practitioners
- 28 October 2014
- 25 November 2014

[2] Master's in Public Administration (2007) from Warwick University Business School

REVIEW PROCESS

15. Individual Management Review [IMR] authors spoke to their reports with the Panel on the 9 July and the 20 August 2014. Key Practice Episodes[3] were identified by the Panel and the Lead Reviewer. These informed the basis of analysis of the four terms of reference conducted at the Learning Event of 4 September 2014, at which all Panel members, IMR authors and relevant front line practitioners attended.

16.The Learning Event was facilitated by the Lead Reviewer using the '5 Whys' and the 'Cause and Effect/ Fishbone' (Hill : 2000, page 517) analytical techniques in an attempt to understand from a systems view why and how decisions and actions were made within the context of prevailing organisational and agency practices and expectations. The Panel and Lead Reviewer were mindful of hindsight and outcome bias (Kahneman: 2011, page 201) in conducting the analysis. The Panel critiqued a draft Overview Report on the 28 October 2014 and the 25 November 2014.

17. Sources of Information were taken from the following;

1. Independent Management Reviews from;

- Tees, Esk and Wear Valleys NHS Foundation Trust
- NHS England Durham, Darlington and Tees Area Team
- South Tees Hospitals NHS Foundation Trust
- Cleveland Police
- Coast and Country Housing, Redcar
- Redcar and Cleveland People Services- Children's Social Care

2. Composite Review chronology

3. Court documents from the Care proceedings (March 2014)

4. Minutes of Initial Child Protection and Review Conferences from 12.01.12 to 22.05.13

PARALLEL ENQUIRIES

18. Care proceedings on Emma and her sister were concluded in March 2014. There were ongoing Police enquiries which resulted in the children's mother being charged with neglect in October 2014. She stood trial in late 2015 and was given a custodial sentence.

[3] These are episodes from the case that require further analysis and are thought to be significant to understanding the way the case developed and was handled. They are not restricted to specific actions or inactions but can extend over longer periods. See SCIE 'Learning together to safeguard children, developing a multi-agency systems approach for case reviews (2008).

FAMILY INVOLVEMENT

19. The Children's parents, paternal and maternal grandmothers and Tom were informed that a SCR was being conducted shortly after the beginning of the Review. At the request of the Cleveland Police due to the impending trial of Lisa, none of the above family members were interviewed by the lead reviewer until after the criminal proceedings and sentencing were concluded in late 2015. Subsequently, the parents and grandmothers were able to give their views on the case to the lead reviewer and RCSCB Business Manager in January and February 2016. These are included in pages 40 to 44 below.

COMPLETION OF SCR

20. Apart from the family interviews undertaken in early 2016, the rest of this report was completed in December 2014 and considered by the full Board of the RCSCB on the 13.02.15. The learning and recommendations of the Review were translated into an Action Plan and implementation has been ongoing since February 2015.

FORMAT OF REPORT

21. This report has been written in a way that is mindful of recent (July 2014) publications[4] about the need for SCR Reports to be succinct, shorter and focussed on learning points and lessons. It has also sought to comply with current statutory guidance (Working Together, 2013) regarding Reports being written in a way that publication will not be likely to harm the welfare of any children or vulnerable adults and is compliant with the Data Protection Act.1998. Therefore, identifying information and personal details have been omitted whilst attempting to achieve a balance with the need for public accountability and transparency.

OVERVIEW OF AGENCIES' INVOLVEMENT WITH EMMA AND HER FAMILY

2010

22. Emma's mother, Lisa, was given a three month referral order in January 2010 to the Youth Offending Service (YOS). She failed to engage on three occasions which delayed the start of the work with YOS. In July 2010 she informed the midwife that she was sixteen weeks pregnant and was referred at her request by YOS and CREST (a substance misuse service) in August to the Teenage Pregnancy service.

23. General Practitioner (GP) records of October noted that Emma's father, Lee, had been previously involved with the Tees, Esk and Wear Valley mental health service. A letter from the agency contained information about an assessment by a forensic consultant psychiatrist undertaken in the previous January. This opined that whilst he did not appear to be a direct risk to his younger half siblings there were potential risks from a situational context were he

[4] See 'First Annual Report' of the National panel of independent experts on serious case reviews (July 2014) and the DfE Research Report into Barriers to Learning from Serious Case Reviews (July 2014, Anne Rawlings et al)

to reside in the family home again. His risk to others needed to be acknowledged if alcohol was a factor.

24. By October it was recorded in the GP records that Lisa was living with her mother. She was reminded by the midwife in October of the importance of attending ante-natal appointments, having missed several. She had also not complied with the conditions of her referral order and received a court summons in late November. She continued not to attend her midwife appointments in November and was advised by the community midwife (MW2) in mid- December that a referral would be made to Children's Social Care if she failed to attend further appointments. MW2 visited her on the 29.12.10 at her mother's house. Lisa said she was prepared for the baby's birth.

2011

25. Sarah was born in hospital (H1) in early January 2011 and transferred to another hospital (H2) soon after for specialist medical care. A referral was made by the hospital social worker to Redcar and Cleveland Children's Social Care (CSC) on the 12.01.11. Concerns had emerged about Lisa and baby Sarah returning to the maternal grandmother's address, following reports of an unsuitable home environment and lifestyle. Pending an assessment by CSC arrangements were made for Sarah and her mother to stay with the paternal grandmother and both were discharged from H2 on the 13.01.11.

26. Lisa was given a six month conditional discharge for breach of her referral order in mid-January with the involvement of the Youth Offending Service ending. The CSC initial assessment finished on the 19.01.11. This identified concerns around previous convictions of violence for Lisa and Lee (mother and father), lack of compliance by Lisa with her recent referral order and suggestions from earlier local authority information of neglect and domestic violence in the maternal grandmother's history. A decision was made to proceed to a core assessment to explore parenting history, parenting capacity and the suitability of the maternal grandmother's home.

27. The health visitor undertook a primary visit on the 26.01.11. There were no concerns noted. The parents were taking Sarah for her specialist medical care every three weeks. The student social worker (SW9) visited on the 28.01.11 and was informed by Lee that he had been previously involved with the adult mental health early intervention team for anger issues and substance (drug and alcohol) misuse. SW9 emphasised that Sarah should not be left unsupervised with Margaret, the maternal grandmother. The parents mentioned that they were planning to move to privately rented accommodation.

28. At the end of January Lee 'trashed' his mother's house in front of his younger siblings and Sarah. He had reportedly hit Lisa and pushed his mother. He was arrested by the Police and an assessment was undertaken following a referral from his GP. He was described in the Crisis Team notes (that were faxed to his GP), as *'can be a very dangerous young man'*. The information received by the GP did not indicate there were children in the household or safeguarding concerns. Tees, Esk and Wear Valley Trust (TEWV) records indicated that there had been a long history of involvement with Lee. The Police made a referral to CSC about the incident.

29. CSC (SW8) telephoned on the 02.02.11 to establish Sarah's welfare following the earlier incident with Lee; she was reported to be 'fine'. A core assessment planning meeting was held the next day (03.02.11) at a children's centre attended by the parents and SW9 but which did not include the YOS, Probation and the Police. Maternal grandmother was not engaging in the core assessment but Lisa agreed to speak to her. Home visits were planned with dates given to the parents but there would also be unannounced visits. SW9 agreed to write a letter of support to housing and a further planning meeting was arranged.

30. Sarah attended the paediatric day unit on the 07.02.11 from Accident and Emergency because of concerns about aspects of her medical condition. After being X-rayed she was discharged home. SW8 and SW9 were told by the mental health Crisis Team on the 09.02.11 that Lee was deemed to be a high risk to professionals and that all future contact would be through joint visiting. The lone worker policy was to be followed with CSC personnel. There was no record of any discussion amongst CSC about possible risks to Sarah, her mother, other family members, or risks to other professionals. Information was sent from the early intervention team to SW9 regarding Lee's discharge report and his last contact with the community forensic team. Additional information on Lee's involvement with an Early Intervention Team was provided to SW9 on the 16.02.11 as part of the core assessment.

31. Sarah received her first immunisation on the 28.02.11. She and her parents moved to a flat on the same date. SW9 received supervision on the 01.03.11 where it was agreed that there would be monthly visiting, that the core assessment needed to be finished and that the case would be transferred to a social worker (SW10) as SW9, a student, would be completing her placement.

32. Sarah had started attending a local children centre and was seen for her 6-8 week check by the GP on the 02.03.11. SW9 noted on the 04.03.11 that the mental health risk assessment of Lee indicated concerns about his mental health when he had consumed alcohol. He needed some education around relapse prevention for his alcohol and drug abuse and psychological work to address his anger, self -esteem and inter personal communication.

33. The CSC core assessment was completed on the 08.03.11 by SW9. It questioned how the parents would care for Sarah once they were living away from the support of the wider family (i.e. paternal grandmother), raised concerns about Lee's mental health and violent behaviour, debts and the current insecure housing situation. The maternal grandmother's home was not viewed as suitable for Sarah. There was no reference to domestic violence or its possible impact on Sarah and little reference to Lee's mental assessment and its implications for risk to Lisa and the baby.

34. The family became involved with a health visitor on the 09.03.11 following their move to the area. On the same date CSC (SW9) decided that following a discussion with the Probation service about the maternal grandmother (Margaret) and information from her social worker, it would be possible for Sarah and her mother to stay overnight there. The working agreement was to be reviewed to include Margaret having unsupervised contact with Sarah consequent to her being assessed that she could care for the baby. A planning meeting was held with Lisa and the health visitor on the 10.03.11. The home was 'warm and comfortably furnished'. Lee was reportedly at work.

35. Sarah and both parents attended the clinic on the 14.03.11 and were seen by the health visitor who noted satisfactory growth; the baby was smiling, clean and appropriately dressed. The parents were reminded about second immunisations and invited to the local children's centre activities. The case was transferred on the 15.03.11 from SW9 to SW10 and their manager, SWTM2.

36. Sarah was seen on the 25.03.11 at Dr1's outpatient clinic at H2 and was noted to be thriving. Dr1 was happy with her progress; the parents seemed to be coping well with managing her medical needs. SW10 visited on the 30.03.11 and discussed the working agreement with Lisa and Lee. Sarah was not seen on the visit and had not been seen by a social worker since the 09.03.11. Lisa was unhappy that her mother was only allowed two hours of unsupervised contact with Sarah.

37. By early April the health visitor was noting that Lisa was not attending baby clinic and that Sarah had missed her appointment at H2. Lisa notified the community midwife on the 07.04.11 that she was again pregnant.

38. A multi-agency meeting was held at the children centre on the 21.04.11 with the health visitor, SW10 and Lisa. Sarah was noted to be behind in her immunisations and had not attended H2 for her specialist medical care.

39. Lisa and Lee split up in late April. SW10 was informed on the 03.05.11 that Lisa had threatened Lee's mother and had left Lee to care for Sarah who had been poorly. She received her second set of immunisations on the 03.05.11, some two months late.

40. Lisa reported to the Police on the 05.05.11 that Lee had assaulted her whilst Sarah had been present. He was arrested and a domestic violence and child protection referral was sent to CSC by the Police. Lisa refused to make a complaint statement, there were no visible injury signs and Lee denied the assault. The enquiry was finalised as 'insufficient evidence to proceed' and Lisa failed to engage with the offer from the Police domestic violence safety planning service.

41. Lisa and Sarah were by the 06.05.11 living with the maternal grandmother which prompted a visit by SW10 on the same day. There was no record of the outcome of the visit or any mention of the pregnancy. The health visitor visited Sarah on the 11.05.11 and found Lee caring for her; she was clean and appropriately dressed. It was noted that he handled the baby well, with good care seen in relation to her medical needs. There was an appropriate feeding regime reported and no concerns for Sarah's growth with the baby smiling. He was going to have weekend contact with Lisa and Sarah.

42. Lisa failed to attend several midwifery appointments in May. She was advised to contact the local housing agency in mid-May regarding seeking her own accommodation.

43. In early June Sarah and both parents were seen at the children's centre by the health visitor who noted no concerns. A 'network' meeting was held when it was noted that Lisa was pregnant with estimated date of delivery of the 26.11.11. She and Lee were separated and Lisa had moved back with her mother. She was looking for her own accommodation as was Lee. There was to be a change of GP for Sarah and Lisa.

44. SW10 and her manager held a supervision session on the 09.06.11. Sarah was reported to be thriving in her mother's care. SW10 was directed to make a referral on the unborn child at the eighteen weeks pregnancy mark. A joint social work probation visit was made to see Lisa and her mother on the 22.06.11.This was the first time that Sarah had been seen by CSC in two months. Lee was arrested on the 25.06.11 for being drunk and disorderly.

45. Lisa missed several ante-natal appointments in June and early July which were noted in the community midwife's supervision. It was also noted that CSC was thinking of closing the case as things appeared to be going well with no other concerns. The midwife's assessment was that it was not appropriate for CSC to close the case given that Lisa was not attending her ante-natal appointments. The midwife questioned how Lisa would cope with two babies, one with additional health needs without on-going support. It was decided to speak to the social worker about her concerns, monitor Lisa's ante-natal attendance, liaise with the health visitor and alert the central delivery suite.

46. Following discussion with the social worker it was decided that CSC should continue working with Sarah and Lisa (and the unborn child) under a Child in Need plan. Very significantly in this case, a child protection referral was made by the community midwife (CM1) to CSC on the 07.07.11 regarding Lisa's non-attendance at ante-natal appointments and concerns around how she would manage with two babies.

