EXECUTIVE SUMMARY
April 2015

SERIOUS CASE REVIEW

In respect of the death of Baby Eve

Born on: 09/03/2013

Died on: 30/03/2013

Presented to the Northumberland LSCB

10th April 2015

Report by: ORA1, Independent Overview Report Writer

CONTENTS: **Page:**

1. INTRODUCTION

1.1 Summary of Case:

Eve is the third child of her mother (M1) and her father (F1). She lived with both parents and her siblings S1 aged 14 years and S2 aged 6 years. F1 has an adult child who does not live with the family.

All three children were subject to Child Protection Plans under the category of neglect, in the case of the older children, since November 2012 and for Eve from birth. The older children had previously been subject to child protection plans in 2006 under the same category.

Concerns for the children focused upon long standing maternal substance misuse, persistent and long standing parental failure to address the children's health and educational needs and non-cooperation with agencies attempting to help the children, and with adult addiction services, both prior to and since the implementation of the Child Protection Plan. These concerns escalated until December 2012, when a Letter Before Proceedings was issued, due to the family's persistent failure to engage with the Plan.

Following that, the family increased their engagement with the Plan and the letter was withdrawn, and a Written Agreement was put in place to clarify agencies expectations of the family. Eve was born on the 09.03.2013, with a dependence on methadone and began to exhibit withdrawal symptoms. Eve was prescribed Oramorph to address this. M1 and Eve were discharged home on the 14.03.2013.

On 30.03.2013 an ambulance was called to the family home at 09.00hrs. S1 had found M1 asleep on the sofa with Eve in her arms. Eve appeared lifeless. M1 was roused and rang the Emergency Services and was advised on administering CPR. The baby was transferred to the Hospital by ambulance and Northumbria Police was alerted. Initially it was believed that there were no suspicious circumstances in relation to the baby's death, but subsequently, the pathology report identified a fractured skull, and another possible neurological injury.

The cause of death is unascertained at the time of writing. The Post Mortem revealed the following:

- Recent large bruise to the top of the head
- Skull fracture
- Haemorrhage to the lungs
- Entradural Haemorrhage around the spinal cord

Although the likelihood is that the fracture was the result of either a forcible blunt blow to the head or an injury caused from being dropped, crushing or symptoms relating to Sudden Unexpected Death in Infancy (SUDI) cannot be fully eliminated therefore and as a result causation cannot be established. Nevertheless Eve, a baby

identified as being at risk has died, whilst subject to a Child Protection Plan, and with unexplained injuries.

M1 was charged with neglect of a child or young person on 24.1.14, and she pleaded guilty to two charges of neglect at Newcastle Crown Court. There was no trial; M1 was sentenced on the 23.10.14. M1 was given a six-month prison sentence, which was suspended for two years with a Supervision Order for two years.

1.2 Purpose of the review:

The Review was carried out in accordance with section 7 of the Local Authority Social Services Act 1970, section 11 and 16 of the Children Act 2004, regulation 5 of the Local Safeguarding Children Boards Regulations 2006 and the statutory guidance Working Together to Safeguard Children 2010, chapter 8.

Working Together to Safeguard Children (2010) states that a Safeguarding Children Board should undertake a Serious Case Review when a child dies **and** abuse or neglect is known or suspected to be a factor in the death. They should consider whether to conduct a SCR whenever;

- A child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; or
- A child has been subjected to serious sexual abuse; or
- A parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004; or
- A child has been seriously harmed following a violent assault perpetrated by another child or an adult;

  and The case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.

The purpose of the review is to

- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
- Identify clearly what these lessons are, how they will be acted upon, and what is expected as a result.
- Improve inter-agency working, better safeguarding and promoting the welfare of children.

1.3 Terms of Reference:

1. The Serious Case Review (SCR) process will be Chaired independently

2. An Overview Report will be commissioned from an Independent Author.

3. Report Authors should provide a detailed chronology and analysis of their involvement with the family from January 2012 up to 30th March 2013.

   Authors are also requested to produce a summary of any historical involvement with the family, with sufficient detail to provide the reader with an understanding of family dynamics and provide a context for the current circumstances. This should include relevant information about S1 and S2's earlier life including the circumstances of the previous child protection plan in 2006. Authors should consider throughout, as part of their analysis whether historical information was given appropriate consideration with regard to decision-making in the present circumstances.

4. Throughout the IMR's, authors are asked to consider any recurring themes from previous local or national case reviews. (The authors group will receive advice in relation to any thematic links emerging with local case reviews)

5. Were practitioners aware of and sensitive to the needs of the child and where appropriate, were the child's wishes and feelings ascertained and taken into account when making decisions about the provision of services?

6. Was practice sensitive to racial, cultural, linguistic and religious beliefs?

7. With regard to the circumstances prior to and during the 2012 Child Protection Plan: Did the agencies assessments include an appropriate assessment of risk? Authors should comment upon the impact of these assessments on the decision making in this case. Please consider the following:

   - Were robust ante-natal assessments undertaken and did they result in appropriate planning and decision making?
   - Was planning around the discharge of Eve made on a multi-agency basis and evidence based?
   - Was professional contact with the family following discharge adequate?
   - What assessment and analysis was undertaken to establish parental competence to administer oramorph and to provide appropriate care generally to Eve, in light of her needs at birth?
   - Did all of the agencies assessments give appropriate consideration to the potential impact of a new baby on this family, in the context of the long standing concerns about parenting capacity, the pre-existing concern for the children's safety and the evidence with regard to the vulnerability of babies?
   - Did assessments pay appropriate attention to the role of the father in this family?

- Were the assessment processes undertaken as part of the 2012 child protection investigation thorough and robust?
- Did all agencies that held information make an appropriate contribution to the child protection investigation? Were all agencies that may have held information asked to contribute to the child protection investigations?
- Did all agencies involved with the family attend and contribute relevant information to the Initial case conference in November 2012?
- Were decisions reached appropriate and justifiable at the time? Was there an analysis of risk in the context of neglect and a danger statement outlining the risk to the children and the unborn baby?

8. Core group meetings:

- Comment on the use made by the Core Group of the Written Agreement and if any changes to the Written Agreement were based upon sound assessment.
- Was there appropriate membership of and attendance at the Core Group meetings, and were meetings held within the required timescales?
- Is there evidence of appropriate, co-ordinated planning to implement the Child Protection Plan with identifiable desired outcomes for the children and the (then) unborn baby? Did the plan change following the birth of Eve and was this based on a reassessment of the family circumstances?
- How did Core group members feel about their contribution to the group, and did they feel able to challenge the views of other members?

