**Kingston LSCB**

**Serious Case Review regarding Family A LSCB Response.**

## Introduction

This case involves the tragic deaths of three children through asphyxiation by their mother. The mother was found guilty of manslaughter by diminished responsibility, and sentenced to a Hospital Order.

The case was formally referred to the Kingston LSCB (Local Safeguarding Children Board) on 22.04.2014. and the decision was made by the LSCB Deborah Lightfoot to consider the case under the Regulation 5 of the LSCB Regulations 2006. Deborah Lightfoot found that this case met the criteria for a Serious Case Review (SCR) and agreed the commissioning arrangements to be led by the LSCB as laid out in HM Government "Working Together to Safeguard Children (2014).

Working Together allows LSCBs to use any learning model consistent with the principles in the guidance, including a systems' methodology. This SCR has used a systems' model, focusing on strengths and weaknesses in the multi-agency network in supporting children and families with complex health needs. The independent lead reviewers and SCR Panel chairs were Edina Carmi, relating from a social work perspective and Nicki Walker - Hall, from a health perspective. Both have considerable safeguarding experience and experience of SCRs.

SCR Panel members were senior managers drawn from involved agencies.

Most agencies produced a report and practitioners were interviewed, some singly and some in groups. The father was interviewed. Learning was tested out on practitioners and the Panel. A full evaluation of the process will be undertaken to learn from practitioners' experience of this methodology.

The LSCB met on 11th November 2015 to consider the overview report. It fully accepted the learning outlined. It then went on to consider actions already taken to date as a result of the learning.

The review found that there was learning for practitioners involved but that the tragic incident was not predictable nor preventable.

The Board has begun to implement an action plan based on the findings and recommendations by the overview authors, below. This plan will be monitored by the SCR Subgroup in Kingston, other involved LSCBs will also make their own responses as will NHS England , who will report back to the LSCBs involved.

## Findings related to the family and professional interactions

### Finding 1: The impact of diagnosis on parents

Practitioners had not taken into account the impact of the diagnosis of a disability on the parents. If this is reflected in current practice within the wider workforce, there is an unmet local need for support for parents. Research shows that the manner in which a diagnosis is explained to parents can have a profound and prolonged effect on the parent's attitudes to the child and professionals.

**Recommendation 1:** Merton, Wandsworth and Kingston LSCBs to assure themselves that there are reliable systems in place to ensure that whenever a child is diagnosed with a disability the parents are offered counselling and information support as routine, and that professionals also explore with them their understanding of, and views towards such disability.

**LSCB view:** Kingston LSCB acknowledges that the parent's needs can often be overlooked when a child receives a diagnosis of disability or significant illness.

**LSCB action 1:** Kingston LSCB will audit agencies' offers of counselling to parents with children with significant health concerns, the likely numbers of families involved, and the capacity of local organisations to provide that counselling. The LSCB will make a recommendation to the Health and Wellbeing Board based on the audit in Kingston in January 2016 regarding future provision.

### Finding 2: The impact of culture, identity, class and previous experience on the family and professionals

The couple's culture, class and background were significant. It would seem that practitioners had little understanding or opportunity to explore this.

**Recommendation 2:** Merton, Wandsworth, Kingston, Camden and Tri-borough LSCBs to consider how to improve assessment practice so that practitioners routinely explore parents' ***individual*** cultural background and attitudes to the provision of services.

**LSCB view:** Kingston LSCB regards best practice as that which takes into account a family's own cultural and historical background. It recognises that staff require training to undertake sometimes sensitive conversations with families.

**LSCB action 2:** Kingston LSCB will provide diversity training in February 2016 and similarly requests single agencies to consider such training in their programme.

**LSCB action 3:** Kingston LSCB will request agency evidence of training regarding culture and diversity as well as evidence of this being discussed during supervision and multi agency meetings.

### Finding 3: The impact of the family on professionals

Professionals modified their usual working practices in order to accommodate the family. The family was not always easy to work with.

**LSCB view:** Kingston LSCB accepts this understanding of the situation by the overview authors and recognizes that each family will have a unique set of circumstances for professionals to engage with.

**LSCB action 4:** Kingston LSCB has begun to disseminate learning in June 2015 to senior leaders in relation to support for their staff, who may modify their usual working practices, or work outside their usual boundaries. The LSCB will continue to highlight this matter.

### Finding 4: Mother's mental health

Throughout the period under review, there was professional concern about the Mother's presentation and mental health, but the mother did not wish to engage to have support.

**LSCB view:** Kingston LSCB supports the authors in this finding and encourages a well trained workforce.

**LSCB action 5:** Kingston LSCB would encourage multi agency training in relation to the impact of parental mental health on parenting. The LSCB has already provided training in 2014 and 2015 and 30 people have attended. Further courses are planned.

### Finding 5: Family Dynamics

The parents related in different ways with professionals; this meant that sometimes information was not shared with both parents at the same time. The parents had different roles in making decisions for the children. Professionals sought to manage this.