47. On the 07.07.11, the Police were called to an incident involving Tom (later partner to Lisa from May 2012) and his father in an argument. No offence was reported but Tom was taken to a friend's address and domestic violence forms were submitted by PC4.

48. A Child in Need meeting was held on the 12.07.11 at the children's centre. The health visitor noted that both of Sarah's parents were living with their respective mothers, Sarah's immunisations were again overdue, the estimated delivery date for the unborn child was the 26.11.11, there had been missed ante-natal appointments by Lisa, Lee had Sarah every weekend at his mother's home. He was also, allegedly, on bail for a GBH charge with the possibility of a custodial sentence.

49. Sarah was seen at the Child Health Clinic on the 14.07.11 and the health visitor noted no concerns for growth, development, presentation or Lisa's handling of her child. The third set of immunisations were arranged for that afternoon which Lisa did not attend. It was agreed that the health visitor would review Sarah every 2-4 weeks; Lisa was waiting for an appointment at H2 for Sarah's specialist medical care. The health visitor updated the social worker on developments and the latter decided to undertake an unannounced visit. On the same day, Lee was arrested for causing damage to a house window and seen by the Criminal Justice Liaison Service. No further action was taken.

50. On the 19.07.11 the Maternity delivery suite at H1 was alerted to the forthcoming birth of Lisa's unborn child, the need to inform the social worker of the delivery and the requirement of a pre-discharge meeting. Clearly, arrangements were in place for the birth of Lisa's second child. The social worker had tried unsuccessfully on several occasions to visit/contact Lisa around the end of July. The midwife had reported Lisa's missing her ante-natal sessions and had not registered with a local GP. SW10 saw Lisa on the 26.07.11 on a home visit. There was no cot for Sarah. Lisa said that she wanted Sarah to sleep with her and she was advised that this was not safe for the child.

51. Lisa's GP received a letter on the 27.07.11 from a consultant obstetrician saying that she had missed three growth scans. This was significant given Sarah's particular health issues. The GP was asked to contact Lisa with a view to her attending hospital appointments. The letter was not copied or sent to the health visitor or midwife.

52. A joint social work/health visitor visit was made to Lisa on the 03.08.11. She said that Sarah was now sleeping in a cot and showed that she understood safe sleeping and the need for a bedtime routine. Some four months late, Sarah's third immunisations were given on the 04.08.11.

53. Several key risk factors were identified by the community midwife at a supervision session of the 09.08.11 regarding Lisa's care of Sarah and her unborn child. It was thought that the Child in Need plan was not facilitating the desired improvements and that the children were at risk of harm from neglect. It was decided that the midwife would suggest to CSC that child protection measures be started by the end of the week on Sarah and the unborn child.

54. On the 11.09.11 Lisa registered a priority band 1 (on the grounds of domestic abuse) housing application with the local authority homeless section. Tom, who at this point was not with Lisa, was stopped by the Police in the early hours of the 12.08.11 and found with a small amount of cannabis. He was given a cannabis warning.

55. Sarah was in specialist hospital having surgery in mid-August. SW10 visited Lisa and her mother on the 25.08.11 who said that they were unhappy at continued CSC involvement. However, they agreed to work with CSC and other agencies on a continuing Child in Need basis. There was no sign that the midwife's thinking around escalating to a formal child protection level had been considered by CSC. No concerns were noted by SW10 regarding Sarah.

56. Sarah was admitted on the 15.09.11 to A and E with vomiting and not eating, with evidence of dehydration and possible post-surgery complications around bowel obstruction. She was discharged the next day but there was no recorded communication (beyond the usual discharge letter sent after an admission) with the health visitor or the social worker, or clarification by the hospital as to why the family was involved with CSC. It was noted that Lisa lived with her mother 'who is going through court for access to own children'.

57. The health visitor made several unsuccessful attempts to contact Lisa in late September, including a cancelled (by maternal grandmother) joint home visit with the social worker in early October. A Child in Need meeting was arranged for the 11.10.11. There had been no social work contact to see Sarah since late August.

58. Some four weeks late, the core assessment on the unborn child was finished on the 05.10.11. Information was limited due to Lisa's refusal to engage. The Child in Need meeting of the 11.10.11 decided to proceed to a strategy meeting because of Lisa's refusal to engage with health service regarding the unborn child. She had done nothing about getting her own accommodation and had not co-operated with the CSC in the core assessment. There was no mention of the previous alleged domestic violence incidents and the Police had noted that the two grandmothers had had a verbal argument during contact with Sarah.

59. A child protection strategy meeting was held on the 13.10.11 which decided to start a section 47 enquiry and update the core assessment. On the 28.10.11 the section 47 enquiry concluded that although there were significant concerns, Lisa was to be given' one last chance' to work with CSC on the Child in Need plan. She was given the tenancy of a property at the end of October. Sarah was not taken for her 9 month development check on the 28.10.11 which was completed on the 03.11.11. The social worker and health visitor were present; no concerns were noted for Sarah. Lisa said that she did not want CSC service involvement, was prepared for the new baby and would work with CSC until February 2012.

60. Emma was born in late November and discharged to her mother's care shortly after her birth with the approval of CSC who reported that there had not been any concerns for Sarah. There were two midwife visits on the 29 November and 5 December with no concerns noted. The social worker visited on the 28 November and noted no concerns.

61. The revised core assessment was completed on the 01.12.11 which concluded that multi-agency support services should continue under a Child in Need plan, at least over the short term to ensure that Sarah's health needs were met and appointments kept. Reports of Lee's violence required discussion with him. He was visited by SW10 on the 05.12.11 to share the core assessment and admitted involvement in fights. He did not want contact with Lisa and was in a new relationship where he was happy. He said that there were lots of 'lads' at Lisa's property drinking and agreed to a referral to the alcohol treatment service.

62. Lisa disclosed to the health visitor on the 06.12.11 a history of domestic abuse with Lee who she said also had a history of alcohol abuse and criminal convictions. They had been separated for some months. She said that her mother had had her own children removed from her due to previous lifestyle issues.

63. An anti-social behaviour case file was opened (by Coast and Country Housing) on Lisa on the 12.12.11 following reports of loud music and a party in the early hours. SW10 visited the home unannounced and found an unidentified male in the property with no sign of Lisa. Piles of rubbish and lager cans were noted with a smell of cannabis. The same male and a female were there on the second visit. There were concerns for the children's welfare and a Police 'safe and well' visit was made the next day when the children were seen. The anti-social behaviour officer (TA1) visited on the 15.12.11 and closed the case on the basis that Lisa, whilst admitting to having held an 18th birthday party, apologised and said it would not happen again.

64. Lisa was given a warning letter on the 20.12.11 by the anti-social behaviour team (Police Community Support Officer (PCSO 1) and TA1 following further complaints of loud parties, aggressive young males coming and going, alleged drug dealing and concerns for the two children. CSC was informed of the developments and SW10 visited on the 22.12.11. She found several young people in the house and told Lisa that her lifestyle was inappropriate given she was caring for two babies. Lisa refused to accept the concerns.

65. A strategy meeting was held on the 23.12.11 due to the concerns. A decision was made to proceed to a section 47 enquiry and an Initial Child Protection Conference (ICPC). Arrangements were made for outreach visits to be made and increased policing over the Christmas period. In the event, the children stayed with their paternal grandmother for part of

the holiday. SW10 undertook four unannounced visits to Lisa at the end of December and beginning of January with no response from the visits.

2012

66. At the beginning of January, Tom was arrested for assaulting his father and a domestic violence report was submitted. Further unannounced and unsuccessful visits were made by SW10 and the emergency duty team (EDT) in early January. EDT found the two babies in the care of several young males on the 4 January with no sign of Lisa. She was contacted and arrived home. Sarah was seen to have some nappy rash.

67. Both children were made the subjects of child protection plans on the 12.01.12 under the category of Neglect. Lisa did not agree with the decision and denied that she neglected her children. The Initial Child Protection Conference (ICPC) identified the risks to the children as being,

- The mother's lifestyle; allowing the home to be used by large numbers of young people for a party-type lifestyle
- The misuse of drugs, particularly cannabis
- Concerns around the children's health needs being neglected
- Parental conflict and previous domestic violence

68. A second warning letter was issued to Lisa by the Anti-Social Behaviour (ASB) team on the 16.01.12 following further complaints of a party and children crying. She agreed to a referral being made to the Coast and Country's floating support service and was told that any further complaints would result in the involvement of tenancy enforcement and the serving of a notice seeking possession. She said that there would be no further incidents. This incident was only four days after the ICPC.

69. Lisa did not take Sarah for her immunisations on the 19.01.12 despite being reminded by the health visitor. Emma missed her hearing screening tests in December and mid-January. CSC was informed. The first core group met on the 24.01.12 in the family home. One of the tasks noted by the health visitor was for Lisa to provide a list of people coming to the house to be police checked. Sarah attended the immunisation clinic on the 26.01.12 with her mother, sister and an unknown male**.** The social worker (SW1) visited on the 30.01.12 and noted the children to be 'fine'. They were in the kitchen with four young men. SW1 queried their names and was told by Lisa that SW10 had them.

70. The ASB team visited Lisa on the 03.02.12 about further complaints of noise nuisance and disruptive behaviour outside her house with people going in and shouting. Her house had been targeted by the Police as a 'hotspot'. She was advised that if the problem continued consideration would be given to serving her with a Notice of Seeking Possession. On the same day, SW1 was informed by the sure start worker that a female known to be a crack user, whose children had been removed, was present in Lisa's house during a home visit.

71. The second core group met on the 20.02.12. It noted that there had been no recent reports of anti-social behaviour about Lisa. She wanted a move closer to her family but was in rent arrears and still subject to ASB warnings. There were no concerns for the children's

growth or development, despite the previous concerns from the health visitor of the 16.02.12, that Lisa was not meeting the children's health needs regarding missed appointments and Sarah's immunisations being outstanding. It was agreed that a 'Working agreement' with Lisa would be drawn up. The ASB team closed her case on the 27.02.12 as there had been no further complaints. Emma's primary immunisations were a month late (23.02.12). The floating support referral was closed on the 07.03.12 as there had been no contact from Lisa.

72. The children were seen on the 16.03.12 at a planned clinic attendance with their mother (35 minutes late). It was noted that their growth was satisfactory, that Lisa's handling of them was appropriate and that she interacted positively with them. The planned core group for later on that day was postponed to the 19.03.12. SW1 noted some improvements but ongoing concerns about Lisa's commitment and consistency in accepting help. The health visitor noted Lisa's continued failure to act on professionals' requests and her minimal engagement. There were no specific concerns for the children's health and development. The core assessment by CSC was still outstanding.

73. The first Child Protection Review Conference (CPRC) was held on the 27.03.12. Lisa, Lee and his mother attended with the social worker (SW1) and the health visitor present but no one from Coast and Country (on holiday). The Conference heard of some positives in the children's care (i.e. no recent nuisance complaints) but concerns remained around the parents' conflictual relationship and its impact on the children, and missed health appointments. The written agreement underpinning the Child Protection Plan was still outstanding. It was decided to continue with the Child Protection Plans.

74. There were three unsuccessful home visits made by SW1 in early April. On the 10.04.12 SW1 made a visit and saw Emma through the house window crying in a car seat. A working agreement was signed by Lisa. A failed planned home visit was made by the health visitor on the 12.04.12 and SW1 was informed. Emma had her second immunisations on the same day, some three weeks late. There was a further failed planned home visit by the health visitor on the 17.04.12. Lisa and the children were seen by the health visitor at maternal grandmothers' on an opportunistic visit later that day. They had been staying there for two weeks as Lisa had no electric but had not told any of the professionals about the move. Sarah was seen but Emma was reportedly out with a female friend of Lisa's. There was no record of the social worker being told of this or a follow up on who the 'friend' was or whether it was safe for the children to be with the maternal grandmother.

75. A core group meeting met on the 23.04.12 with apologies from TA1 (Coast and Country Housing). There was little evidence of progress with the child protection plan. Lisa was seen on the 27.04.12 moving her things into a friend's house. This was notified by Coast and Country to SW1 who visited the same day. Lisa denied moving in with a friend and was with her mother.

76. Lee was arrested on the 01.05.12 following a serious incident of domestic violence against his current partner. However, no action followed due to no complaint being made from the partner and Lee was released. The partner's child was placed with family members by CSC. SW1 told Lisa on the 04.05.12 that she should not allow Lee to have the children at the weekend. Emma was not taken for her immunisation on the 10.05.12. In supervision, the health visitor noted on the 15.05.12 Lisa's continuing lack of co-operation with home visits and health appointments. An ASB file was opened on the same day following a complaint

made about Lisa and her mother. Reportedly, the maternal grandmother had acted in a threatening manner to a neighbour and had climbed onto the roof. This was witnessed by the two children.

77. On the 18.05.12 the Independent Reviewing Officer (SW5-Chair of the CPRC) responded in an e-mail to a query from SW1 about difficulties in implementing the Child Protection Plan. The suggestion was to discuss the case with her team manager and seek legal advice. This was the first reference of recourse to legal action in this case.