9. When the family failed to engage with the child protection plan, did agencies respond appropriately? Please consider:

a. Had the practitioners in the core group attended NSCB training on working with families who are difficult to engage?
b. Were agencies aware of the NSCB guidance on working with hostile and resistant families? Was this guidance followed?
c. Were decisions made and actions taken concerning failure to engage, appropriate and justifiable at the time?
With regard to the Letter before Proceedings (both in terms of issuing it and withdrawing it):

- Were the decisions made appropriate and justifiable at the time and based on a current understanding of the family's circumstances?
- How were these decisions reached?
- Was the assessment process with regard to this (especially the withdrawal of the letter) robust and based upon sound evidence of change?

10. Was supervision provided to staff working with the family and if so, taken up in accordance with the agencies supervision policy? Describe the quality of the supervision and how it influenced the management of the case.

11. Were there organisational factors that had a bearing on how the work within the family was conducted by the agency? E.g. workload, staff sickness, vacancies, absence of supervisor, organisational change.

12. Was there sufficient Management accountability for decision-making and was information escalated to Senior Managers/supervisors as appropriate?

13. Each agency should consider what the key points of intervention were in this case, which may have influenced the outcome.

14. Agency recommendations should be concise and specific and enable the Board to be assured that the frameworks and agreements it puts in place are fit for purpose, fully understood and applied.

15. **For NHS Commissioning IMR only**

A NHS commissioning IMR should be completed by the Designated Nurse based upon relevant information and recommendations from individual Health Reports, but also to consider:

a. What does the review tell us about the safeguarding aspects of the health service offered to the family including: most significant learning, any significant gaps and missed opportunities in care or service delivery?
b. What were the most significant elements of notable practice in the commissioned health services provided?
c. Were there any relevant issues regarding how health organisations interacted together? If so how did they impact upon the progress with the case?
d. Are there lessons to be learned in relation to the interfaces between the health services?
e. Are there any proposed changes to the commissioning arrangements or process with provider organisations to ensure robust arrangements are in place?

NB-Authors should consider the events that occurred, why decisions were made, and the actions taken or not taken. Where judgments were made or actions taken which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why something either did or did not happen. Particular reference should be made to the learning issues for the agency and any areas of good practice should be highlighted. Authors should also reference current research, as appropriate throughout their reports.

1.4 Individual Management Review Reports:

Agencies involved with Eve and from whom IMR reports were required were as follows:

1. Northumberland County Council Children's Services
2. Northumberland County Council Education Services
3. North East Ambulance Service

4. Northumbria Healthcare NHS Foundation Trust
5. Northumbria Probation Service (it should be noted that Northumbria Probation Service had no contact with the family either during M1's pregnancy with Eve, or following her birth. Within timescale for this review, there were only three months remaining of M1's last order. However, with the requirement to examine historical involvement with regard to S1 and S2's earlier life, the IMR considered contact with the family from July 2002
6. Northumberland Tyne & Wear NHS Foundation Trust
7. Newcastle Upon Tyne Hospitals NHS Foundation Trust
8. Primary Care (GP Service)
9. Northumbria Police
10. Northumbria Dental Service
11. Northumberland Clinical Commissioning Group
12. Northumberland County Council Legal Services

1.5 NHS Commissioning IMR:

An NHS commissioning IMR was also required for this review, in line with Working Together 2010.

1.6 The Involvement of the Family in the Serious Case Review:

The Safeguarding Standards Manager wrote to the parents on 19.04.2013, to inform them of this review and ascertain how they wanted to contribute to the review and to seek consent for professionals to view family medical records.

Both parents were interviewed on the 8th January 2015 by the overview report author and the NHS commissioning IMR author. This was towards the end of the review process following the court proceedings in relation to Eve's death. The purpose of the meeting was to listen to the views of both parents regarding the help that was offered to them as a family and to understand their perspectives on the important learning that arises from Eve's death.

A decision was made not to interview the siblings S1 and S2. It was felt that on balance this would have been damaging to their emotional well-being.

Overview Report Author details: The Overview Report author has a professional background of over 20 years in the statutory Social Work sector including Senior Management of Children's Safeguarding Services in Northumberland County Council until 2011. His final position was Safeguarding Standards Manager, which included the Conference Chairs Team; however, this did not coincide with any period that the children were subject to child protection plans. In this capacity he also had no management responsibility for any of the operational teams subject to this Serious Case Review (SCR) for the time period under review.

As an independent social work consultant since 2011, he has authored several case and service reviews. He has also led improvement work for a range of Local Authorities, including as a safeguarding sector specialist on behalf of the Children's Improvement Board and as part of a safeguarding peer review team on behalf of the Local Government Association.

2. SUMMARY OF KEY LEARNING

2.1 Views of Eve's parents

Both parents were seen towards the end of the review process following the court proceedings in relation to Eve's death. The purpose of the meeting was to listen to the views of both parents regarding the help that was offered to them as a family and to understand their perspectives on the important learning that arises from Eve's death.

M1 recalls being very happy with the pregnancy and that she had gone to the Hospital to detox.

She was happy with the service provided by the Substance Misuse Clinic and found the most positive professional to be the family Health Visitor, who both parents felt was genuine and down to earth. They also felt that the Community Support Worker provided useful practical support.

In terms of the earlier concerns regarding Eve's sibling's dental health, F1 felt that there was unfair criticism of their parenting because you would have had to be a Dentist to see what was wrong and that one child would often run away when an appointment was due. M1 felt that she should have watched over the children when they were brushing their teeth.

M1's view was that she did not understand the reason for Eve's death but that M1 suffered from fits and when M1 had woken up on the morning of Eve's death, she found that Eve was not responding.

Both parents felt that they didn't receive information about the dangers of co-sleeping and that dad wasn't included in discussions regarding this type of advice. They both felt that this information giving should be improved. M1 stated that, "I should not have been co-sleeping on the settee with her".

Both parents felt that they were not able to trust the Social Worker and that communication was poor. In particular they felt that evidence would be interpreted negatively by the Social Worker and this contributed to a lack of a good working relationship. For example, a camera and tripod in the living room was described as *"suspicious"* when it actually related to F1's work as a photographer. The parents stated: *"They have their agenda, they are not interested in what parents say"* and that *"They never wrote the positive things down".*

Both parents found multi-agency meetings very difficult and formal and that they were not really supported to get involved. They felt communication was poor and stated that sometimes they didn't know that meetings were taking place. Both parents felt that the Child Protection Conferences were one sided against the family and, for M1, although the chair showed some understanding this was not enough. Meetings would be improved if the understanding was better and practical help offered. The parents felt that professionals *"looked down on them".*

Furthermore they only received professional's reports 1-2 days before the meeting, sometimes only on the day of the meeting and that there was too much to read and really understand.

Also when there were lots of people absent from meetings they felt this didn't reflect the supposed seriousness and were left with a feeling that people were not really concerned but were just doing their job.

Overall, they did not feel the assessment or written agreement was of any value, they did not agree that the children were at risk and from their point of view no aspect of the assessment was correct. M1 felt that they were painted as *"bad people".* F1 thought that the Social Worker was working from a template and did not have a specific understanding of their family and was not interested in their views as parents. Overall they felt that there was a fundamental lack of fairness.