**LSCB view:** Kingston LSCB has commissioned training into working with families for multi agency practitioners**.** We will ensure this training includes an understanding and assessment of family dynamics and how to manage these.

## Findings related to professional and organisational culture:

### Finding 6: Commitment by professionals and the complexity of the case led to working outside professional boundaries

The commitment expressed by professionals working with this family was high, and many went out of their way to provide services for the family. This could be exhausting at times, and with many professionals involved, it was sometimes hard to discern a lead. This gave progress in terms of the mother's acceptance of professional involvement with the children.

**Recommendation 3:** Wandsworth and Kingston LSCBs to consider what checks and balances are needed in the system to identify when a complex case is resulting in staff working outside their normal roles and responsibilities, and when further independent objective consultation needs then to be available for staff.

**LSCB view:** Kingston LSCB recognises that many staff in many agencies have a high engagement to, and commitment for their work. Senior managers need to be aware that staff

are working over and above their normal roles and responsibilities and need appropriate support and supervision

**LSCB action 6:** At the Joint Kingston and Richmond LSCB Board in June 2015, the LSCB highlighted to senior managers the need to be alert to staff needs in cases where commitment and family need were high. There was a need to support staff and ensure that retention and recruitment remained positive in such circumstances.

**Finding 7: Lead professional role**

The report found that the role of the lead professional is critical in complex cases. Statutory guidance provides a framework to this role. At times, there was confusion in this case as to who the lead professional was.

**Recommendation 4** Wandsworth and Kingston LSCBs to agree with member agencies a consistent process for identifying the lead professional and the responsibility for the various functions of the lead professional.

**LSCB view:** Kingston LSCB recognises that the Lead Professional role is not always clear for the multi agency network, not only in Child in Need work for disabled children but in early help, safeguarding and looked after children cases. The LSCB is mindful of statutory guidance.

**LSCB action 7:** Kingston LSCB to offer guidance and training around the Lead Professional role to all agencies.

**LSCB action 8:** Kingston LSCB will work with NHS England to consider the lead professional role and ensure guidance is disseminated and followed.

**Finding 8: Team around the child (TAC)**

Team around the Child meetings took place regularly and tried to formulate and implement plans. It is important those meetings take account of all family members and all professionals in the network. It was found that they would benefit from guidance and a cycle of review, updates and assessments.

**Recommendation 5** Wandsworth and Kingston LSCBs to agree with member agencies minimum expectations regarding the conduct of TAC meetings, including when to use written agreements, when to request further assessments, consideration of all family members' needs as well as identification of involved professionals to attend meetings, a process to enable others to have their views adequately represented both at the TAC and directly to the Lead Professional. Critically, there needs to be understanding of the circumstances when this form of multi-agency coordination should become part of the Child in Need planning, coordinated by a social worker.

**LSCB view:** Kingston LSCB wishes to reinforce the value of multi agency working and to ensure that multi agency meetings work smoothly at every level from CAF (Common Assessment Framework) TAC Meetings in early help to Child in Need Meetings, Child Protection Core Groups and Looked After Child Reviews.

**LSCB action 9:** Kingston LSCB will ensure that there is clear and accessible guidance and templates on its website for all types of local meeting. The need for a cycle of review and assessment was encouraged at the LSCB Conference on 1st October 2015, when practitioners were reminded of the need for oversight in situations of neglect and a plan which is regularly reviewed and evaluated.

**Finding 9: Management and supervision**

This was a complex case and it was found that this case was managed in a collaborative manner. Decisions were often taken at senior levels, however this sometimes led to the loss of objective overview and advice.

**Recommendation 6:** Merton, Wandsworth and Kingston LSCBs to establish if the Designated professionals receive professional supervision, and if not, what arrangements should be in place to ensure that this is available.

**LSCB view:** The Kingston Board accepts this finding and the unique and helpful role designated health professionals play.

**LSCB action 10:** Kingston LSCB to work with NHS England in defining the understanding of the named and designated health role, and ensuring practitioners are aware of it and following its guidance.

**Finding 10: Changing case holding social workers**

Changes of professional role naturally will occur and the reviewers found that changes could have been developed more positively in the handover of social workers.

**Recommendation 7:** Kingston LSCB to assure itself that the existing transfer protocol within Achieving for Children is developed further to include transfer of cases between social workers within the same team.

**LSCB view:** The Kingston Board agrees that working relationships between families and professionals are crucial and need to be developed appropriately.

**LSCB action 11:** The Board will audit local casework to consider transfers of cases between professionals and teams, as well as overseeing the amendment of the transfer protocol in CSC.

**Finding 11: Continuing Care Payments as opposed to Direct Payments**

The context of direct payments is not new in the UK and can provide a flexible system to offer support to families. In this case, there were difficulties in recruiting support which the family was happy to receive and the full entitlement of funding was not used.