78. Despite being reminded, Lisa failed to attend the planned core group meeting of the 21.05.12. Serious concerns about housing and the prospect of eviction for the children were noted in addition to ongoing health appointments. There appeared to be no mention of the recent incident with the maternal grandmother's aggressive behaviour. There were two unsuccessful social work visits made in late May and a further missed immunisation appointment for Emma. The health visitor did manage a planned visit on the 29.05.12 and saw both children. She noted no concerns for their development and presentation and observed Lisa showing emotional warmth and affection towards her children. She said that she had a boyfriend living nearby.

79. A legal meeting was held on the 31.05.12 when a recommendation was made to start the pre-proceedings, Public Law Outline. SW1 noted on the 01.06.12 that no evidence had been forthcoming regarding Lee's alleged assault against his partner. On this basis it was decided that Lee could resume weekend contact (it having been stopped on the 04.05.12 at the request of CSC) with Sarah and Emma. The PLO option was not pursued by SW1 as the aggression was with the maternal grandmother and not Lisa.

80. The sixth core group met on the 18.06.12. It was noted that Lisa's new partner's details were to be obtained with a view to CSC requesting police checks on him. The core assessment was still outstanding. The partner, Tom, was present when the health visitor visited the home on the 28.06.12. He was also present on the same day at the GP surgery for the children's immunisation appointment. Lee and his partner were involved in a late night drunken argument in late June. Lee was arrested and given a fixed penalty notice. The information was passed to SW1.

81 Lisa refused to let SW1 in during an unannounced visit to see the children on the 10.07.12. The Police were called to an incident on the 12.07.12 alleging that Lisa and Tom had been fighting in the street in front of the children. All was quiet on arrival and the children were seen 'safe and well'. A domestic violence report was submitted to SW1. Lee told SW1 on the 13.07.12 that the girls were dirty and hungry, that Lisa was using cannabis and was always fighting with her boyfriend as she had put it out on Facebook.

82. The seventh core group met on the 17.07.12. It was noted that Lisa remained hostile to professionals, that she had a new partner and had agreed for police checks to be done. Lisa said that she was no longer in a relationship with Tom. She was seen to have numerous bruises to both arms which she said she got from a ride at a theme park. Sarah, who was on a child protection plan, was noted to have red discolouration to her upper lip. Lisa said that she had fallen over at her partner's mother's house and banged it. No further consideration was given to the injury.

83. It was noted in the GP records of the 25.07.12 that Sarah had attended the Walk in Centre for a bump to her head; this information was also shared with the Health Visitor. The eighth core group meeting was held on the 30.07.12 which was not attended by Lisa; Lee was present but there was no discussion of the previous incidents between him and his girlfriend. There was no mention of the minor injury to Sarah by the Health Visitor at the core group.

84. On the 02.08.12 Lee and partner were involved in a domestic violence incident. Lee became violent to the Police and was arrested. The information was passed to SW2. There was a violence incident involving Lee on the 07.08.12 with his partner. A police officer's hand was bitten by Lee.

85. A legal meeting involving SW1, her manager (SWTM2) and a legal advisor (solicitor) was held on the 09.08.12 when it was agreed that the matter should go to care proceedings. A letter from the legal advisor on the 10.08.12 stated that in the light of the lack of co-operation and engagement by the parents a 'letter before proceedings' was not an appropriate option. The advice was that the section 31 (Children Act 1989) threshold for court intervention was available to the local authority and the recommendation was to issue care proceedings immediately. The solicitor was instructed by the team manager and social worker to start care proceedings urgently and to have the matter listed before the Court. There was no record of the decision being discussed with and agreed to by a more senior manager.

86. The second CPRC was held on the 15.08.12. Although a local authority legal representative was present there was no record in the conference minutes of any discussion of the recent legal advice. It was noted that there had been no Coast and Country Housing representation at core groups or child protection review conferences for some time. There was an expectation that they attend all meetings as a member of the core group and the social worker was tasked to contact them within one week. The children remained on their child protection plans given the continuing concerns about them, the lack of progress with the plans and Lisa's intransigence. Lisa agreed that she would work with the plans.

87. A further legal meeting was convened on the 16.08.12 by a senior line manager who had been informed of the ineffective practice of SW1. She was not made aware of the legal letter of the 10.08.12, or (presumably) the advice and subsequent instruction for care proceedings to be issued. It was agreed that Lisa would have one week to show that she could co-operate with the multi-agency child protection plan prior to the local authority sending out a 'letter before proceedings' initiating the Public Law Outline (PLO) process.

88. A follow up PLO meeting of the 30.08.12 noted that Lisa had engaged with CSC and other agencies over the previous two weeks. In the light of this it was decided to take no further legal action at that stage. Children's Social Care was to keep the matter under close review in ensuring the parents' adherence to the plan with the group being told of any change in circumstances. The letter before proceedings was therefore not sent; Lisa and her mother said that they were agreeable to the proposed plan for the children. There was an expectation from CSC that both parents would now co-operate with the child protection plan and show at the next CPRC in January 2013 that positive change could be sustained in the longer term to meet their children's safety needs.

89. Lisa and the children started to attend the crèche at the local children's centre at the beginning of September as per the child protection plan. Both children settled in well and Lisa was to start a 'Mellow parenting' course. The ninth core group meeting was held on the 04.09.12 and attended by Lisa. The new social worker (SW3-an experienced social worker in child protection cases) was introduced. There was no mention of the outcome of the recent legal meetings, the result of any police checks on Tom; nor was the core assessment completed and distributed. SW3 visited the family on the 11.09.12 with no concerns noted. The children attended the children centre on the 10.09.12. and the 17.09.12. A bruise was noted by the health visitor on Lisa's right lower arm on the 13.09.12, apparently done on the stairway.

90. Tom (Lisa's partner) attended his GP (GP14) in mid-September for mental health matters. It was noted that he got angry easily, punched doors and self-harmed (cut). It is important to note that at no time was information relating to Tom requested from the GP. Lisa made a new application for a housing transfer on the 21.09.12. The children continued to attend the children's centre in late September.

91. Lisa's progress and positive engagement with agencies proved to be short lived and started to break down in early October. She was unable to attend the tenth core group scheduled for the 02.10.12 as she was 'unwell'. It was re-arranged for the 29.10.12 which, in the event, she did not attend. Lee was arrested for an assault on his partner on the 07.10.12 and a referral was made to the Multi-agency risk assessment conference (MARAC)[5] in the local authority area where he resided. An ASB case was re-opened on Lisa on the 09.10.12 because of alleged intimidation and threats made by her on Facebook. The social worker heard a verbal argument between her and Tom on a home visit on the 09.10.12. She was reported by the health visitor not to have attended the Mellow Parenting course on the 10.10.12 (but did attend the next day). Her attendance over the next four months was sporadic.

92. Lisa did not attend the core group of the 29.10.12. Her minimal engagement and sporadic attendance at the Mellow Parenting course was noted. However, there were no reported concerns about the children's general care and safety. The ASB case was closed on the 07.11.12. Tom gave SW3 his details for a police check at a home visit in mid-November and said that he did not have a police record, which was not true. Sarah was noted to show aggressive behaviour towards other children at the children's centre on the 22.11.12 and was deemed to need one to one staff support.

93. The eleventh core group met on the 27.11.12 and discussed Tom's dishonesty about his police record and the verbal argument he and Lisa had during SW3's visit in October. Lisa continued not to attend the Mellow Parenting sessions in early December. A MARAC (Multi-Agency Risk Assessment Conference for domestic abuse victims) meeting on the 05.12.12, held in the local authority area where he resided, noted that Lee stated that he was having unsupervised contact with Sarah and Emma every fortnight. This was not risked assessed. He was arrested on the 06.12.12 for an assault on his partner and reported to have cut himself with a knife and overdosed, leading to a mental health assessment. His partner was

[5] This is a multi-agency risk assessment conference for domestic abuse victims which develops a multi-agency plan to minimise and manage risk in order to protect victims of domestic abuse.

issued with a 'threat to life' notice as directed by the MARAC. There was no evidence to suggest that the incident had been notified to CSC and risk assessed.

94. Further evidence of Lisa's non-engagement was when the health visitor attempted a planned home visit on the 12.12.12 to see the children and was told by Lisa that it was not convenient as the children were having a nap. She was asked to attend the clinic on the 14.12.12 and reminded of the core group meeting of the 18.12.12. The children's centre noted on the 13.12.12 that Lisa was moody and short tempered. She shared with the Mellow Parenting group that she was a good mother and did not meet the criteria for attendance. Concerns were shared with her about her present partner (Tom) staying at the house overnight, given that he had not yet been policed checked. There was no record that she brought the children to the clinic and she did not attend the core group (the twelfth) held on the 18.12.12.The children's centre staff noted on the 20.12.12, following a home visit, that the children were ill, according to Lisa, with chickenpox.

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95. The Children's Centre noted on the 10.01.13 that the children were not appropriately dressed and did not have coats. Sarah's behaviour was difficult; she had physically attacked another child causing bleeding. The third Child Protection Review Conference was held on the 15.01.13 which was not attended by Lisa. It was noted that her attendance at the Mellow Parents course had been sporadic and that it was part of the child protection plan that she complete it which had not happened. Reference was also made to Tom and that the police check on him had been done. However, he was not part of the written agreement and had not been included in the core assessment which remained uncompleted. Concerns were expressed about the risk Lee presented to the children given his recent violence towards his partner and being subject to a MARAC in in the local authority area where he resided. The Review Chair stated that Lisa needed to attend all future core groups. The Chair commented on some progress having been made by Lisa with the child protection plan but suggested that the children remain on their plans and that a CPRC be set for three or four months hence, given the 'stringent efforts' made by their mother.

96. On the 12.02.13 the health visitor noticed that Emma had two scratches to her neck which, according to her mother, were self- inflicted. The children's growth and development gave no cause for concern. The thirteenth core group met on the same day and was attended by Lisa. It noted that there had been no reported concerns regarding inappropriate people being in the family home and that Lisa had allowed the social worker and health visitor access to the house. Discussion took place about the recent domestic violence incidents between Lee and his partner and the risks presented to Emma and Sarah. It was agreed that the local authority would supervise contact between Lee and the children given the concerns about him.

97. CSC received information from the Probation service that the maternal grandmother had a new partner who had a record of concerning behaviour. There was no record of this having been followed up by CSC.

98. Lisa attended the urgent care centre on the 21.02.13 (according to her GP records) , she said that she had, 'fell on a pint glass and cut her head'. The hospital noted that she had attended for a head laceration and head injury that required an X- ray.

99. Neither child attended the crèche on the 05.03.13 and there was a failed unplanned home visit by the health visitor the next day. There were two further occasions in March when Emma did not attend crèche with no apparent explanation. The Children's Centre informed SW3 of the non-attendance. Sarah did not attend an appointment with Dr1 at the specialist hospital on the 22.03.13. The fourteenth core group meeting was held on the 26.03.13 which was attended by Lisa who said that the children had not been to crèche due to a tummy upset. No concerns were reported about the children's care. Outstanding dental appointments for the children had not been made by Lisa.

100. Regarding contact with their father, it was agreed that Lee could see the children once a fortnight under local authority supervision and that they could have an overnight stay with their paternal grandmother on condition that she did not allow contact with Lee in the home.

101. Crèche sessions and important health appointments for the children were missed in early-mid April and the social worker was notified. A joint health visitor/social worker home visit was made mid-morning on the 18.04.13 with Lisa and the children still in bed. A development review was completed with no concerns for Sarah. Emma's growth and development were deemed satisfactory. However, she was noted to have a scratch to her right shoulder and neck and bruising under her left arm, sustained by falling off a trampoline, according to her mother. The explanation was accepted despite Emma being on a child protection plan.

102. Lee and his partner were involved in a further serious incident of violence on the 21.04.13 when the former was arrested for grievous bodily harm. A core group (fifteenth) met on the 23.04.13 which was not attended by Lisa despite being asked to do so by the Chair of the recent CPRC. There was no Coast and Country housing professional present. The meeting noted the missed health appointments, no dental appointment despite this being a requirement of the child protection plan and non-attendance at the nursery. The injury to Emma was not discussed and supervised contact with Lee had not been arranged. There were no reported concerns on either child.

103. The children continued not to attend nursery in late April and early May. The children did attend on the 14.05.13 when there was a core group meeting which was attended by Lisa (twenty minutes late), Lee and his mother. A small cut to Emma's inside upper lip and a small bruise to her left check were noted by the GP on the 20.05.13. Lisa said she had received it by falling on a safety gate. There was no reference made by the GP to the children being on child protection plans. However the GP had recorded the injury was consistent with the explanation. Lisa told the social worker the next day about the GP visit and the injury to Emma. This was the second injury to Emma within a month.

104. The final Child Protection Review Conference (CPRC) was held on the 22.05.13. A report was requested from the GP but there was no information sent about the recent injury to Emma although the issue was referred to by the health visitor. The children were taken off their child protection plans and several recommendations were made regarding their attendance for health appointments and at Sure Start. Six weekly multi-agency meetings were to continue, the next being on the 09.07.13.

105. Emma was not taken to the nursery in June, Sarah did not attend a specialist hospital appointment and no dental appointments were made. SW3 was made aware of this by the

children centre. They were seen by the health visitor at home on the 20.06.13 and reported to be happy and sociable. The children's centre recorded on the 02.07.13 that Lisa had said that Emma was dragging one of her legs. The multi-agency meeting of the 09.07.13 was not attended by Lisa who seemed to have effectively dis-engaged from the professionals.