2.2 Understanding and working with children's experiences

Throughout the entire period of this review and specifically between January 2012 and April 2013 it is difficult to see the children's experience being considered as central to professional practice. The needs and behaviour of both parents is crucial to the children and of course professionals were seeking to assess and deliver services that were helpful, however, there is a sense of the needs of M1 and understanding the risk she might present overwhelming the ability of professionals to view events through the eyes of the children.

Both children had lived all their lives with M1 and substance misuse, the involvement of the Northumbria Police and physical discomfort in terms of S2's eyesight and S1's dental health. S1 was relatively marginalised at school and S2 was significantly behind her peers. How the children felt about this, what they wanted to be different, how they wanted to be parented does not come through in the records considered as part of this review. I think it was unlikely that the Social Worker was able to spend enough time with the children that would allow this relationship to develop, and to develop from this relationship, a plan of intervention sensitive to their needs and detailed enough to address the sorts of issues raised by Cleaver et al:

"Children's ability to cope is related to their age, gender and individual personality. Children of the same gender as the parent experiencing difficulties may be at greater risk of developing emotional and behavioural problems. Children's ability to cope is related to a sense of self-esteem and self-confidence; feeling in control and capable of dealing with change; and having a range of approaches for solving problems. Such traits are fostered by secure, stable and affectionate relationships and experiences of success and achievement."

Very early on the well-being of the children appears not to have been considered by the GP. According to the Primary Care (G.P Service) IMR they were *"overlooked".* This may be a function of the lack of opportunity taken by the GP to engage in the broader conversation with other professionals about the needs of the children.

Many other decisions appear to have been taken without consideration of the children's wishes and feelings, for example:

- S1's and S2's de-registration from the Child Protection Register, in 2007, 2 months prior to M1's assessment by the Addictions Service.
- Offending behaviour, medical and dental issues for the children were not properly integrated into the shared professional understanding of the family. For example, S1's dental health (in March, July and October 2011, S1 was seen by 3 different GPs for gum swelling, dental abscess and toothache due to apparent inability to see a dentist) and S2's squint. This period also marked the beginning of S1's offending behaviour, burglary, in November 2009, aged 10. There was also the failure to follow up for S1's medical review in relation to a leg injury in June 2011.

There was also a significant gap during 2012 when the children were not being seen at home by the Social Worker and their experience of home life was largely invisible. It is not clear what focused assessment took place and there is a persistent gap in relation to understanding the children's views of their own *'safety and welfare'*. Why this was the case is difficult to understand, nevertheless I think it is likely that the children were suffering significant harm throughout this period and that child protection action could and should have been instigated on a number of occasions from 2004 up to the Initial Child Protection Conference (ICPC) in 2012 (excluding the period in 2006-07 when they were placed on the Child Protection register). In their analysis of serious case reviews Ofsted (2010) have noted how some children were only able to speak about their experiences once away from the home and suggest this underlines the importance of providing a safe and trusting environment, away from carers, for children to be able to speak about concerns. For S1 and S2 this opportunity was never realised and may explain why so little was understood about their feelings.

Multi-agency safeguarding practice in relation to Eve was inadequate in most respects and showed little sensitivity to her need for the right level of care and protection. This is evidenced throughout most of the IMRs in relation to the absence of acceptable standards of multi-agency planning around her birth and discharge from Hospital, poor levels of midwifery and health visitor oversight following discharge, the confusion and lack of management of M1's prescription and Eve's needs as set out in the joint pathway between health professionals and the failure of the core group to escalate this concern as one of critical and immediate risk.

Understanding the needs of children through a meaningful relationship with them features in both the Daniel Pelka and Keanu Williams serious case reviews and was highlighted as a key safeguarding practice issue by Eileen Munro. It is likely therefore that this issue is not going to be restricted to work with this particular family and potentially underlies and challenges safeguarding practice in Northumberland, as it will in many other Local Authorities. As will be clear from the above my view is that this could potentially have a serious and detrimental impact on the reliability of safeguarding practice and the safety of children. Establishing a relationship with children in families where the adults are rejecting concerns and the help offered is difficult, but should remain central to the social work task.

Eve and her family were of white British descent with English as their first language.

The family members' religion is recorded as Church of England. The family lived in a relatively deprived area with high unemployment although F1 had been self-employed at times. There is no evidence in the IMRs that practice was insensitive to racial, cultural, linguistic and religious beliefs.

2.3 Assessment, thresholds for action and decision-making

There are major flaws in assessment practice in relation to S1 and S2's needs prior to 2012 and to the multi-agency work undertaken in relation to Eve from September 2012 onwards. In addition there are examples of flawed application of thresholds and decision-making apparent in this case. The children remained as "children in need" for too long and although there was a period of Child Protection Registration this was not particularly distinguishable from any other period, in terms of the risks they were likely to be exposed to. The removal of the children's names from the Child Protection Register in 2007 was over optimistic and unrelated to the facts of family life at that point or the evidence. Further evidence of risk was clear in 2009, 2010, 2011 and much earlier in 2012 than November, when a Section 47 Investigation took place. Care team meetings in retrospect can give the impression of being snapshots of current events rather than providing a longer-term perspective and analysis.

It appears that any evidence of parental engagement or improvement, however short term, led to professionals becoming reassured very quickly. This was not corrected by either multi-disciplinary Conferences or care and Core Group meetings. Some professionals did raise concerns throughout 2012 but this did not as a rule, lead to child protection action and when it did, in November, the investigation fell short of the expected standards of safeguarding. Although attempts were made, the parents were not interviewed; in fact they had not been seen by SW2 since 12.9.12. The children's views were also not gathered. The Initial Child Protection Conference (ICPC) meeting was clearly not compliant with the LSCB multi-agency safeguarding procedures and these practice failures were a significant detriment in engaging with the family on a new safeguarding footing and developing a meaningful child protection plan.

It may be that "confirmation bias" was undermining accurate assessment at this point and that practitioners were overwhelmed by the case:

"The capacity to understand the ways in which children are at risk of harm requires clear thinking. Practitioners who are overwhelmed, not just with the volume of work but by the nature of the work, may not be able to do even the simple things well." **(Cooper et al 2003, Cooper 2005 in A Biennial Analysis of Serious Case Reviews 2005-07).**

No evidence has been presented regarding specific caseloads for professionals at this time so how much this factor was present is difficult to assess.

As described in other reports (Pelka, Williams and the most recent management review "John" in Northumberland) there was no attempt to clarify the background history in relation to F1, which is basic social work practice and a procedural requirement. F1 continued to be viewed positively whilst very little was actually

known about him. This hypothesis should have been tested through evidence gathering and focused assessment.