**Recommendation 8:** Merton, Wandsworth and Kingston LSCBs to establish if the system for providing carers to families has sufficient flexibility to ensure that children receive the care they need. Such arrangements need to recognize that for some families:

- The ability to directly employ and manage their own staff will work better, along with provision for the Local Authority or agency to be involved in a vetting process to ensure the staff are competent to undertake the tasks required;
- Such funding should be available for domiciliary help as well as health care tasks, so that parents are able to choose if they are released from some household tasks to have more time to provide the health care needs themselves, as opposed to the other way around.

**Recommendation 9:** Wandsworth and Kingston LSCBs to establish what occurs when there are instances that the full package of care is not taken up over a prolonged period; there should be senior management involvement to consider the impact on the safety of the children.

**LSCB view:** Kingston LSCB recognises the independence of families to ensure a lifestyle more acceptable to themselves, when they have caring responsibilities. This however does need to be balanced with oversight of packages of care and their impact on families.

**LSCB action 12:** Kingston LSCB is to review the oversight of Direct Payments.

## Findings in relation to safeguarding practice

### Finding 12: Tensions between supporting the family as a whole or safeguarding the children

The family was under considerable strain and stress. Professionals had to balance working slowly to gain parental agreement to actions and procedures or facing confrontation in working to the children's timescales. Neglect is a form of abuse which is hard to assess.

**Recommendation 10:** Kingston LSCB to consider if there are adequate resources available for practitioners to seek consultation on complex cases such as "complex multi-agency panels" to offer advice on "stuck cases", as well as the consultation with named, designated and specialist staff.

**Recommendation 11:** Kingston LSCB to establish the extent of use of specialist tools by practitioners to order thinking and keep sharp focus on the need to safeguard the welfare of children eg. Chronologies, centile charts, risk assessment tools;-the use of multi-agency chronologies is particularly helpful to understand the history.

**LSCB view:** Kingston LSCB accepts this view of possible practice and the need for practitioners to have adequate resources. Kingston LSCB will consider through multi-agency focus groups and its multi-agency audit cycle whether there are adequate resources available for practitioners who require more support on cases. The Board will consider whether offering group supervision on complex cases by objective senior partnership leads

as in Richmond, will be an effective measure of support. The LSCB launched a multi-agency neglect toolkit in October 2015 with the help of the local Designated Nurses for Safeguarding Children.

**LSCB action 13:** Kingston LSCB will consider through multi-agency focus groups and its multi-agency audit cycle whether there are adequate resources available for practitioners who require more support on cases. The Board will consider whether offering group supervision on complex cases by objective senior partnership leads as in Richmond, will be an effective measure of support.

**LSCB action 14:**

The LSCB to work with local health providers, commissioners and the CCG to encourage implementation and monitoring of the neglect assessment toolkit.

**Finding 13: Quality of life as opposed to longevity?**

The parents' laudable aim for their children was a good quality of life which was as painfree as possible. Despite misunderstandings, this was the goal and view of professionals.

**LSCB view:** In considering the overview report, the LSCB accepts this finding.

**Finding 14: Role of consensus in decision making as opposed to individual responsibility?**

Professionals worked hard to find consensus in this case but this became an obstacle in initiating child protection procedures. There was no evidence of escalation of concerns by practitioners, who did feel that child protection processes should have been used.

**Recommendation 12:** All LSCBs to establish if professionals are able to make specific child protection referrals when they have such concerns on open cases, so that their view does not get lost as part of the usual information sharing process;

**Recommendation 13:** All LSCBs to ensure that the culture in their area is one where:

- every professional understands their own individual responsibility to make a referral to children's social care if they suspect a child is suffering or is likely to suffer significant harm;
- all practitioners, whatever their role, feel *able* to make such specific referrals to escalate their concerns.

**LSCB view:** Kingston LSCB accepts this finding, and the subsequent recommendations, and it accords with the results of LSCB local multi-agency audits. The LSCB escalation policy was amended and highlighted in spring 2015, and will be highlighted again.

**LSCB action 15:** Through its regular multi agency audit work, the LSCB to assure itself that cases are now being managed appropriately, referrals made as required, and escalations take place, if required.

**Finding 15: Focus on legal intervention instead of the wider child protection process**

There were welfare concerns for the three children and suspicions that they were being neglected and at time, emotionally abused. Instead of using child protection processes, the use of legal interventions were repeatedly debated. Legal interventions should be the final stage following the use of child protection processes.

**Recommendation 14:** Kingston LSCB to establish if the practice in this case about wanting to go straight to legal proceedings without going through the child protection process is unusual, or representative of a misunderstanding of the child protection process in the children with disability service.

**LSCB view:** Kingston LSCB accepts this finding.

**LSCB action 16:** Kingston LSCB to carry out a specific multi agency audit of children with disability cases as part of a review of the services provided to these children.