106. An Anti-Social Behaviour case referral was opened on Lisa on the 15.07.13 following reports that she had been arguing loudly with her boyfriend at various times of the day. Emma failed to attend the nursery on the 16.07.13 and SW3 was notified. There was a further ASB report made on the 26.07.13 regarding allegations that Lisa and Tom were being threatening to others in the neighbourhood. The Police were alerted.

107. SW3 asked the Children Centre to send their engagement officer to see Lisa with a view to getting her and the children back to the nursery. Lisa failed to attend a meeting with the housing office on the 05.08.13 to discuss the ASB complaint. The health visitor noted on the 15.08.13 that Sarah's weight was static from the last recording and that Emma's had dropped a centile. There was still no dental appointment. No-one attended the multi-agency meeting of the 21.08.13. The CSC supervision session of the 23.08.13 noted that the children were progressing well with mother parenting well.

108. Lisa was seen by the ASB team (Police Community Safety Officer/Coast and Country tenant adviser) on the 06.09.13 to discuss the complaints. The presence of the children was noted. Lisa stated that she and Tom were no longer seeing each other so there would be no further issues of domestic violence. There was no liaison with CSC regarding this visit. A warning letter was issued by the ASB team on the 09.09.13 and the case closed.

109. A multi-agency meeting was held on the 10.09.13 when the children were reported to be with Tom whilst Lisa attended. It was noted that Emma had recently fallen down some steps and sustained bruising to her forehead and cheek. Lisa did not seek medical attention believing Emma to be alright. This was the third reported injury to Emma since April but was not followed through by CSC as a possible non-accidental injury. SW3 had spoken to Tom the previous day on a home visit whilst the Police were there regarding the ASB issue so he was in contact with the children. Lisa was arrested for possession of cannabis on the 20.09.13 and given a caution. There was no liaison with CSC regarding the children. Another ASB case was opened on Lisa and Tom on the 23.09.13 following further complaints about their alleged threatening behaviour which involved the reported crying and screaming with fear of a local five year old child. The Police received further intelligence on the 30.09.13 about Lisa and Tom's alleged drug taking and causing anti-social behaviour. There was no intelligence sharing with CSC.

110. At a home visit on the 03.10.13 the health visitor saw both children. Emma was reported by her mother to have had some swelling and discolouration to her right eye, apparently caused by a puppy knocking her off balance and falling onto a toy. Three small scabs/spots on her cheek bone were noted. This was the fourth injury to Emma since April. No medical attention was sought. Several attempts were made by the Children's Centre to contact Lisa in early October to see if Emma wanted to start at crèche. Lisa agreed on the 10.10.13 to Emma starting crèche on the following Wednesday. SW3 saw the children on the same day on an unannounced visit and noted no concerns.

111. On the 19.10.13 Emma was taken by ambulance to hospital (H1) with burns to her left hand, thigh and unexplained bruising. Emma and Sarah were taken into Police protection. Lisa and Tom were arrested and interviewed by the Police about the injuries. A criminal investigation was started. Care proceedings were started on the 22.10.13 regarding the children who were placed in foster care.

ANALYSIS

112. This section of the Report seeks to address the four terms of reference. It is informed by the SCR Panel's examination of agencies' Individual Management Reviews and the findings of the learning event which considered the five key practice episodes.

Term of Reference 1

How effective were the child protection plan and reviewing process in safeguarding Emma and promoting her welfare?

113. Emma and her sister were appropriately identified at the Initial Child Protection Conference (ICPC) as being at risk of likely significant harm and properly made the subjects of child protection plans under the Neglect category. The reasons identified for doing so were around their mother's lifestyle and the attendant dangers to and impact on the children. Specific risk factors included allowing the home to be used by large numbers of young people for a party type lifestyle; the misuse of drugs, particularly cannabis; concerns around the children's health needs being neglected, parental conflict and previous domestic violence. Emma's mother had not been willing to accept the professionals' concerns and dangers posed to her children and had not previously engaged with agencies to mitigate them. Indeed, she did not agree with the decision for child protection plans and denied that she had neglected them.

114. The evidence of this Review suggests that Emma and her sister did not suffer any actual significant harm whilst subject to their child protection plans (CPP) from January 2012 to their ending in May 2013. Moreover, their physical growth and development were noted by the core group and subsequent Child Protection Review Conferences (CPRC) to be satisfactory and within the normal limits for young children. From this limited perspective the child protection plans thus seemed to have prevented any significant harm befalling Emma and her sister.

115. The detailed CPP of January 2012 was in principle of good quality in content. It accurately identified the children's needs and risks and set out an appropriate range of child focused outcomes and services aimed at reducing the risks and meeting their needs. The outcomes could have been more specific by way of being SMART[6]. The core group's membership was appropriate in the early stages of the CP Plan, although the later non-attendance of the Coast and Country representative was not helpful. There was a clear contingency measure, namely that,

[6] Specific, Measurable, Achievable, Realistic and Timely (SMART).

'*Should the protection plan not be followed or should Emma be placed at risk of further significant harm, then the local authority to take immediate legal advice'.*

116. However, it was in the Plan's implementation that problems very quickly arose with difficulties emerging from the beginning. These were due principally to Lisa's denial of concerns about her parenting and its impact on her children; her resulting lack of commitment to the plan and reluctance to engage with the core group of professionals. Her behaviour was part of a pattern. She had a previous known record of not engaging with agencies as evidenced by her breach of the referral order with the Youth Offending Service and lack of involvement with the Child in Need plans of 2011.

117. Albeit, there was no evidence that she had been asked to agree to the CP Plan and sign it, her non-cooperation resulted at an early stage in many of its key objectives not being met. These included, stopping unknown males from being in her home, taking the children to important health appointments, completion of the Mellow Parenting course, ensuring her children's consistent attendance at the nursery and avoidance of professionals at scheduled contacts. Such important omissions compromised the safety and welfare of Emma and her sister and limited the effectiveness of the child protection plan in optimally promoting their wellbeing. Lisa's non-co-operation should have triggered an early discussion with her about the stated contingency measures of the CP Plan.

118. By the first CPRC in late March 2012, it had become evident that the CP plan was not being fully and effectively progressed, due in large part to Lisa's unwillingness to co-operate with it. To be sure, the Review Conference noted some 'positive progress in the care of (the girls)'. The health visitor's report stated that the children had a positive relationship with their mother and that Emma was a 'happy sociable baby who was growing appropriately and reaching her developmental milestones'. However, concerns remained about the continued conflict in the parental relationship and the impact of this on the attempts at sharing the care of their children, missed health appointments and support for Lisa. In short, minimal progress had been made with implementing the CP Plan. All of the numerous outcomes and children's needs were noted as only partially achieved or unachieved; the exception being the Police and CSC knowing of the addresses where the children were staying. The contingency measures had not changed. The Housing agency representative had given her apologies for absence.

119. Lisa's non-engagement continued through April and May 2012 with missed health appointments for the children and unsuccessful home visits by professionals. She and the girls had been staying with her mother since late April and there had been an incident of violence reported to the Police that involved the maternal grandmother and a neighbour which was witnessed by the children. Moreover, Lee had been involved in a serious domestic violence incident in May with his (then) current partner. This had implications for Emma and her sister's safety and wellbeing given they were having regular contact with their father.

120. By mid-May it had become clear that the child protection plans for Emma and her sister were not achieving their purpose of safeguarding them from likely (future) significant harm and promoting their welfare. Lisa's continuing non-compliance with the Plan and the deteriorating situation prompted a legal review at the end of May which recommended to CSC that the Public Law Outline (PLO)/pre-proceedings process be started. SW1 and her

manager (SWTM2) chose not to pursue this option on the grounds that the aggression was on the part of the maternal grandmother and not Lisa. It may be asked, why were Lisa and the children allowed to live with their maternal grandmother, given the concerns around her and the lack of any robust risk assessment? Lee was also allowed to resume contact with the girls on the somewhat questionable basis that his partner declined to make a complaint against him regarding the recent alleged violent incident. An additional new and unknown factor was the presence from late May 2012 of Tom (Lisa's new boyfriend/partner) in the household where he was taking on a caring role for the children.

121. A key objective of the CP Plan stipulated the need for an adult who was to be considered as a potential carer for the children to be assessed as safe to do so. There was no evidence that either the maternal grandmother, Lee or Tom had been effectively risk assessed in relation to any possible dangers they may have presented to Emma and her sister. Self-evidently they should have been as per the CP Plan and reflected the poor standard of social work, management oversight and supervision in this case during this period.

122. CSC's decision not to start the PLO process at the end of May 2012 was, in the lead reviewer's opinion, a missed opportunity to take control of the Plan and encourage Lisa to focus on engaging with it in the interests of her children. The evidence of Lisa's previous history (and her mother's own hostility towards CSC due to her children being placed with their father in 2010) of non-engagement with agencies should have indicated to CSC that a more robust and authoritative approach was needed to get the CP Plan back on track and protect the children.

123. The CP Plan continued to drift during June and July with little or no progress being made and Lisa's continuing intransigence. Further worrying reports of arguments in the street between Lisa and Tom, more incidents involving Lee's violence towards his partner, unsuccessful attempts at home visits by SW1, reports of cannabis use by Lisa, bruises to her arm and a mark on Sarah's lip, added to the increased sense of risk to the children.

124. The legal meeting of the 09.08.12, assessed that the Section 31 (Children Act 1989) threshold for significant harm was met and recommended in writing (letter dated 10.08.12) that CSC should issue care proceedings immediately, without recourse to the PLO process. The social worker and her team manager instructed the legal adviser to start care proceedings immediately. There was no consultation with or agreement by the Service Manager about starting care proceedings, which given the seriousness of such a step, would have been expected to have happened. It is not known why this did not occur and would seem to be have been a key gap in the CSC's 'gatekeeping' and accountability processes around decision making regarding children entering the care system. An important, albeit obvious, piece of learning from this episode is the requirement for senior management to have an input into decision making around starting care proceedings and the PLO process.

125. The minutes of the second CPRC of the 15.08.12, (which was inquorate), do not record any mention or discussion of the legal recommendation or that the Section 31 'significant harm' threshold had been met. However**,** the minutes of the meeting records that there was a local authority legal representative in attendance. According to evidence provided to the Panel by CSC (feedback from the first draft overview report meeting of the 28th October) the conference chair did ask about the legal position. The legal representative advised the

conference that a legal meeting had been held and that the legal view was that the threshold for court intervention was available. The conference was advised that a further legal meeting would be arranged to formulate a plan.

126. The CPRC did not consider the risk implications to the children of the argument between Tom and Lisa, Tom's presence in the home or the bruising and marks to Lisa and Sarah respectively. The core assessment was still outstanding. None of the identified needs of the children or the safeguarding actions of the CP Plan had been met or achieved (or even partially achieved). The evidence was clear that the CP Plan had made minimal progress since its inception in January 2012 and was not effective in safeguarding the children from likely, future significant harm or promoting their welfare. The Conference Chair should have promoted a discussion and had it noted that that the local authority was considering legal proceedings as per the stated contingency measure. The logic of the situation indicated that the CP Plan's continuation needed to be considered at that point in mid-August, in favour of care proceedings, or at least a robust PLO process. SW1 was tasked with contacting the Coast and Country core group member within one week as there had been no attendance from them since March.

127. The rationale for CSC's decision (SW1, SWTM2 and ADSW), taken at the meeting of the 17.08.12 with a legal adviser, not to start care proceedings is not entirely apparent, given the very clear written legal advice of the 10.08.12 and CSC's instruction to initiate them. The legal record (given to the lead reviewer) of the later meeting (17.08.12) does not reference the earlier legal advice of the 9/10.08.12. Indeed, the ADSW has stated (in a communication to the lead reviewer) that she was unaware of it. This begs the question as to why she was not told about it by TMSW2 and SW1. The legal note of the 17.08.12 meeting references some criticism of SW1 and her failure to 'adequately visit or work with this family'. Again, there are no CSC case records of the meeting which, in itself is concerning. ADSW, in her communication to the lead reviewer, states that SW1 was challenged about what she had done to support the family in meeting the tasks within the plan. It was evident to ADSW that SW1 had done insufficient work with the family.

128. The meeting came to the view that SW1 had not given Lisa the opportunity, advice and encouragement to make improvements. On this basis a decision was made to provide a tight, time limited, seven day support package. It was intended for the local authority to be able to demonstrate the support provided to enable mum to engage with services, as at that point it was evident the plan was not progressing. It was not established as an alternative to initiating services. According to CSC, the meeting that initiated the 7 day support package was agreed at the moment in time when the Service Manager was alerted to the ineffective social work practice of SW1. The support provided was implemented immediately within the 7 days in order to establish the immediate risk; to ascertain whether there was enough evidence to remove the children; and ensure all support services had been made available to engage the family.

129. This was to be Lisa's, 'last chance', (given the previous legal advice in May 2012 for the use of PLO proceedings), to show she could co-operate with CSC and the core group prior to the local authority invoking care proceedings. SW3 was allocated as the key social worker in early September.

130. The threat of potential legal proceedings resulted in Lisa's short term co-operation with CSC and the CP Plan. The follow up legal meeting at the end of August decided not to issue the 'letter before proceedings'. However, Lisa was not able to sustain the changes made in late August and September. By October, with the pressure of possible legal proceedings off her, she had reverted back to her 'default' position of non-cooperation and non-engagement. In the lead reviewer's opinion there should have been a longer 'pre-proceedings' period of say three months, rather than one week to test out whether Lisa could keep to the CP Plan.