The GP assessments of M1's wellbeing and capacity almost never led to any further action in relation to the welfare of the children and this was compounded by the lack of contribution to the Child Protection Conferences in 2006, 2007, 2012 and 2013. Critical information was as a result not available to inform any assessments being made and subsequent decision making.

The safeguarding practice by the Midwifery Service was inadequate, both in terms of engaging with multi-agency assessment and recognising when thresholds for action had been reached, for example, the failure to refer to Northumberland County Council Children's Services by the CMW1 at the booking in appointment on 15.11.12. It must also be of concern that the CMW1 did not have any knowledge of withdrawal symptoms in babies or the risks in relation to the management of a baby suffering withdrawal including the risks associated with Oramorph. Perhaps in part as a consequence of this the Community Midwife did not discuss the issues with M1 and did not consider the risks for Eve, make appropriate referrals or seek support in relation to her practice.

There was no multi-agency birth plan for Eve and no multi-agency pre-discharge meeting to ensure that the proper assessments had been completed to gauge her potential impact on the caring capacity of the family and to establish her safe return home. Mixed messages were given in relation to concern regarding the amount of drugs M1 was leaving Hospital with and whether Eve was fit to go home. Advice was given by hospital staff regarding administration and safe storage of Oramorph; however, in light of the inadequate planning in relation to Eve's discharge home, I do not believe that parental competence to administer Oramorph was established to a high enough level of confidence. There was no clear and robust plan regarding the management of M1's prescription or care pathway followed. These were serious and fundamental failures of safeguarding practice. The care pathway, that was so inadequately applied to the care of Eve, and support offered to pregnant substance misusers, was of concern in Northumberland in a 2008 Case Review. This reinforces the importance of resolving the underlying dysfunctional organisational relationship between Obstetrics and the Addictions Service that was present at that time, which could have potentially affected the care of other vulnerable babies. I would strongly endorse the NHS commissioning IMR's conclusions and recommendation in this respect. It is also to be noted that the relevant agencies have, during the course of this review, recognised the need to improve their systems, practice, the pathway and the assurance to the LSCB that it is working satisfactorily.

Northumbria Police could have raised concerns in 2009-10 and sought further discussion with Northumberland Children's Services regarding the welfare of the children, if the pattern of Child Concern Notifications (CCNs) had been reviewed as a whole. The CCNs were focused in the main on poor supervision of the children. The incident involving S3 and an alleged assault on 11.1.13 was inadequately investigated. The lack of a Police CCN prevented a more rounded assessment of S3's safety. It also prevented any implications for S1, S2 and unborn Eve being considered.

Both Northumberland County Council Children's Services and Northumbria Healthcare NHS Foundation Trust IMR authors note the absence of chronologies as a working tool in Eve's case. The value of an integrated chronology during this period would have been enormous in highlighting the longstanding chronic neglect and the persistence of M1's drug misuse. It would also have provided other professionals with the evidence required, to reflect on their understanding of risk and, if necessary, challenge decision-making. This may have resulted in earlier child protection action.

On occasion the Signs of Safety framework was used to help organise the assessment and analysis being done in meetings. For example, the designated person for child protection from S1's school is noted in the Education Service IMR as commenting that "*There is agreement that S1 was a victim of neglect but not that he was in danger, for example there were no scores of 0 at the Signs of Safety event."*

Interestingly a previous SCR also undertaken by Coventry LSCB (child W) examined the use of the signs of safety tool and reported:

"The Review Team concluded that problems resulting from the use of the tool were likely to be due to its application when the scoring is not clear-cut rather than a fundamental problem with the tool itself… The 'signs of safety' tool has much to commend it and is now in widespread use in Coventry and elsewhere. The case under review revealed the possibility of ambiguous interpretation of its findings and a lack of confidence in some staff regarding results in the mid-range of its scale where there was an indefinite indication of risk."

There is no evidence presented by the Agency IMRs in relation to Eve that the Signs of Safety framework was a barrier to proper assessment and the understanding of risk or whether a lack of confidence following mid-range scores was present in relation to work with Eve's family.

One aspect of the case management that may have changed if intervention levels had increased earlier was the likelihood of Legal Orders being sought and being in place for Eve at birth, setting a safe framework for assessment, as apparently understood to be the plan by the SHA1 prior to the end of her involvement in January 2013. These children were not invisible, they had an allocated Social Worker, M1 had an Addictions Worker for a considerable amount of time and at the time of Eve's death all the children were subject to Child Protection Plans.

In my view, cumulative professional misjudgement over a considerable period of time resulted in thresholds of concern not being adequately recognised in particular the threshold of "significant harm". Although it is difficult to attribute any of the circumstances of the case as directly relevant to the cause of Eve's death it is possible that had legal orders been sought then, following her birth, Eve would not have returned home to the sole care of her parents, until proper assessment had taken place in circumstances where Eve's safety was guaranteed away from the family home.

2.4 Commitment and contribution to multi-agency safeguarding and information sharing practice

Information sharing in this case often failed to ensure accurate assessments and plans were in place for the children.

Information sharing by the GP practice was inadequate and they were peripheral to the work with the family and the management of any risk. They neither attended nor provided reports to critical Child Protection Conferences in clear breach of the guidance contained in the GP toolkit for General Practice[1]. They were also omitted from the report distribution list on occasions, which compounded their exclusion from the safeguarding system. They had important information in relation to M1 on a number of occasions following appointments and did not consider the need to share with Northumberland County Council Children's Services. The Keanu Williams Serious Case Review referred to the importance of assessments including all relevant agency information and two previous Management Reviews in Northumberland have found serious deficiencies in GP information sharing and engagement in multi-agency safeguarding practice. The question asked in the previous review was whether this was evidence of a wider 'cultural' development in local safeguarding practice and of a growing professional gulf between GPs and the investigation of safeguarding concerns? This was subject to a previous recommendation and will be returned to in this report's recommendations.

The Northumbria Healthcare NHS Foundation Trust IMR provides a clear analysis of the failure of the dental service to share information in relation to S1 with other professionals. This included the diagnoses of severe dental caries; extremely poor oral hygiene and that S1 had missed a number of important appointments for treatment. This suggests that the dentists did not consider that these issues may have been an indicator of neglect or that they had clearly thought about the possible social impacts on S1 and what this may have meant in terms of the parental care he was receiving. The dentists acknowledged that for many reasons, they struggle with deciding when a case reaches the threshold for further intervention. The Northumbria Healthcare NHS Foundation Trust IMR addresses this in recommendation 4.

The NHS Commissioning IMR author has also made a recommendation for NHS England to ensure that private dentists receive safeguarding training in particular with respect to the impact of neglect on children dental health.

