Hampshire Safeguarding Children Board

Serious Case Review

Child M

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1. INTRODUCTION

1.1 Child M died at the age of 11 in a road traffic accident in a neighbouring local authority. Her mother (known throughout this report as "Mother") was driving the car and evidence presented at the inquest suggests that Mother and Child M were not wearing seatbelts at the time of the accident. Child M's two year old sibling was appropriately restrained in a car seat and did not suffer any injuries. The Crown Prosecution Service was consulted by the neighbouring police force regarding any potential criminal action against mother for driving offences but they decided that such action was not in the public interest.

1.2 The reason for this serious case review is that at the time of her death, Child M and her sibling were both the subject of child protection plans. The family had been known to children's social care since May 2013 and Mother had also been in contact with a number of organisations, including mental health services.

2. REVIEW PROCESS

2.1 Jane Wonnacott, an experienced lead reviewer, was appointed to lead the review and write the final report. For full details of the review process and further details of the lead reviewer please see appendix one.

2.2 The lead reviewer worked with a small team of senior professionals from within Hampshire who represented the organisations who had contact with Child M and her family. Each organisation prepared a chronology and outline of their involvement and the review team agreed questions that would need to be considered by the review.

2.3 The review aimed to understand events from the point of view of practitioners working with the family and the lead reviewer arranged to talk to individual practitioners with the member of the review team representing their organisation. It was possible to speak to all key practitioners with the exception of the social worker in the community mental health team who was on extended leave throughout the review period. These individual discussions were followed up by a group meeting of all practitioners to check the accuracy of the case narrative and discuss the emerging findings of the review.

2.4 Mother and her children had been involved with the local church and the lead reviewer spoke to the vicar and his partner in order to understand more about the church's involvement. As a result of these discussions, a member of the local diocesan safeguarding team joined the review team.

2.5 Child M's mother was asked by letter and verbally whether she wished to contribute to the review but did not feel able to do so. Child M's father, who lives some distance from Hampshire, was also invited via two letters to contribute. Neither parent expressed a wish to contribute to the review.

2.6 Although the serious incident took place in December 2014 this review has not been completed until the summer of 2016. The reasons that lay behind the length of time taken to complete the review were:

- The complexity of the case including the large number of organisations and professionals who had been involved with the family,
- The identification of organisations only becoming clear as the review progressed.

3. BACKGROUND PRIOR TO REVIEW PERIOD

3.1 Mother was born in mainland Europe and moved to England at the age of 19, following a family disagreement. GP records note mental health problems in her home country and a significant issue in Mother's history is that she alleges that she was sexually abused by a close family member from the age of 10 to 17. This allegation has not been investigated as mother has not given specific details to any of the professionals working with the family.

3.2 Mother's heritage is Sri Lankan/Christian and she met the father of the children whilst living in the UK, his heritage being Sri Lankan/Hindu. There are allegations that Father was violent towards Mother and they separated, with Mother moving to Hampshire. At first Mother lived in privately rented accommodation, later moving into social housing provided by a housing association.

3.3 Prior to Mother's pregnancy with Child M's sibling, in February 2011 a local family support team (FST[1]) managed by a local schools partnership, received a referral from the primary school expressing concerns about Child M and the mental health of her mother. This led to a CAF[2] and a team around the child meeting. Support from the family support team continued until September 2011 when it was agreed that support structures were in place through school and universal services. At this point Mother was enrolled in parenting classes but she missed the first session, attended the second and did not complete the course.

3.4 Mother was involved with the local church community and from the time that she was pregnant with Child M's sibling they became very involved in providing support to Mother. This support included developing a rota to visit the home every morning to give breakfast to the children as well as taking and picking up Child M from school.

4. CASE SUMMARY

Jan 2012	Child M's sibling born. (Child M was age 8). Family support team support started again.

[1] An early intervention service
[2] A CAF is an early help assessment using the Common Assessment Framework.

March 2013	Mother was referred by the GP to the community mental health team. Regular support from the team social worker started.
May 2013	GP referred to children's social care: children at risk of neglect. Health visitor referred to Home-Start[3].
June 2013	An initial legal strategy meeting took place.
July 2013	Initial child protection conference – both children made subject of a plan under the category of neglect with a second category of emotional abuse. A Public Law Outline letter (first stage of legal proceedings) was sent to Mother.
Aug 2013	Assessment by consultant psychiatrist; recommended counselling and emotional coping skills group.
Sept 2013	Mother started emotional coping skills group. (Three out of six sessions were fully completed).
Oct 2013	A review child protection conference recommended that both children should remain subject of a plan.
Nov 2013	A legal strategy meeting requested a parenting assessment and a psychological assessment of Mother. A strategy discussion agreed single agency Section 47 enquiries by children's social care following an allegation by Child M that her uncle had attempted to hit her. The outcome of these enquires was no further action (NFA). Home-Start visits finished as Mother had a job
Dec 2013	A “notice of seeking possession” was issued by the housing association due to rent arrears.
Jan 2014	Debt advice given by the Housing Association. Mother started counselling at a sexual abuse counselling service. A third legal strategy meeting took place: the parenting assessment had been completed but no psychological assessment. No conclusion could be reached until the assessment had been discussed with Mother.
Feb 2014	A fourth legal strategy meeting agreed that the Public Law Outline