131. Given her record of previous non-cooperation with agencies it should have come as no surprise that she was unable to sustain the short lived changes made. In the lead reviewer's opinion, and that of the CSC IMR author, a significant opportunity was missed by the local authority in August to secure the safety and wellbeing of Emma and her sister. Care proceedings should have been started following the legal advice of the 9/10 August; or, at least an insistence on a longer pre-proceedings period to test out Lisa's insight and willingness to engage with the CP Plan in the interests of her children. It is of concern that there were no case recordings setting out the rationale for decision making regarding this key practice episode. Moreover, inter-agency communication on this important matter seems to have been poor as there was no evidence that other members of the core group or the CPRC Chair were apprised of the situation regarding the legal considerations after the meeting of the 17.08.12.

132. Key learning points from this episode are that, firstly, all legal and case work decisions and their rationales need to be recorded, in line with existing agency policy and practice. This includes setting out the reasons for CSC not following legal advice when care proceedings are proposed. Secondly, senior management, core groups and Conference Chairs need to be told of significant developments which need to be recorded. Thirdly, pre-proceedings planning needs to be over a reasonable period of more than one week in order for families to show that change is sustainable. Fourthly, PLO plans need to have clarity regarding outcomes, actions and milestones that families need to achieve as part of these proceedings. Finally, PLO planning needs to be consistent with existing Child Protection Planning.

133. Lisa continued not to co-operate with the CP Plan for the remainder of 2012 (October to end of December), failing to attend core groups, not presenting the children for important health appointments, sporadic attendance at the 'Mellow Parenting' programme and involvement with the ASB team. The implications of Tom's presence in the home had still not been assessed, despite police checks of the previous August indicating that he had five recorded violent incidents to his name, and reports of conflict with Lisa. Lee's known violence against his partner and involvement with the MARAC, in the local authority area where he resided, had not been assessed. The core assessment was still outstanding. These issues will be explored in the next Term of Reference.

134. Neither parent attended the Child Protection Review Conference of the 15.01.13 with no apologies given. SW3, the health visitor and a worker from the local Sure Start programme were present, with reports provided by the Police and the GP. There was no representative from Coast and Country. Emma and her sister were noted to be sociable children who were doing well with their growth and development. Despite not completing the ' Mellow Parenting' course and sporadic attendance, Lisa was described by the Sure Start

worker as being the best parent in the group who always interacted with her daughters and responded, 'lovely' to them. SW3 agreed with the observation. Somewhat in contradiction it was also noted that Lisa had missed too much of the course to benefit from it. The Conference Chair said that she wanted Lisa to start another parenting course as part of the Plan and also attend all future core groups.

135. However, notwithstanding the positive observations it was still the case that Lisa had not co-operated with many of the outstanding actions of the Child Protection Plan and practically all of the outcomes of the Plan remained unachieved. Tom, who had been Police checked still remained unassessed regarding any potential risk to the children. He was known to be having a significant amount of contact with them. One of the actions was to include him in the written agreement. To be sure, the Conference was concerned about Lee and his involvement with the MARAC and resolved to follow this up. Contact between the children, their father and paternal grandmother was to halt pending an assessment.

136. The overall Conference view was that although some positives had been noted regarding the children's growth and development concerns remained. It was too early to stop the CP Plan as professionals felt that Lisa would not be able to sustain the changes and would revert back to type without it. The Chair suggested that Lisa still needed to complete outstanding work and therefore the CP Plan needed to continue but with a shorter review period of 3-4 months. The proposal was agreed by the Conference.

137. Given Lisa's continued lack of engagement to the CP Plan, evidenced by her non-attendance at the CPRC and the large number of unachieved outcomes noted by the Conference Chair, there seemed to be little logic in shortening the review period. Arguably, it should have been kept to the usual six months to see if she could have kept to the Plan and maintained the changes. The spate of minor injuries, neglect of medical needs and sporadic engagement with the nursery and parenting course were not given due consideration. Moreover, Tom's presence was still not assessed. The focus was predominantly on the risk from Lee. It seemed as though Lisa's consistent attrition tactic of non, or at best, selective co-operation had worn down the core group and wrested control away from it in relation to the implementation of the CP Plan. However, by this time CSC and the core group had effectively run out of options in trying to elicit Lisa's engagement and keep control of the CP Plan. There was no evidence identified by conference members at this time that Emma and her sister had suffered significant harm, indeed, they were reportedly thriving in terms of their growth and development. The Conference seemed to have become subject to the 'Rule of Optimism' (a common phenomenon in cases involving intransigent families) where greater emphasis was given to weighing up the positives against the negatives. The 'threat' of using the PLO/ Care proceedings route was therefore not a realistic option, at this point in the case, for CSC and the core group.

138. Lisa's head laceration ('fell on a pint glass and cut her head') in late February and the scratches to Emma's head the week before were not followed up by CSC and the health visitor; albeit, there was no communication between the GP/hospital and the core group regarding the injury to Lisa. The children were not taken to the crèche in March and April as per the CP Plan. Lisa did not attend any new parenting group as stipulated by the Chair of the recent CPRC and health appointments were missed. The CP Plan continued to be ignored by Lisa although Lee did obtain supervised contact with his children once a fortnight

under local authority auspices. Emma's growth and development were eventually noted in mid-April as being satisfactory but the marks and bruising to her shoulder, neck and right underarm (said to have been caused by falling off a trampoline-at the age of 17 months) were not followed up as a possible child protection concern. Tom's risk potential remained unknown to CSC and the core group. None of these issues were discussed at the fifteenth core group of the 23.04.13 which was not attended by Lisa, despite being asked to.

139. The final Child Protection Review Conference met on the 22.05.13 and decided to discontinue the Child Protection Plans for Emma and her sister. The rationale for doing so was that the children no longer met the criteria for being at risk of significant harm in so far as the original concerns around Lisa's lifestyle were far less. Arguably, the decision to discontinue the plans was, to an extent understandable, within the narrow rationale of the original risk factors having lessened, the positive reports of the children's growth and development, and both of them doing well in their mother's care with significant improvements having been made; albeit that Lisa had not attended all of the core groups or the parenting class as previously insisted upon by the Conference Chair.

140. However, in the view of the Overview Panel and the lead reviewer, the decision was flawed. This was because there were two key risks that remained to be assessed, namely, the impact of Tom's presence in the household and its implications for the children. Secondly, the matter of Lee's violence towards his partner and the conditions for safe contact. Both matters had been outstanding for some-time and were important elements of the Child Protection Plans. They should have been completed by SW3 and signed off by her manager prior to the Child Protection Review Conference. Moreover, the Conference Chair should have insisted on both items being completed before agreeing to the CP Plans being discontinued.

141. Had these been done and no new significant risks been identified then it would have been valid to have discontinued the CP Plans, albeit that Lisa had not effectively engaged with the core group and CSC. Lisa was not likely to co-operate with a further period of her children being on child protection plans so no future value would have come from prolonging them. Moreover, the option of starting the PLO/care proceedings process - on the assumption that neither Tom nor Lee presented any risks - would not have been a realistic proposition as there was little evidence to suggest that the children had suffered or were likely to suffer significant harm. The Child Protection Plan was 'stepped down' to a Child in Need plan to run for six months.

142. The key lesson from this practice episode is for Conference Chairs, core groups and managers to ensure that all actions assigned to professionals; especially assessments, have been completed before Child Protection Plans are considered for dis-continuation.

Term of Reference 2

How well did agencies engage with individual members of the family including the extended family and significant others?

143. A key issue in this Serious Case Review was Lisa's lack of engagement and non-compliance with agencies which runs right through the time period under examination. From the start in 2010 she refused to comply with the Referral Order and did not co-operate with the Youth Offending Service in its implementation. The Service was eventually required to breach her in late 2010 resulting in a conditional discharge in early 2011, after the birth of Sarah.

144. The midwifery service only learnt of her first pregnancy at 16 weeks and quickly became concerned at the number of missed ante-natal visits; necessitating the prospect of informing CSC of their concerns, which, in the event was not needed.

145. Redcar CSC's involvement with Lisa and the new baby, Sarah, in early January 2011 resulted in a core assessment being undertaken and both mother and baby going to stay with the paternal grandmother and the father. The evidence suggests that there was a relatively effective level of engagement between the social workers, Lisa, Lee and the paternal grandmother during the assessment phase. However, as was to become the dominant pattern later in the case, Lisa, on moving into her own accommodation with Lee in February, quickly became dis-engaged with CSC and other professionals such as the health visitor. The resultant Child in Need multi-agency plan was, by April 2011, not being adhered to by Lisa and concerns arose around Sarah's welfare in respect of missed specialist hospital appointments and health visiting checks.

146. Like Lisa, her own mother proved to be difficult for professionals to engage, possibly due to her reported dislike of CSC whom she seemed to associate with the removal of her two other children and their placement with their father. To be sure, the maternal grandmother in her conversation with the lead reviewer did acknowledge that on occasions she might have been perceived by CSC staff as aggressive when responding to emotional situations. Whilst not wanting to minimise the potential challenges and complexities for professionals working in the safeguarding arena, the lead reviewer had some sympathies with the maternal grandmother's view for grandparent involvement in the child protection process and for professionals to be mindful of setting up barriers to partnership working with significant adults in the lives of children, through their labelling as 'aggressive'.

147. Following the knowledge of Lisa's second pregnancy in mid-2011, a pre-birth assessment was started, partly in response to the child protection referral from the midwife in July 2011. This took place concurrently with the on-going work around the faltering Child in Need plan. The mounting concerns from professionals during the remainder of 2011 met with a denial of any problems with her childcare from Lisa and her mother. No supportive work around childcare and parenting was able to be undertaken by the multi-agency group of CSC, the health visitor, midwife and the Children's Centre. The lack of Lisa's engagement and the mounting risks to Sarah and the unborn child steered CSC and the other professionals down the track of starting the formal child protection process. This eventually resulted in Emma and Sarah becoming the subjects of Child Protection Plans in January 2012.

148. The evidence thus suggests that prior to the start of the Child Protection Plans in January 2012, CSC and the other involved professionals did try and engage with Lisa in the interests of herself and her children through a Child in Need approach, but with only limited success. Lee was able to be engaged by CSC and had already been involved with the Adult mental health services, his GP and the Police. Likewise, his mother was co-operative with the CSC and was an important source of support and care to the children.

149. The previous Term of Reference (1) has already dealt extensively with the difficulties encountered by CSC and the core group in trying to engage Lisa and her mother in the CP Plan. As was previously mentioned there should have been a more authoritative and robust case work approach by CSC and the core group in ensuring that the CP Plan was implemented and that the professional network retained control over events in the interests of the children's safety and wellbeing.

150. Engaging Lee and his mother did not prove to be a problem for the core group. They were frequent attenders at core groups and CPR Conferences and were relatively open and honest in their dealings with professionals. Indeed, as commented upon by these two individuals in their conversation with the lead reviewer, for the most part they felt marginalised and not listened to by key professionals in the safeguarding process. As noted, they would have welcomed involvement in the assessments which could also have afforded them a voice in the proceedings and a sense of having been listened to.

151 In the event the key issues were the lack of a timely risk assessment of Lee's propensity to violence on his partner and others, his mental health and their implications for the safety and wellbeing of Emma and Sarah during contact.

152. None of the core group agencies engaged with or purposefully sought to involve Tom in the child protection process despite the professional awareness that he had been part of Lisa's household since mid-2012. In the words of the South Tees Hospital NHS Foundation Trust IMR author, Tom had become an 'invisible' male to the core group. Police checks and other intelligence showed that Tom had come to that agency's notice on ten occasions. Tom had issues with alcohol and drugs, was involved in several incidents of domestic violence with his father and had previous matters of concern. Given that the children were on CP Plans this information should have been shared with CSC and the core group. As stated elsewhere, CSC should have completed a risk assessment of Tom in relation to the children's safety and wellbeing as per the CP Plan. This was not done**.**

Term of Reference 3

To what extent did agencies understand the risks presented to Emma in respect of the violent behaviour of the individual members of the family and significant others?

153 Lisa was never seen by professionals as a physical threat to her children, albeit she did have a record of violence towards her grandmother that never seemed to have been explored in any of the assessments. She was known by the Anti-Social Behaviour agencies (Coast and Country, Police PCSO) to have been intimidating on occasions to neighbours, particularly in the months leading up to Emma's injuries in October 2013. However, the links

with the children were not made by these agencies and intelligence was not shared with CSC regarding possible safeguarding issues. A key issue not sufficiently professionally understood was the degree of domestic violence and abuse inflicted on Lisa from her partners, Lee and Tom (and latterly her father in August 2013) and its impact on Emma and Sarah's emotional health and development. Lisa seemed to minimise the violence meted out on her which was mirrored by the lack of professional curiosity and follow up when incidents became known about.

154. CSC took appropriate protective action immediately after the birth of Sarah in January 2011 by not allowing her and Lisa to be discharged into the care of the maternal grandmother. The ensuing assessment by the student social worker correctly identified the maternal grandmother as not being a suitable person to care for Lisa and Sarah. However, there was little evidence to show that CSC had effectively assessed Margaret's (the maternal grandmother) level of physical threat to the children, especially after the threatening incident with the neighbour in May 2012 which was witnessed by them. Nor was the potential impact of such violence on the children's emotional health and development really understood.