There was a significant information sharing failure by S2's school, an independent school, in July 2012 in relation to informing Northumberland County Council Children's Services that M1 was pregnant. A connection was not made between the failure to share this information clearly and the potential level of risk to the unborn baby. The two other children were also without school as a protective factor during

[1] Safeguarding children and young people. A toolkit for General Practice (2011) Royal College of General Practitioners (RCGP) and the National Society for the Prevention of Cruelty to Children (NSPCC)

the 6-week holiday which ensued. There then followed further delays by others in sharing this information with the Addictions Service that at that time had the responsibility for M1's prescription.

The Northumberland County Council Education Service IMR identified a number of learning points in relation to independent schools, for example, safeguarding, professional boundaries, training, Governor body safeguarding experience and accountability issues.

I would endorse the importance of the areas highlighted above and the recommendation with respect to the application process.

Of course the Northumberland County Council Education Service IMR and this Overview Report are not suggesting that one can attribute the failure to clearly report M1's pregnancy to the fact that the school was an independent school. However, the duty to safeguard children and the complexity of multi-agency safeguarding practice challenges do not, in my view, appear prominently enough in any of the independent school application documents reviewed, these include the application forms and relevant DfE guidance.

There is reference to a 'child protection policy and procedures' as a required document but to get any detail regarding safeguarding, for example, from Working Together 2013 or the Governors Handbook (s.4.9 Safeguarding and promoting the welfare of pupils), this has to done through links from the main documents.

Legal advice to this Serious Case Review (SCR) notes that:

"Section 175 of the Education Act places a duty on local authorities in relation to their education functions, the governing bodies of maintained schools and the governing bodies of further education institutions (which include sixth-form colleges) to exercise their functions with a view of safeguarding and promoting the welfare of children who are either pupils at a school or who are students under 18 years of age attending further education institutions. The same duty applies to independent schools . . . by virtue of regulations made under Section 157 of this Act…all educational settings to whom the duty applies should have in place the arrangements that reflect the importance of safeguarding and promoting the welfare of children set out in 'Working Together' 2013."

For there to be professional and public confidence in the ability of all independent schools to fulfil their statutory duties in relation to protecting children the application process and documentation should address safeguarding issues much more robustly.

The invitations issued and attendance at Child Protection meetings was insufficient and a consistent theme of practice from 2006 onwards. Professional understanding and commitment to safeguarding, as an essentially multi-agency practice, is not evidenced nearly enough. In 2006, there was a pre-birth meeting in relation to S2, which was good practice, but there were significant gaps in information and attendance at the subsequent Initial Child Protection Conference (ICPC). These gaps were not addressed in the assessment work that followed. The attendance at

the Child Protection Conferences of 2012 and 2013 was flawed as was the distribution of the outline plan and minutes (as indicated by Northumberland Tyne & Wear NHS FoundationTrust IMR), and it is likely that both meetings, whilst going ahead to ensure minimum oversight, should have been quickly reconvened to allow proper arrangements to be put into place. As described earlier both parents felt that they were not given reports prior to the meetings in order for them to properly read and understand the content and that this affected their ability to properly work with professionals. They also felt that with the number of apologies for some meetings that this left them confused regarding the seriousness with which the issues were being viewed.

Where there were clear gaps in communication more assertive engagement should have been sought and management escalation used to assist improvements in practice. This did not happen. There was also evidence that some staff who did not attend conferences also did not read subsequent minutes. This will not have assisted the safeguarding process.

M1 did not attend any Core Group meetings and neither did the Addictions Worker. The core group did not implement an adequate child protection plan for Eve and was not challenged by the Review Child Protection Conference (RCPC) in terms of the lack of a birth plan or written agreement and did not question the lack of knowledge of the expectations set out in the Letter Before Proceedings. A professional blind spot appears to have been present in the core group of the 28.3.13 where the critical issue of M1's prescription is not addressed at all. The Core Group was not therefore involved in drawing up a Written Agreement or in agreeing critical aspects in relation to F1's supervision of M1, and the recording of F1's role, noted in various meetings, is confused. There was a serious and fundamental lack of clarity regarding the protection plan for Eve.

The Head Teacher for S2 felt that there was a shared view of risk amongst professionals in the Core Group. The Head Teacher confirmed however, that to their recollection, a birth plan was never discussed. The Head Teacher was also surprised at the decision that M1 would medicate the baby herself, and the Head Teacher knew that M1 slept on the sofa every night with her children S2 and Eve. There is no evidence that this important insight was shared with other Core Group members. If known, it should have reinforced the vulnerability of Eve to health professionals and given a more urgent focus to the work with M1 and the assessment of whether Eve could be safely cared for at home.

SHA1 did challenge and raise their concerns repeatedly in relation to the older children. All of the other health staff interviewed by Northumbria Healthcare NHS Foundation Trust stated that they felt able to challenge but did not feel any necessity to challenge the decisions.

There were discussions regarding the effectiveness of multi-agency liaison between the Obstetrician and the Addictions Service Manager but these did not lead to a demonstrable improvement in information sharing and joint action. The Core Group had a role in formally calling attention to these deficiencies but did not do so. Even with the benefit of hindsight the evident vulnerability for Eve was high and more leadership should have been given by those providing supervision to escalate

concerns to more senior managers. The circumstances around the risks were evident and were known to the multi-agency team, which are summarised well in the NHS Commissioning IMR Report:

"Eve was 3 weeks old when she died, her vulnerability was profound:

- *She was unplanned,*
- *M1 had delayed seeking ante-natal care.*
- *M1 had abused a variety of drugs while pregnant.*
- *She was born into a household with a long history of neglectful parenting.*
- *She was the subject of a Child Protection plan for neglect.*
- *She was small at birth.*
- *She was suffering from withdrawal (NAS).*
- *She was on medication (morphine).*
- *She was co-sleeping with M1 on a settee.*

None of the information listed above has been obtained as a result of information gathered for this review, it was all known (Sic: bar the co-sleeping, which was known only by the Head Teacher), by the professionals working with the family at the time and if it had been used and acted upon, Eve's vulnerability would have had the recognition it needed. Eve's vulnerability was acknowledged in the Child Protection plan; there is "increased vulnerability of the baby": this statement should have translated into actions by all the professionals involved in her care in the form of a birth plan, hospital discharge meeting and a co-ordinated, intensive visiting plan once M1 and Eve returned home."

It is difficult to explain the extent of the information sharing failure in this case and one can only consider whether Cooper et al comments regarding "overwhelm" is an unrecognized, but fundamental, feature of professional practice in relation to these children. If this is a legitimate theory as to "why" practice was the way it was, then this in itself requires further investigation and explanation.

2.5 Reflecting on practice: supervision, professional challenge and leadership

The supervision of practitioners working with Eve's family does not appear to have allowed for challenge and any error correction in thinking, analysis or planning. Although supervision with the School Health Advisor did log child protection concerns, it was only following the pregnancy of M1 that a Section 47 Investigation was undertaken. Escalation should have raised these concerns at a more senior level in Northumberland County Council Children's Services.

The ability of professionals and organisations to critically reflect on their practice is an essential component of a safeguarding system that is able to protect children. Burton's (2009)[2] key messages are worth reiterating in full:

[2] C4EO Safeguarding Briefing 3, November 2009. The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information?

- Assessments are fallible, and contexts constantly changing. Therefore, professionals need to keep their judgements under constant critical review (Munro 2008)
- The single most important factor in minimising errors is to admit that you might be wrong (Munro 2008)
- Nonetheless there is a tendency to persist in initial judgements or assessments and to re-frame, minimise or dismiss discordant new evidence. Bias is inevitable and comes from the many ways our minds can distort, avoid or exaggerate information.
- On the other hand some practitioners can respond to new information, not by sticking to their preferred view, but by jumping around from one item or theory to the next, never reaching a coherent conclusion or coordinated response.
- Therefore, practitioners must be willing, encouraged and supported to challenge, and where necessary revise, their views throughout the period of any intervention.

She concludes that:

"Supervision should provide a safe but challenging space to oversee and review cases with the help of a fresh, experienced pair of eyes and to systematically guard against either rigid adherence to a particular view or the opposite tendency to jump from one theory to another without resolution."

The supervision of Social Workers does address important items of evidence but failed to recognise the extent of the lack of engagement by parents, the importance of the children's views and the absence of a relationship with them and appears in retrospect to adhere too rigidly for too long to the view that the threshold for child protection action was not reached or that evidence was "thin". A Northumberland management review in 2011 recommended that:

"Children's Services should review the supervision guidance and the training support in place to consider whether it is fit for purpose and making recommendations for improvement. This should include how best to support critical reflective thinking and deliver regular in-house consultation to reinforce the supervisory function."

Another Management Review in 2013 found supervision remained an issue and on the basis of this Serious Case Review (SCR) the above recommendation would still appear to be relevant.

As with another recent Management Review in Northumberland there was no evidence found that the GP Practice contacted the safeguarding team, Designated Nurse/Doctor or named GP for advice or support. Again I think it is likely that this is a widespread issue in Northumberland and one that reduces the ability of GPs to act in the best interests of children when their safety is at risk. It was the subject of a previous review recommendation and will be returned to in this report's recommendations.

CMW1 informed the Northumbria Healthcare NHS Foundation Trust IMR author that she had not received any safeguarding children supervision for more than two years

and SMW1 had not received supervision since the 28th August 2012. It should also be recognised that there is an individual professional code of conduct duty to seek appropriate support and supervision, however, in response Northumbria Healthcare NHS Foundation Trust have confirmed that they have already made plans to improve and monitor this situation.

The Addictions Worker received both management and clinical supervision for this case from their line manager, although this was not always recorded within health records. The children were on a 'Child in Need' plan during the majority of the time scale of the review so specific safeguarding supervision was not required. However, once subject to Child Protection Plans safeguarding supervision did not take place.

Much more challenge should have been provided by the Child Protection Conferences and in particular by the conference Chairperson. In terms of the assessment, information to and professionals attendance at, meetings, engagement with parents and the procedural guidance which should have been followed in relation to the planning for Eve's birth and hospital discharge.

2.6 Procedural guidance and recording

There was procedural confusion with a number of documents apparently guiding action regarding substance misusing pregnant women and with no consistent cross-referencing between them. Since July 2011, there has also been a Northumberland Child Protection/Child in Need Birth Plan Protocol in place which is agreed by all of the hospital Trusts and LSCBs North of Tyne. The procedural requirement as set out in this last document is very clear; unfortunately this document was not referenced in the LSCB procedures. This lack of procedural clarity was a critical omission that continued throughout the work of the Core Group. This set the context for the persistent absence of coordinated action by the professionals providing care to Eve.

I believe that both the Initial Child Protection Conference (ICPC) in November 2012 and the Review Child Protection Conference (RCPC) in February 2013 should have been re-convened and that they failed to scrutinise professional practice and compliance with procedural guidance.

As stated previously it is difficult to identify comprehensive assessment work and any that did take place did not consider information regarding F1 as central to an understanding of the family. Few practitioners involved in this case appear to have completed the LSCB training 'Working with Hostile and Un-Cooperative Parents'. Not all appeared to be aware of the guidance and this may have hindered professional confidence in working with the family.

Proper case recording is also fundamental to professional safeguarding practice. The Northumbria Healthcare NHS Foundation Trust IMR, however, notes serious weaknesses in relation to recording by midwives, and I would endorse the recommendations made by this report and the NHS Commissioning IMR Report. It should be noted that the Northumbria Healthcare NHS Foundation Trust have already taken steps to improve this issue.

The Northumberland, Tyne & Wear NHS Foundation Trust IMR is also clear that record-keeping policy was not always followed and very often telephone calls and emails were not recorded or uploaded onto the health records electronic system. The Northumberland, Tyne & Wear NHS Foundation Trust has taken immediate action to ensure all emails etc and Multi-Disciplinary Team meetings are recorded in patient's health records.

2.7 Organisational factors

Whilst most of the IMR authors have not identified any major adverse impacts of any organisational factors on service delivery the general uncertainty that the change in the NHS produced is raised by the NHS Commissioning IMR Report Author who notes that some of the services in this review underwent a transfer of employment from Primary Care Trusts into acute Foundation Trusts. This resulted in changes of management personnel and structures.

There is a comment in the Northumbria Healthcare NHS Foundation Trust IMR with respect to the reduction in the capacity of the Substance Misuse Midwife and an increase in caseload, which may have affected service delivery. SMW1 cites this as negatively impacting on their ability to fulfil their role. Notwithstanding the constraints on this professional's practice, their role in this case has been examined in detail and the Northumbria Healthcare NHS Foundation Trust IMR author has addressed this issue in recommendation 7 of their report. It is to be noted that during the course of this Serious Case Review (SCR), Northumbria Healthcare NHS Foundation Trust has undertaken work around implementing improved ways of working around service delivery, procedural guidance and individual roles.

The Northumberland County Council Education Service IMR cites the lack of responsiveness to emails as a significant organisational factor and the lack of escalation early enough given the evidence provided by professionals. Further that there continues to be a concern about the overall poor professional attendance at care/core team meetings.

The Northumberland Primary Care (G.P Service) IMR also notes that the GP practice does have a monthly child safeguarding meeting which is attended by all GPs. Health Visitors are also invited, but don't always attend. The IMR author accepts that this practice may have a disproportionate level of families with child protection concerns (given the geography of the GP Practice) and has offered some advice on how to manage the caseload more effectively. The GP at interview has also agreed to invite school nurses and midwives to this meeting. Had this been in place, then there may have been different action taken in the protection of the children.

The Northumberland Tyne & Wear NHS Foundation Trust IMR doesn't highlight any organisational factors; this I feel is an omission. Although it is considered in detail elsewhere the organisational dysfunction that contributed to the rift with Obstetrics and the lack of senior management resolution is an extremely significant organisational element relevant to the findings of this review.