155. The extent of the risks presented by Lee to both Lisa and the children were not sufficiently assessed and understood by agencies. The violent outburst at his mother's house at the end of January 2011, soon after Sarah's birth was not risk assessed by CSC. The Crisis Team had described him as, ' can be a very dangerous young man' and a community forensic report of January 2010 had recorded that there were potential risks to his siblings, from a situational context, were he to live in the family home. Whilst passing on the latter information to CSC, the former was not shared with CSC. Likewise with Lee's GP who had knowledge of his propensity to violence and his mental health record. Neither the TEWV nor the GP made any links between Lee's behaviour and the implications for Emma and Sarah. In short, they did not 'Think family, think child'.

156. The incident of late January 2011 resulted in the core assessment of March 2011 recommending that Lee, Lisa and Sarah should remain as a family unit but with support from appropriate services. In the opinion of the lead reviewer, this incident should have triggered a section 47 child protection enquiry into the potential threat from Lee to Lisa and Sarah. The assessment was undertaken by a student social worker who was supervised by a practice teacher and team manager. The assessment outcome raises questions about the quality of the supervision and managerial oversight of the student.

157. Lee was involved in further incidents of violence to his new partner, other adults and police officers following the breakup of the relationship with Lisa in April 2011. CSC made a correct decision not to allow Lee contact with Sarah and Emma pending a risk assessment. Because Pamela declined to make a complaint and denied any domestic violence, a decision was made by CSC to allow Lee to resume unsupervised contact with the girls. This was a very naïve and flawed decision that was not based upon a rigorous risk assessment and failed to determine the extent of Lee's potential threat to his daughters during contact.

158. Thereafter, although Lee was open with CSC and the core group and certainly showed an interest and commitment to his children, he was not risk assessed for contact or the impact of the volatile relationship with Lisa, as set out in the CP Plans.

159. Previous mention has been made of the 'invisibility/marginality' of Tom who was not risk assessed despite reports of domestic abuse between him and Lisa, injuries with unconvincing explanations to her in February 2013 (the head laceration), four sets of injuries to Emma between April to October 2013 and a Police record of violence. There were also suggestions of cannabis misuse by him and Lisa that, the children may have been exposed to. The later care proceedings on the children and subsequent judgement (March 2014) found that Emma suffered significant harm whilst in her mother's care. In addition, both Lisa and Tom (see paragraph 74 of the judgement) 'had the opportunity to cause the injuries' and that both adults failed to protect her (paragraph 75). CSC and the core group never had an understanding of Tom's potential for violence against Lisa or the children, the potential impact of domestic abuse on Emma and her sister or an appreciation of them being exposed to possible substance abuse.

160. This case contained elements of the 'Toxic trio' (Ofsted; 2010) of domestic abuse, substance misuse and adult mental ill health; the interaction of which, could have significantly increased the level of risks to the children. There was no evidence that the professionals made this link in their assessments, thereby leading to an under appreciation of the potential risks of harm to the children.

Term of Reference 4

Was the work in this case consistent with each organisation's and the LSCB policy and procedures for safeguarding and promoting the welfare of children and with wider professional standards?

Children's Social Care

161. There were several instances where this agency's practice was not consistent with existing LSCB policy and procedures. The first of these concerned the incident when Lee was violent in front of Sarah, Lisa and his siblings, at his mother's house in late January 2011. He had reported to the Crisis and Home Resolution Team (CHRT) of hitting Lisa and pushing his mother during the incident. The case had just been allocated to a student social worker (overseen by a practice supervisor and team manager) to undertake a core assessment. This was completed in early March and concluded that a further period of support was needed because of the parent's untested ability to care for Sarah independently. The parents and the baby were intending to move into their own accommodation in late February. In the lead reviewer's opinion the assessment significantly under-estimated the risks to both Sarah and her mother from Lee's violence.

162. This episode also raised questions about the efficacy or otherwise, of using student social workers to undertake complex child protection assessments. Whilst important for social work students to be able to partake in assessment work, it would seem more appropriate for them to undertake such work jointly and directly with an experienced social worker, rather than on their own, albeit under the supervision of a practice supervisor and team manager as in this instance.

163. Albeit mindful of hindsight bias, a strong case can be made that child protection action informed by a strategy discussion and a Section 47 enquiry should have been started in

early February. Such measures would have been warranted given the incident itself, the previous known record of violence of both parents, the father's mental health background (with the Early Intervention Team), his alcohol misuse and his identified risk to professionals; he was subject to a 'lone worker' risk assessment. Further concerns should have been evident from the provision of the forensic services psychiatric report of January 2010 to SW9. Crucially, this had identified that he was a risk to children, albeit, indirectly; but posed a potential concern in the event of any volatility in the environment. The report had indicated that there was a need for a discussion with CSC should he move in to a family household where his siblings were present. This did not take place.

164. The absence of child protection action in February 2011 raises questions about the quality of supervision and management decision making. The decision not to proceed to child protection measures did not safeguard Sarah and was not consistent with CSC or LSCB safeguarding standards.

165. As pointed out by the CSC IMR, the completion of Emma's pre-birth assessment in October 2011 was some four weeks late. It was limited in an understanding of the risks to Sarah and the unborn child due to Lisa's refusal to engage, which in itself was a risk. It should have been started much earlier given the mounting multi-professional concerns for both children, Lee's grievous bodily harm charge in July and Lisa's disclosure of being pregnant in April. The ensuing strategy meeting and section 47 enquiry of October did not proceed to an Initial Child Protection Conference (ICPC) despite the conclusion of 'Significant concerns'. CSC decided to continue with the Child in Need plan to give Lisa, 'one last chance'.

166. In the lead reviewer's opinion, this decision was overly adult focused and not sufficiently child centred; and did not sufficiently consider the impact of the (limited) known risks on Sarah and the unborn child. There should have been an ICPC in October which, amongst other things, could have made a co-ordinated post birth discharge plan for Emma. This omission and the late start on the limited pre-birth assessment did not safeguard and promote Emma's wellbeing.

167. Neither Emma nor Sarah were ever seen by the social workers (SW1 and SW3) on their own or engaged with in play activity to get a sense of what they were like when not in the presence of their mother. Encounters with Lisa and the children tended to be descriptive and lacked analysis. Thus, there was little evidence of analysis by the workers on how well, or otherwise, the parents were working with the child protection plan and the implications for the children.

168. Clearly, there should have been some observations of the children undertaken without their mother present, perhaps whilst at the nursery and in conjunction with one of the early years workers. There should also have been more analysis on the impact of the adults' behaviour on the longer term health and development of the children. This should have been picked up in management supervision.

169. There was no case work supervision recording by the team manager between late April and late August 2013 which breached agency and LSCB practice standards. This raises questions about the quality of case management oversight during the significant period

leading up to the serious harm caused to Emma in October 2013. For most of this time Emma and her sister had been subject to an ineffective Child in Need Plan.

Tees, Esk and Wear Valleys NHS Foundation Trust

170. The agency had no direct involvement with Lisa or the two children. It was involved with Lee by way of a forensic assessment in January 2010 following concerns from his mother and a referral from his GP. As already mentioned, Lee was assessed as posing an indirect risk to children. A referral to CSC would be needed in the event that he moved into living with either parent and their younger children. The referral was closed in May 2010 as there was no role for the forensic team. There was no evidence of any follow up or sharing of the forensic assessment at the time with CSC to check whether he was in a household with children, albeit the report was sent to SW9 in February to assist with the core assessment. Whilst current expected practice would be to share information, this does not appear to be consistent with either the Trust or the LSCB's safeguarding policies and procedures at that time.

171. During the relevant time frame, Lee was seen by the Criminal Justice Liaison Team (CJLT) twice and once respectively by the crisis team and access team. On none of these occasions was any consideration given to assessing the potential impact of Lee's behaviour and mental state on Emma and Sarah, or on the child of his later partner, Pam. As the Trust IMR says, '*there was limited understanding by Trust staff in adult mental health services of the need to be aware of and share information about the needs and risks to children – living with or in contact with parents/carers'*.

South Tees Hospital NHS Foundation Trust

172. The relevant services from this agency that had contact with the two children, their parents and Tom, were community midwifery and health visiting. By and large the service standards and safeguarding practice of the two services were consistent with the Foundation Trust's own policies and that of the LSCB, albeit there were some instances of sub-optimal practice detailed below. Good practice was shown by the midwife (CM1) in making a child protection referral to CSC in early July 2011, (at week nineteen gestation, in line with procedures), because of concerns that the unborn child (Emma) might be at risk of neglect due to her mother's non-attendance for ante-natal care appointments.

173. The agency IMR identified that it was unclear, what, if any handover of care took place between CM1 and CM2, as there was nothing recorded regarding this. Given the concerns this should have taken place either verbally or in written format. Also, HV3 did not record the details of Lisa's new 'boyfriend' when told of his presence in late May 2012. HV3 could have challenged CSC in mid-July 2012 around the reports of Sarah's top lip being red, bruises to Lisa's arm (said to have been sustained from a Theme Park ride) and consideration of an early convening of the Review Child Protection Conference.

174. There was poor liaison between HV3 and the GP, an example being the lack of a follow up by the former when Emma was seen by the latter on the 20.05.13 for the small cut to her upper lip. Given that the child was still on a child protection plan and that this was the second injury in recent weeks, HV3 should have spoken with the GP to confirm his/her view of it being accidental in nature. Emma's centile weight drop and Sarah's static weight gain

observed by HV3 in mid-August 2013 did not raise any concerns and there was no plan to follow this up.

175. The Trust IMR opined that HV3 did not challenge Lisa sufficiently about her parenting and appeared to 'normalise' the neglect of the children. Lisa was seen by HV3 (and other professionals) as able to meet her children's physical needs and to warmly interact with her 'happy, sociable children'. However, she was deemed to have not considered their long term emotional development.

NHS England Durham, Darlington and Tees Area Team

176. This agency delivered General Practice services to the children, their parents and Tom and involved three GP practices. However, as Tom was unassessed there was never a request to access his GP information to inform the assessment. Only GP practice 2 had midwifery clinics (provided by South Tees Hospital Foundation NHS Trust) run from the surgery. Child Protection Policy and Practice Guidance for GPs were circulated to practices in the Tees area in 2010 and were developed from the Royal College of General Practitioner's guidance. However, since 2012, Safeguarding Children Procedures for all agencies have been web based and all GPs interviewed for the IMR were aware of procedures and able to access them.

177. The agency IMR analyses and identifies instances when GP safeguarding practice fell short of expectations in five key areas, these being;

- The recognition of adults with mental health issues and/or violent tendencies, linking them to children and considering parenting capacity and potential risks to children. This did not happen after the incident in late January 2011 when Lee became violent in his mother's house in the presence of Lisa and Sarah.

- The need to ensure that relevant child protection information is effectively entered and coded onto GP clinical recording systems. Health professionals in the practice need to be aware of this and must be alerted when children are subject to child protection plans and other safeguarding measures. This was done by GP practice 3. The IMR author identified that 'practices need to be aware of administrative factors to ensure its availability (i.e. flagging up major alerts on clinical systems such as System One) to clinicians'.

- Poor liaison and information sharing between GPs, health visitors, midwives and Children's Social Care regarding Emma and her family. Only GP practice 2 held a meeting between the GP safeguarding lead, the health visitor and other health professionals, albeit this was before the birth of Emma. None was held on Emma and her sister by the other two GP practices during the timeframe in question, particularly whilst they were subject to child protection plans. The lip injury and small cheek bruise to Emma seen by GP14 on the 20.05.13 was not discussed with the health visitor and was not reported to the Child Protection Review Conference on the 22.05.13 which dis-continued the plan. Of concern was that GP14 did not reference in the consultation that Emma was on a child protection plan when seen for the injury,

however the GP had noted that the injury was consistent with the explanation. The IMR notes the need for GP practices to hold regular, structured multi-agency health meetings (GP, Health visitor, midwife, school nurse) facilitated by the practice safeguarding lead.

- The IMR also highlighted that only GP practice 2 had a practice policy (Local child protection policy and practice guidance for General Practice, November 2013). *'Two of the General Practices involved showed a lack of thorough understanding regarding internal policies and procedures that are required to underpin good safeguarding children practice'.* The IMR concluded that, ' *having robust policies and procedures in place, which are understood and followed by all practice staff, is a corner stone of effective practice in Primary Care')*, a finding that this Review wholly agrees with.

- Finally, the IMR found that there seemed to be a lack of understanding of the '*pervasive and chronic nature of neglect which led to inappropriate inaction during significant consultations'*, amongst some of the involved clinicians.

Cleveland Police

178. Cleveland Police had no direct involvement with Emma until 19.10.13 when she was admitted to a local hospital with serious, unexplained injuries that triggered the current police investigation. A Police officer attended the Initial Child Protection Case Conference on 12.01.12 when Emma and Sarah were made the subjects of a child protection plan under the neglect category.

179. The Police and Coast and Country Housing dealt with several allegations of Anti-social behaviour episodes involving Lisa and Tom during the period in question. The Police also responded to reports of domestic abuse involving Lisa, Lee and latterly Tom. Lisa and Tom were cautioned for possession of cannabis in September 2013.