The Northumberland County Council Children's Services addendum describes different views regarding the demands on the Team and Team Manager. Clearly, capacity issues were recognised, given that there were conversations taking place about increasing management capacity. This is borne out by some of the detail regarding caseloads noted by the Team Manager. The view of the Service Manager interviewed points to comparable capacity to other "neighbouring" teams. Of course this does not account for differences in demand and the fact that Senior Practitioners do not have the same formal roles and responsibilities as Team Managers, as acknowledged elsewhere in the addendum.

Northumberland County Council Children's Services has quickly put in place increased management capacity following the events of this review and this is to be noted. There is not enough performance and staffing data to make a confident judgement regarding the influence of organisational factors on the service offered to Eve, however, there is a significant possibility that such factors are relevant and did affect the quality of practice.

3. CONCLUSION

The cause of Eve's death is still unascertained and therefore no one factor could be said to have predicted this tragic event. However, there were significant safeguarding failures both in front line practice across agencies and in the management systems intended to check that practice was appropriate. As a result Eve was not afforded the protection that she deserved. These challenges are not unique to Northumberland; a number of the issues which have arisen in this serious case review are also familiar themes nationally, such as:

- Poor communications between and within agencies.
- A lack of analysis of information.
- A lack of professional curiosity in questioning the information.
- A lack of confidence among professionals in challenging parents and other professionals.
- Shortcomings in recording systems and practice.
- Professional over optimism rather than to '*respectfully disbelieve'* and dealing with events as one off episodes often referred to as the '*start again syndrome*'[3]

Many of these failures relate to doing the simple things well: sharing information, seeing children, thinking and planning in relation to risk and persistence in challenging practice and decisions.

It is striking that none of the safeguarding shortfalls would have been the subject of focused investigation and reflection or come to the Safeguarding Board's attention

[3] Building on the Learning from serious case reviews: 2007 – 2009 Brandon et al.

had Eve not died. As a result of this review improved professional practice must be supported and the ability to reflect on the quality of assessment and planning for children strengthened.

4. RECOMMENDATIONS

All recommendations identified in the NHS Commissioning IMR, Agency IMRs and the Northumberland County Council Children's Services addendum are accepted with the following additions intended to strengthen existing recommendations or address additional issues (timescales are in relation to the period following the overview report being accepted and signed off by the LSCB).

Understanding and working with children's experiences

1. Northumberland County Council Children's Services – In response to the gaps in contact with the family evident in this case, an audit of home visiting frequency and duration of time spent with children in need and those in need of protection should be undertaken to seek assurance that this is not a broader feature of practice. Quantitative and qualitative performance measures should be established in relation to the:

- Time spent with children by social workers.
- Quality of work undertaken including the voice of the child.

This will be assisted by Northumberland County Council Children's Services reviewing and clarifying the expectation for staff in relation to the purpose and activities undertaken with children that are considered most helpful in understanding their wishes and feelings. **Proposal to be presented to the Board within 3 months. Review and report to the Board within 6 months.**

2. LSCB – The levels of professional contact with the family, including significant gaps in contact and missed appointments, was an issue for all agencies and the LSCB should investigate whether this is a broader feature of practice in other cases. This investigation will need to take into account the different levels of relationship that are expected to be established with children within the context of individual services' roles and purpose. This should inform a report to the LSCB with any further recommendations for improved guidance and practitioner support. **Proposal to be presented to the Board within 3 months. Review and report to the Board within 6 months.**

Assessment, thresholds for action and decision-making

3. LSCB – A recent Management review in 2013 recommended that:

Building on lessons from 'Ages of Concern' the NSCB should take a strategic overview of the involvement of fathers in assessments of risk. Recommendations for improvement and reporting to the NSCB should follow.

The assessment of fathers remains an issue in this case; therefore this recommendation should be revisited. The LSCB should seek assurance in terms of the implementation of the previous recommendations, identify gaps and work yet to be completed, complete outstanding work and audit impact. **Review and Report to the LSCB within 9 months.**

4. LSCB - Few practitioners involved in this case appear to have completed the LSCB training 'Working with Hostile and Un-Cooperative Parents'. Not all appeared to be aware of the guidance and this may have hindered professional confidence in working with the family. The Board should audit awareness of the guidance and review the on-going training provision in this area of practice including the uptake of the current training course or any other method of practice support, by all partner agencies and establish targets for attendance. **Review and proposal to the Board within 3 months, agreed framework for practice support in this area in place by 6 months.**

5. LSCB – The findings of this review are that multi-agency assessment work in relation to the children was inadequate. Key areas of weakness relate to:

- Poor understanding and analysis of risk and the impact of chronic neglect.
- Over optimism in relation to assessed improvement.
- Lack of understanding regarding the history and role of the children's father.
- Poor understanding and analysis of the children's experiences and the impact of the care provided to them.
- Poor use of chronological information to support the analysis of risk.
- Poor understanding of the threshold for significant harm.

The LSCB should seek assurance that under the recently implemented new assessment framework the quality of assessments in relation to children is of an acceptable standard. **Review and report to the Board within 6 months.**

Commitment and contribution to multi-agency safeguarding and information sharing practice

6. LSCB and NHS England – A management review in 2011 and more recently in 2013 recommended that:

LSCB, Northumberland Clinical Commissioning Group (CCG) and NHS England should commission a broad investigation/thematic review of the role and responsibilities of GPs in the safeguarding system, in order to answer for Northumberland the following questions:

- Is there sufficient understanding of safeguarding information sharing practice?

- How can any barriers to multi-agency safeguarding practice be reduced?
- What additional support is necessary?
- How can the specialist support via named and designated staff be made more accessible and utilised by GPs?

The responsibilities of GPs in the safeguarding system remain an issue in this case; therefore these recommendations should be re-visited. The LSCB should seek assurance in terms of the implementation of these previous recommendations, identify gaps and work yet to be completed, complete outstanding work and audit impact. This supports the related Primary Care (G.P Service) IMR recommendation. **Recommendations for improvement and report to the LSCB from NHS England should follow within 9 months.**

7. LSCB and Department for Education - For there to be professional and public confidence in the ability of independent schools to fulfil their statutory duties in relation to protecting children the application process and documentation should be reviewed in order to ensure that it addresses safeguarding standards much more robustly. **Report to the LSCB on agreed actions within 6 months.**

Reflecting on practice: supervision, professional challenge and leadership

8. LSCB – The Board should review its multi-agency mechanisms for supporting practitioners' critical reflection in their work in the following ways:

- In relation to specific areas of practice to ensure that they are fit for purpose. The processes in place or to be developed should begin with the issues set out in this review in relation to the investigation and working with neglect, substance misuse, understanding and working with children's experience, legal planning and the risks to babies.
- The role of conference chairs and safeguarding nurses are critical in developing criteria for the need for additional reflection in specific cases. The LSCB should establish ways in which their challenge and reflection role can be strengthened in order to provide a fresh pair of eyes, identify and prevent drift and focus on the effectiveness of multi-agency working.

Review and Report to the LSCB within 9 months.

9. LSCB – As part of its responsibility to monitor the effectiveness of partners' implementation of their duties under S11 of the Children Act 2004, the Board should ensure that the learning from this review informs any future S11 review/audit. In particular that single agency supervision guidance and training is fit for purpose and that any recommendations for improvement are put in place. **Review and Report to the LSCB within 12 months.**

10. LSCB – A recent Management review in 2013 recommended that: LSCB to review the operation and use made of the "escalation and resolution of professional

disagreements protocol", and to recommend any improvements to the Board for implementation.

The escalation of concerns remains an issue in this case; therefore this recommendation should be revisited. The LSCB should seek assurance in terms of the implementation of the previous recommendations, identify gaps and work yet to be completed, complete outstanding work and develop a process for understanding impact. **Report to the LSCB within 6 months.**

Procedural guidance and recording

11. LSCB – The LSCB should implement local procedural change to ensure that integrated multi-agency chronologies are available to core group meetings, initial child protection conferences and review conferences. Chronologies should be proportionate and focus on improving the quality of analysis in individual cases. Procedural guidance should place the responsibility for maintenance of an up-to-date chronology with the core group. **Planning and preparation for this change within 6 months. Implementation by all partner agencies within 9 months.**

12. LSCB – Given the non-compliance with the Northumberland birth plan protocol the Board should ensure that the LSCB procedures do include the protocol and review its processes for agreement and dissemination of changes to procedures and guidance. In particular ensuring that changes as a result of this serious case review are communicated and accessible to all staff in relevant agencies. **Review and report to the Board within 3 months.**

13. LSCB and Northumberland County Council Children's Services – Given the absence of a shared written agreement for the core group, the LSCB multi-agency procedures in regard to core groups and working agreements should be reviewed to ensure that they are fit for purpose. This should include, but not be limited to, timescales for completion, factors in relation to parental agreement and specific scrutiny/review at core group meetings and conferences. The LSCB should communicate the expectations to all partners and conduct a themed audit to give assurance regarding the quality of practice regarding core groups and working agreements. **Procedural review and LSCB communication immediately, themed audit within 3 months.**

14. Northumbria Police and Northumberland County Council Children's Services – Northumbria Police could have raised concerns in 2009-10 and sought further discussion with Northumberland County Council Children's Services regarding the welfare of the children, if the pattern of Child Care Notification's (CCNs) had been reviewed as a whole. In partnership with Northumbria Police, Northumberland County Council Children's Services and to link in with new practice in Northumbria Healthcare NHS Foundation Trust, there should be a review of procedural guidance around CCNs. In particular whether thresholds/trigger points should be put in place regarding patterns and numbers of CCNs that would trigger a specific procedural requirement for a case discussion between the agencies. **Review and report to the Board within 6 months.**

15. Northumberland County Council Children's Services and Northumberland County

Council Legal Services - To revise procedural guidance in relation to the use of Letters Before Proceedings. To ensure that Northumberland County Council Children's Services in making their decisions in legal meetings/discussions or in Letter Before Proceedings planning meetings, including later decisions to withdraw, have robust multi-disciplinary involvement. This will support a focus on evidence and multi-disciplinary responsibility to assess improvement and the formal escalation of concerns where necessary. Any guidance should stipulate that escalation should be considered above the level of Team Manager and should include child protection chairpersons where they are involved. This endorses the IMR recommendations made by Children's Services and this should be additionally scrutinised by a themed audit of practice within 9 months. **Procedural change - review and report to the Board within 3 months. Audit to report to the Board within 10 months.**

Organisational factors

16. LSCB – Given IMR statements that conference documentation was not always received and the expressed views of parents regarding the poor sharing of reports and attendance at meetings, a review of the conference process should be undertaken to ensure it is fit for purpose. This should include a review of the:

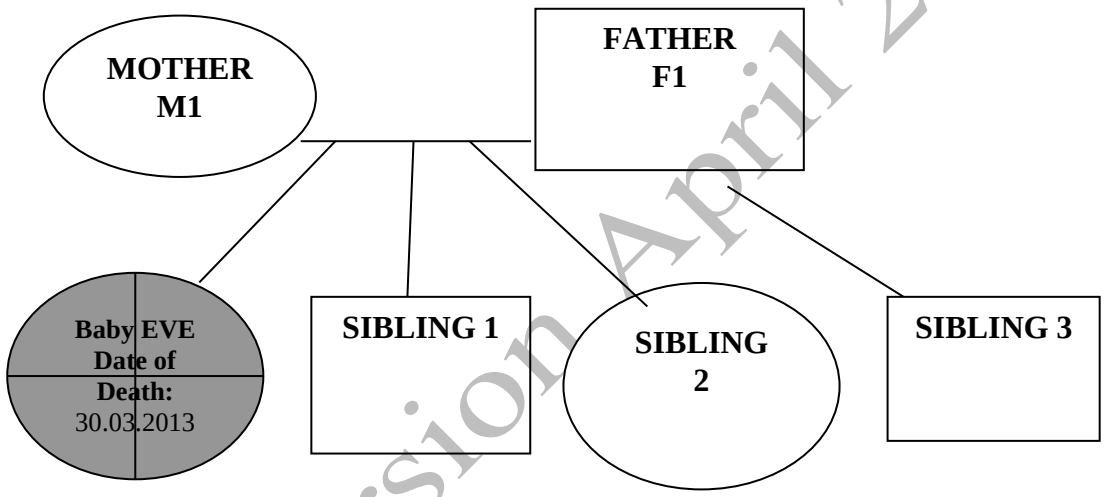
- Invitation process including standard attendees at unborn, initial and review conferences.
- Practice of the conference chairpersons in maintaining procedural standards in relation to attendance at and reporting to child protection conferences.
- Provision of reports to parents to ensure that they are fully informed and able to engage and contribute to the work of the conference.
- Subsequent distribution of minutes and plans.
- Chairperson's role in monitoring plans during the review period.

This will assist in assuring the safeguarding board that all agencies are fulfilling their statutory safeguarding responsibilities. **Review and report to the Board within 3 months.**

Appendix 1: Genogram as at April 2013

Family Name XXXXX

Period of Review January 2012 up to 30th March 2013.



A Genogram is a way of representing a family tree and relationships within the family.

Key:

○	□	△	X	⊕	⊞	●	■	_____	Enduring Relationship
								- - - -	Transitory relationship
Female	Male	Pregnancy	Abortion or Miscarriage	Deceased – Cross is placed inside gender symbol		Subject		/	Separation
								//	Divorce
……..	Family members who are part of the same household are indicated by a dotted line which is placed around the household members								