Coast and Country Housing

180. Coast and Country Housing (CCH) provided housing and tenancy support to Lisa and her family and intervened on occasions in relation to reported episodes of anti-social behaviour by Lisa and others. The agency was present at the Initial Child Protection Conference in January 2012 and was a member of the core group. In addition to housing support it had a key role in providing relevant information to the Police, CSC and the core group regarding substance misuse behaviour and anti-social activity by the parents and other adults that had a potentially negative impact on Emma and Sarah.

181. The tenant adviser (TA1) attended the first three core groups between January to March 2012 and provided information relevant to the safeguarding of Emma and Sarah. However, due to staff leave there was no agency attendance at the first Child Protection Review Conference held at the end of March 2012. Moreover, no report was provided when it should have been. Apologies were sent by TA1 for her absence at the core group in late April but she did attend the fifth core group in May. Information relevant to the child protection plans was thus shared with the core group from January to the 21.05.12.

182. Thereafter, the link between CCH and the core group was broken and there was no further attendance at core group meetings, child protection reviews or involvement in the child protection plan. TA1 did not attend the sixth core group held on the 18.06.12 (she sent her apologies) and SW1 was asked to contact CCH. There was no evidence that she did. An invitation was received by CCH on the 06.08.12 to attend a Child Protection Review Conference (CPRC) set for the 15.08.12.

183. TA1 did not attend the CPRC despite CCH receiving the invitation; it is not known why she did not attend. The Conference Chair noted that CCH needed to be reminded of future core group dates and advised of the expectation that they attend all meetings. The social worker was to do this within one week. There was no evidence that this happened although on the 11.09.12 CCH (TA1) recorded a note to speak to SW1 but was unable to make contact with her. The date of the next CPRC was set for the 15.01.13.

184. Thereafter, TA1 was seconded to another post/service area from the 15.10.12. Her position was taken over by TA2 in September 2012. There is no evidence that a handover meeting was held although it would appear that TA2 received information on a housing application (21.09.12) that the children were on a child protection plan.

185. TA1 recalls contacting CSC (Seafield House) to inform them that any future invitations to meetings or minutes of meetings needed to be sent to the CCH district housing office for the attention of TA3. TA3 did not receive any invitations to core group meetings or case conference reviews.

The Post Child Protection Plan/Child in Need Period

186. Given her non-co-operation with the child protection plans, there was very little chance of Lisa effectively co-operating with the Child in Need plan following the dis-continuation of the former on the 22.05.13. This proved to be the case.

187. She did not take Emma to the nursery in June, failed hospital and dental appointments and did not attend the multi-agency meeting on the 09.07.13 which effectively marked her dis-engagement with the Child in Need plan.

188. The Police and CCH became involved with the family between July to September 2013 regarding anti-social behaviour and reports of domestic abuse but did not pass on any information to the CSC. Attending Police Community Support Officers did not make the link between Lisa's behaviour, possible domestic abuse with Tom and possible negative impacts on the children. CCH staff had not had any involvement with CSC since May 2012.

189. By the middle of August 2013 Sarah's weight gain was static and Emma had dropped a centile, neither of which were picked up by professionals. The children were not attending any offered nursery provision and their progress was not being effectively monitored. No-one turned up for the multi-agency meeting of the 21.08.13.

190. The Child in Need meeting of the 10.09.13 noted the injury to Emma – the third since April - which was accepted and not followed through as a possible non-accidental injury. There were further anti-social and substance misuse episodes involving Lisa and Tom in September 2013 which were dealt with by the Police and CCH but were not shared with

CSC. Emma sustained a fourth injury – to her eye - in early October when no medical attention was sought or enquiries carried out.

191. Both children were seen by SW3 on the 10.10.13 who noted no concerns. Emma sustained serious non-accidental injuries and burns on or around the 19.10.13 whilst in her mother and Tom's care.

FAMILY VIEWS

192. Relevant family members were invited to give their views on the services received on the conclusion of Lisa's trial and are set out below:

(i) Father (F) and Paternal Grandmother (PGM)

Summary of Main Issues

Below is a summary of the relevant key issues/themes discussed in relation to the various agencies involved between mid-2010 and Oct 2013.

1. ***Father and Paternal Grandmother felt marginalised by agencies, particularly Social Care and were not treated as partners in the process:***

   Throughout the period discussed both F and PGM repeatedly raised concerns and highlighted issues that they felt needed addressing by professionals however they weren't listened to and received very poor responses.

   F – Raised concerns with Social Care regarding home conditions of the children, including lack of carpeting, drug use, bruising and general neglect.

   In respect of the allegation of drug use they were told that there was no evidence, however the house was 'littered' with evidence of drug taking. Both F and PGM felt that professionals were aware of this activity.

   PGM felt that the threshold set for the level of care was very basic.

   Neither F or PGM were involved in any of the assessments undertaken by Social Care.

   They were invited to and attended Child Protection reviews, which was the only time they had contact with other agencies.

2. ***Social Workers appeared to be intimidated by the children's mother and maternal grandmother which prevented robust challenge:***

   Both F and PGM felt that the social workers were scared of the mother and weren't forceful or challenging enough with her.

They also thought that the social workers felt threatened by the maternal grandmother.

3. Workers had pre-conceived ideas of Father :

Both felt that Father was marginalised due to his past, which they focussed on more than the concerns he highlighted. F felt he was not listened to by professionals until the injuries occurred. This resulted in the sole focus by agencies in terms of parental responsibility/capacity being on the children's mother. F was not considered in assessments.

Ultimately he felt that this resulted in him being denied access to his children.

4. Positive interaction has taken place with Police:

Officers have been very supportive and kept both PGM and F up to date with Court etc.

5. *Positive interaction with Health Visitor was highlighted.*

Lessons Identified

Both F and PGM felt that the following lessons should be learnt by agencies:

- Professionals should listen more to Grandparents/Fathers and they should be included in assessments rather than focusing only on mother. They should be treated as partners in the process.

- Social Workers and others should be 'on the ball', particularly in respect of drug taking and should undertake more regular checks.

(ii) The children's mother (M)

Summary of Main Issues

Below is a summary of the relevant key issues/themes discussed in relation to the various agencies involved prior to Oct 2013.

Health Visitor
M said that the involvement from the Health Visitor throughout the period was very good and she was happy with the support she received. It was noted that the same Health Visitor was involved throughout the period.

Social Care

M said that she had a number of social workers and admitted that she did rebel at times as she felt they were intruding. M said that they did explain why they were involved but she wanted to look after her children herself without interference.

The lead reviewer asked about the child protection plan and what was expected of M as part of it. M said she found it hard and that the social worker was visiting a lot, making both expected and unexpected visits. She was not always in at the unexpected visits but did tell the social workers that if she wasn't there she would be close by at her mothers and that they were welcome to visit her there but they declined to do so.

In respect of the Child Protection Plan, M said that in addition to being expected to work with social services and the health visitor she had to take the children to the crèche. She confirmed that she did do this some days but that she had some concerns regarding one of the members of staff because her youngest daughter always seemed to have a full nappy when she went to collect her causing soreness. She did complain about this but was unsure of the outcome.

M said that the reason why the children were on a child protection plan was explained to her and that it was due to her having too many different visitors to her house. She said she explained to the Chair of the meeting that it wasn't like they thought and that she did stop them coming.

The lead reviewer asked about the review meeting in respect of the Child Protection Plan and M said that at a meeting before Christmas (2012?) housing officers were in attendance and reported that there were no problems and Police also advised that they had no concerns.

M met her new partner in May 2012 and he was spending a lot of time at her house.

The children were taken off the Child Protection Plan in May 2013 and became Children in Need.

The lead reviewer asked what had happened between May and October 2013. M advised that she saw the Social Worker a couple of times some were planned visits and others were unplanned.

M said that she felt a weight had been taken off her shoulders when the child Protection Plan ended and that she felt she could be with her girls. She felt the level of support during this time was better that she was doing well and was taking the girls to the crèche. She was happier with the children being subject to Child In Need status rather than being on a Child Protection Plan. She felt that people were more 'against' them when they were subject to a 'plan' then when off it. She did not feel that the girls should have been subject to a Child Protection Plan for as long as they were, but did understand why it was necessary initially.

M said that the Chair at the review meeting had highlighted that M needed positive re-enforcement from professionals.

A brief discussion took place regarding issues in August 2012 when Social Services were concerned regarding the care of the children and were considering care proceedings. M said she did recall this and remembered the Social Worker saying they would be removing the children but was unsure of when this was. M said that she made the changes required so this didn't happen.

M acknowledged that she sometimes struggled to get to appointments on time and did miss some appointments, particularly when her mum was without a car, but that she did look after her children. Due to some medical issues with her eldest daughter she did need to go to a lot of medical appointments which her mum supported her with when she was able. When this wasn't possible she struggled to get to appointments on time due to issues with public transport.

The lead reviewer raised the issue of concerns in relation to a number of young men being present in the house and M responded that they were helping her to decorate the house and that the children weren't there at the time.

Lessons Identified

M said that lack of consistency from social workers had a negative impact. She explained that having them change so often meant that they never really got to know and understand her and the girls. This resulted in a reluctance to engage with new workers as she didn't expect them to be around for long.

(iii) Maternal Grandmother (MGM)

Summary of Main Issues

Below is a summary of the relevant key issues/themes discussed in relation to the various agencies involved prior to October 2013.

Health Visitor

MGM said that the relationship with the Health Visitor was very positive and that it was the same Health Visitor throughout the period.

Social Care

MGM reported that the relationship and interaction with the initial Social Worker was positive, in that she would praise and provide support to her daughter, M. MGM felt able to talk to her. She did feel that the Social Worker challenged M when appropriate but did so in a positive way.

MGM felt that support for M (as with all mothers) was essential. MGM advised that the relationship with social care deteriorated when there was a change in social worker. MGM did not know why the social worker was changed. She felt that the approach and attitude of the new social worker was negative and that she 'told' M what to do rather than discussing and working with her.

MGM felt that there was no 'direction' or plan aimed at improving the situation and progressing it to a ''happy place'.

The relationship between the new Social Worker was conflicting from the start and MGM did not feel that they ever formed a working relationship. MGM acknowledged that at times she might have been perceived as being aggressive when responding to such emotional situations.
MGM did attend the core groups/Review Conferences to support her daughter. She said that agencies appeared to work together.

Children's Centres

MGM felt that the experience with Sure Start couldn't have been better. The staff appeared very nice and helpful and M could talk to them.

Housing

Interaction with housing officer in respect of ASB complaints was fine.

Police

MGM said that the interaction with the local police officer was very positive.

Lessons Identified

MGM expressed the view that grandparents such as herself should be involved more as she felt excluded from discussions and she would have contributed if given the opportunity. MGM also felt that there were 'fixed ideas' about her and she was labelled as aggressive, which affected relationships with professionals.

CONCLUSIONS AND KEY LESSONS

ToR 1

Conclusions

193. There was no evidence to suggest that Emma and her sister suffered actual significant harm whilst subject to their Child Protection Plans. The objectives and outcomes of the Plans were sound although they could have been 'SMART'er. Lisa's intransigence and opposition to the Plans made their implementation difficult. From this perspective, the child protection

plans, were to a degree, ineffective, given that the children missed out on consistently attending health appointments and Children Centre programmes which would have been to their benefit. In this sense, they did not adequately promote the children's wellbeing.

194. There should have been a more authoritative and robust approach by CSC to case management involving the early use of the PLO/care proceedings process in line with the stated contingency plan. The optimum time for this was in August 2012 following the legal advice from the 09.08.12 meeting and agreement (but with no senior management input) to start care proceedings, bypassing the PLO process. CSC's later decision not to proceed with this course of action was a missed opportunity to try and secure the children's safety and wellbeing, albeit that there was no absolute certainty that a court would have agreed to care orders.

195. It would appear that the decision to initiate a short (one week) pre-proceedings option may have been influenced by the social worker's lack of prior effective intervention with the family which, amongst other things, raises the question of management oversight and effective case supervision. There should have been a much longer period of time (say three months) for the PLO process to have run its course in order for Lisa to have shown that she was able to sustain any change over the longer term.

196. Poor (and lack of) recording was also identified as another issue, especially in regard to the lack of a clear audit trail around the rationale for decision making, especially in regard to starting care/PLO proceedings.

197. The Reviewing process correctly identified that many of the Plan's objectives and actions consistently failed to be achieved with the needs of the children being unmet. The Assistant Director for Children and Families (People's Services) should arrange for the development and use of a process of facilitated Complex Case Supervision for Core Groups when it is evident that there are significant difficulties in progressing The Child Protection Plan.' The August 2012 CPRC, whilst apparently being informed of legal matters, did not record any discussion on this matter, which clearly should have happened. Thereafter, neither the core group nor the Conference Chair were kept informed by CSC of subsequent legal developments. They should have been informed by CSC of these matters which could have empowered the core group and Conference to support possible moves towards care proceedings or at least, a more robust approach to the PLO process. These could have been incorporated into the CP Plan.

198. The decision to discontinue the Child Protection Plans in May 2013 was flawed and should have been considered only after the completion of the risk assessments.

Lessons

199. Child protection plans need to be SMART with clear, child focused outcomes and named individuals taking responsibility for the implementation of assigned actions.

200. Case management needs to be authoritative and robust when working with difficult to engage and non-cooperative parents/carers. Contingencies need to be clear and reverted to in a timely manner when parental non-compliance with CP Plans is encountered.

201. The PLO/pre-proceedings process needs to run for a reasonable time (say 2-3 months) to give parents/carers the opportunity to sustain change and demonstrate it to professionals.

202. CSC should record all legal advice and the rationale for decision making in regard to starting the PLO or care proceedings processes. All decisions regarding PLO/care proceedings should have the written approval and oversight of appropriate senior line managers (e.g. Service Managers).

203. Conference Chairs and core groups should be informed of the outcome of legal advice meetings with CSC. PLO pre-proceeding plans need to be integrated with existing Child Protection Plans and both need to be signed by parents/carers.

204. Child Protection Plans should only be discontinued if it is judged that the child is no longer continuing to, or is likely to, suffer significant harm and therefore no longer requires safeguarding by means of a child protection plan; and that all assessments have been completed.

ToR 2

Conclusions

205. Child care professionals were able to engage with Lisa, Lee and his mother relatively well during the assessment period in 2011 but experienced increasing reluctance from Lisa to be involved in the Child in Need Plan. Her non-co-operation became more pronounced during the second pregnancy with Emma and minimal during the time of the Child Protection Plans of 2012/2013. Professionals failed to recognise this for what is was which contributed to the lack of authoritative practice.

206. Professional engagement with Lee was generally positive but risk assessments on the implications of his violent behaviour for the children were not completed in a timely way.

207. Tom was marginal to the core group professionals and was not engaged with. His presence in the family should have been risk assessed.

208. There was insufficient professional encouragement of Lee, his mother and arguably the maternal grandmother in their involvement in the assessment and planning processes and subsequent arrangements for the children.

Lessons

209. There are three key learning points which arise from the above conclusions, namely, the difficulties of recognising and working with un-co-operative and hard to engage parents, the inclusion of males in ongoing child and family practice and the inclusion of grandparents. Regarding the first, it is understood that since March 2013 professionals in Redcar and Cleveland have been able to access guidance on working with un-cooperative families from the Tees Local Safeguarding Children Board website. Self-evidently these procedures would have been introduced towards the end of Emma's child protection plan and would not have been available for most of it. However, this Review is keen to emphasise the importance of practitioners having a thorough knowledge of this aspect of working with families. It would

expect to see the topic on the RCSCB programme of professional learning and development opportunities.

210. Many previous Serious Case Reviews have identified the crucial importance of including male partners in the child protection/welfare process (e.g. the Baby P SCR 2008, Hamza Khan, 2013, Bradford SCB) and the tendency for them to remain largely 'invisible/marginal', as was the case with Tom. The learning here suggests that agencies in Redcar and Cleveland need to consider ways of ensuring that significant males (and others) in households where there are children about whom there are concerns, are involved in family assessments and risk analyses in a timely manner.

211. Finally, policy and practice needs to recognise the potential importance to children of including grandparents and other wider family members in the processes of case management and decision making by professionals and, when in the interests of children, actively promote such practice.

ToR 3

Conclusions

212. Agencies had a poor understanding of the nature and extent of potential violence that the children were exposed to. This was both on an individual level with Lisa, Lee, Tom and the maternal grandmother and also regarding the violent interactional dynamic of the relationships between these individuals. Sarah's aggressive behaviour noted at the Children's Centre in November 2012 and January 2013 may have been a possible reaction to the atmosphere of violence experienced by her in the home.

213. The raised levels of potential risk to the children from the interaction of the 'Toxic Trio', which was not recognised by the professional network.

Lessons

214. Where present, the impact of domestic abuse and violence from individuals on children and young people must always be factored in to all family/risk assessments where there are concerns that children are at risk of harm or abuse.

215. Professionals should be aware of the existence of the 'toxic trio' and, where appropriate, factor into all family/risk assessments their cumulative impact on children and young people.

ToR 4

Children's Social Care

Conclusions

216. The assessment of February 2011 significantly underestimated the risks to Sarah and her mother from Lee's violence. A strategy discussion and Section 47 enquiries should have been started in February 2011 and the episode was a missed opportunity to better understand the risk of harm to Sarah, and later on, Emma.

217. The quality of supervision and managerial decision making around this incident regarding the safeguarding of Sarah was not consistent with expected agency and RCSCB.

218. There was insufficient analysis of the impact of the parent's behaviour on the longer term health and development of the children.

219. The children's Child in Need plan from May to October 2013 was for the most part ineffective, due to Lisa's continued non-cooperation. Case management oversight between May to October 2013 was below accepted agency standards.

Lessons

220. No additional learning has been identified that is not already in this agency's Individual Management Review.

Tees, Esk and Wear Valleys NHS Foundation Trust

Conclusions

221. The lack of timely information sharing with CSC and the absence of consideration for the children put them at potential risk of harm. Such practice was in breach of the Trust and the LSCB's safeguarding procedures. Had the Trust been operating to the RCSCB safeguarding procedures it would have enquired whether Lee had contact with any children, identified any potential risks to them from him and proactively shared information with CSC. It should have been invited by CSC to the ICPC in January 2012.

Lessons

222. The Trust reports that it has since taken action to address these deficiencies in its safeguarding practice. Training started in September 2013 on use of the Pre-Common Assessment Framework and the Procedure for Assessing and Responding to the Impact of Parental Mental Health on Children (PAMIC) tool. The Trust IMR reports that there has been a comprehensive training package disseminated to all of its services over the last year. Within the agency, ' *there is a clear emphasis on the need for a family approach ensuring the needs of the child are considered when adults are receiving services from the Trust'.*

223. The Trust reports that there has been an audit of the impact of the recent training to see if the needs of children are being considered. Positive evidence was reportedly shown both by the audit and a recent CQC inspection that children's needs were being considered and addressed. However, this Review would suggest that the RCSCB needs to be assured that the Trust is operating safely in respect of the protection of children and is compliant with the Board's policies and procedures. This would apply especially in regard to the recognition of child abuse and neglect, proactive and timely information sharing and referral to CSC.

South Tees Hospital NHS Foundation Trust

224. It is recommended that South Tees Hospital NHS Foundation Trust work with NHS England area team to establish Safeguarding Children Multidisciplinary face to face meetings which should be held at least quarterly between General Practice and Health visitors, School Nurses and Midwives.

NHS England Durham, Darlington and Tees Area Team

Conclusions

225. The evidence suggests that there were a lack of robust safeguarding policies and practice Guidance available in some of the GP practices involved in this IMR. In addition there were issues with regard to the communication systems between GP practices and the Local Authority Review Unit. Part of the problem at a strategic and developmental level seems to be associated with the lack of a Named GP for Safeguarding Children in the last two years and the resulting absence of Safeguarding Practice Lead meetings.

Lessons

226. The IMR recommends (amongst other things) the appointment of a Named GP for Safeguarding Children by South Tees CCG and the NHS England (Durham, Darlington and Tees). This SCR is of the view that this should be progressed as a matter of urgent priority and notes that this was a recommendation from the Ofsted report of 2012[7] Moreover, the IMR findings and recommendations should be shared with NHS England Area Team (Durham, Darlington and Tees) and an action plan implemented without delay. NHS England Area Team should develop a system of audit relating to Primary care practice in Safeguarding children in order to provide assurance to RCSCB that Primary Care staff are contributing effectively to the safeguarding children process.

Cleveland Police

Conclusions

227. The evidence indicates that, for the most part, safeguarding practice by the Police was compliant with internal agency and RCSCB policies and procedures. The IMR does identify a lack of recording of information which was not compliant with expected practice. Also, there were some instances of intelligence reports regarding anti-social behaviour episodes by Lisa and Tom that did not consider the potential safeguarding implications for the children which were not acted upon sufficiently.

228. Reportedly, information by front line officers was not fully shared with specialist departments within the Police and with external agencies. The Panel identified that the potential risks to Emma and her sister from the adult's behaviour may not have been fully understood by front line officers who dealt with instances of anti-social behaviour and Lee's violence. There may have been a lack of awareness of the links between negative parental behaviour and the impact of this on the children.

Lessons

229. These lessons have been identified in the Police IMR and are to be addressed in the action plan.

[7] See Ofsted Report (July 2012) ; Inspection of safeguarding and looked after children services; Redcar and Cleveland at page 8, ' Within six months….NHS Tees should recruit to the post of named GP for Redcar and Cleveland to ensure that primary care are represented at the RCSCB'.

Coast and Country Housing

Conclusions

230. The lack of any Coast and Country involvement after the 21.05.12 detracted from the effectiveness of the child protection plans. The agency was a member of the core group and would have had useful information on the children's welfare to impart at meetings. Whilst the social worker should have been more persistent in contacting TA1 *' a proactive approach could have been undertaken (by CCH) through contacting Redcar and Cleveland Children's Services to request further meeting dates and scheduling them in relevant staff's calendars"*.

231. Self-evidently, it is crucial that all core group agencies and their representatives understand their roles, responsibilities and importance regarding their involvement in the child protection process. In this instance there appeared to be a breakdown in communications between the core group, the key worker and CCH leading to the agencies non-attendance at core groups and Child Protection Review Conferences. The lead reviewer understands that this has been an issue with CCH in a previous SCR so it is even more imperative that action is taken to ensure that this agency maintains its consistent involvement in core groups and Child Protection Review Conferences.

Lessons

232. CCH needs to ensure that it has in place effective systems and processes that provide for continuity of attendance and the provision of reports at child protection meetings when its staff are not able to attend meetings or where staff transfers occur.

233. There also needs to be an effective management process which monitors practitioner performance in regard to attendance, the provision of reports at child protection meetings and the overseeing of any emerging issues.

234. All of the above three learning points are identified in the CCH IMR and will need to be proactively and effectively implemented in a timely way.

RECOMMENDATIONS

235. The following Recommendations are drawn from the conclusions and key learning points identified in the previous section. Within six months from the date of the approval of this Serious Case Review by the RCSCB the following Recommendations should be implemented by way of an action plan which will be produced and progress against this will be monitored by the RCSCB's Learning Lessons and Improving Practice Sub Group.

ToR 1

1. The Chair of RCSCB should be provided with evidence from the Assistant Director for Children and Families (People Services) that;

a) All Public Outline pre-proceedings, (1) Run for a minimum of two months (unless early removal is necessary due to the risks to the child) so as to give parents/carers a reasonable opportunity to achieve and sustain desired changes and demonstrate them to professionals, (2) Have SMART actions and child focused outcomes, (3) Be reviewed at timely intervals, (4) Ensure that all PLO/Pre-proceeding plans are integrated into any existing Child Protection Plans.

b) Before dis-continuing a Child Protection Plan all assessments have been completed.

c) Should ensure that all Child Protection Conferences (both Initial and Reviews) are fully informed of all decisions and outcomes of legal discussions held on children by the local authority.

ToR 2

2. The Chair of the RCSCB should be provided with evidence from Board Members of Statutory Agencies where there are concerns about children, that they consider and engage with significant others (particularly males) in the household, where appropriate in family assessments and risk analysis. This should also include grandparents and other significant wider family members when in the interests of children.

ToR 3

3. The Chair of the RCSCB should be provided with evidence that, where present, the impact of the 'toxic trio' (domestic abuse, adult mental health and adult substance misuse) on children and young people are included in all family and risk assessments.

ToR 4

4. The Chair of RCSCB should seek evidence that the Assistant Director for Children and Families (People Services) has taken steps to be assured that the quality of first line management supervision and case work oversight of both Child Protection and Child in Need cases is consistent with agency standards.

5. The Chair of the RCSCB should seek evidence of adherence to the safeguarding practice of Tees, ESK and Wear Valley NHS Foundation Trust, particular relating to, (1) the impact of adults' behaviour on children, (2) the timely and proactive sharing of information and appropriate referral to Children's Social Care, is consistent with the standards of the agency and the RCSCB.

6. The NHS England Team should secure as soon as possible the employment of a named GP and it is recommended that once secured the initial priority should be on supporting practices to put in place robust internal policies and practice.

7. The NHS England Team should develop an audit programme for primary care which provides assurance to RCSCB that primary care staff are working effectively to safeguard children.

8. The Assistant Director for Children and Families (People Services) and the Chair of the RCSCB should seek evidence that processes are robust to ensure that Initial Child Protection Conferences, Child Protection Review Conferences and core group meetings are quorate, are held in a timely way and that appropriate agencies are invited and attend.

9. The Assistant Director for Children and Families (People Services) should arrange for the development and use of a process of facilitated Complex Case Supervision for Core Groups when it is evident that there are significant difficulties in progressing the Child Protection Plan.

APPENDIX 1

GLOSSARY

ASB: Anti- Social Behaviour (Team)
CCH: Coast and Country Housing
CHRT: Crisis and Home Resolution Team
CM: Community Midwife
CiN: Child in Need
CPRC: Child Protection Review Conference
CPP: Child Protection Plan
CSC: Children's Social Care
CREST: Substance Misuse Service
EDT: Emergency Duty Team (Out of Hours Service)
GP: General Practitioner
H1: Hospital 1
H2: Hospital 2
ICPC: Initial Child Protection Conference
IMR: Individual Management Review
KPE: Key Practice Episode
MARAC: Multi-Agency Risk Assessment Conference (Domestic Abuse)
PAMIC: Parental Mental Health on Children (Tool)
PCSO: Police Community Support Officer
PLO: Public Law Outline
RCSCB: Redcar and Cleveland Safeguarding Children Board
SCR: Serious Case Review
SW: Social Worker
SWTM: Social Work Team Manager
TA: Tenant advisor
TEWV: Tees, Esk and Wear Valleys NHS Trust
YOS; Youth Offending Service

APPENDIX 2

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