[3] Home-Start is a family support charity who work with families and young children through a network of volunteers.

	process should be ended and the threshold for legal proceedings no longer deemed to be met. Good progress noted in community mental health team and Mother to be discharged.
March 2014	A review child protection conference removed both children from child protection plans.
June/July 2014	Further concern noted by housing association about rent arrears and court action pending: support offered and payment plan agreed. Deterioration in home conditions noted by health visitor.
Sept 2014	Referral by school to children's social care concerned about Child M as young carer and Mother's mental health.
Oct 2014	A child protection conference made both children subject of a child protection plan under the category of neglect. A legal strategy meeting deemed that the threshold for legal proceedings was not met. Recommendation from the meeting was that report should be obtained from Mother's private counsellor in London. Father should also be contacted.
Dec 2014	Child M died in a road traffic accident.

5. NARRATIVE / EVALUATION OF PRACTICE

5.1 The main purpose of a serious case review is to improve services to children and their families. Much of the forthcoming section therefore focuses on the services provided to Child M and her family and in line with the requirements of a report which is expected to be in the public domain, personal details have been kept to a minimum. Where family details including aspects of Child M's life, these are included, this is because they are relevant to an evaluation of professional practice. This approach does mean that when many services are primarily focused on the adult, it may seem that a focus on the child has been lost. This is not intention of this report and it should be read with the understanding that Child M and her sibling are at the heart of this review.

From birth of Child M's sibling in 2012 to child protection conference in July 2013

5.2 After the birth of Child M's sibling, in January 2012, (when Child M was age 8) Mother requested further help from the family support team and records note that she was having difficulties with her relationship with Child M. The home was chaotic and routines were not in place. It is not clear from the records what support was offered,

although the health visitor referred Mother to baby massage to encourage attachment with the baby. Mother attended only one session and did not return.

5.3 In October 2012 at a home visit by the family support team worker, Mother shared concerns regarding Child M's "controlling behaviour" and it was arranged for a parent support adviser to visit the home. The records show visits from the adviser between November 2012 and February 2013.

5.4 In March 2013 the GP referred Mother to the community mental health team (CMHT) noting concerns which included Mother's poor relationship with Child M and problems relating to Mother's past experience of sexual abuse. (This assessment took place on 10th June).

5.5 In May 2013 the GP was contacted by a friend/neighbour of Mother, who was concerned about the children. The concerns included physical neglect that could have compromised the children's safety and the GP took proactive action and referred to children's social care the same day.

5.6 The case was allocated within the referral and assessment team with a S17 assessment[4] being carried out by a student social worker. With hindsight and the benefit of experience, this social worker (now qualified) believes this should have been treated as a child protection enquiry (S47)[5] from the start. At that time decisions regarding thresholds were made within local social work teams whereas current practice is that the decision would be made within the Multi Agency Safeguarding Hub (MASH) and be based on full consideration of information from a multi-agency perspective. Whilst it cannot be said with absolute certainty that the decision by MASH today would be different, the application of consistent thresholds across the county combined with multiagency discussions means that that decision making at the point of referral would be more defensible and robust.

5.7 An additional issue at this point is the allocation of the case to a student social worker. Discussions with Hampshire workforce development team have clarified that historic and current practice is that the team's policy, supported by instructions from senior managers, is that cases involving statutory assessments (child in need or child protection) must be allocated to a qualified worker even though tasks may be carried out by the student. In this case the social worker who was a student at the time recalls being "allocated" the case and that usual practice in the team was that it would have only been allocated to a qualified worker if it had involved child protection enquiries. This was not in line with expected practice and importance of clarity in relation to the role of students within social work teams is discussed further in paragraphs 6.20 – 21.

[4] This is an assessment of a Child in Need; where the child is not believed to be a risk of significant harm.
[5] This is an enquiry under section 47 of Children Act 1989 where there is cause to suspect that a child is suffering or is likely to suffer significant harm

5.8 There were occasions during this assessment period where information was shared between practitioners working with the family:

- The health visitor had referred Mother to Home-Start and following an initial visit the Home-Start co-ordinator completed a record of concern and called the student social worker. Concerns included Mother's mental health, chaotic home, disorganisation and difficulties in caring for the children.
- On 10th June 2013 there was a clinic assessment by a social worker at the CMHT which explored both social and mental health history. This assessment noted an answer of "yes" to whether there were any actual or potential risks to children, with a note that there were two children in the house and concerns of neglect and emotional abuse. As a result there was liaison with the student social worker in children's social care.

5.9 On 11th June there was a joint visit to the home by the student social worker, health visitor, parent support adviser from the school and a supporter from the local church. The student social worker recalls Mother saying that she had recently fallen asleep on the sofa while cooking and only woke up when the fire alarms were going. No practitioner challenged Mother about the implications of this for the children's safety and it is to the student social worker's credit that they did recognise the risks to the children and after the visit appropriately recommended that the case should be escalated to S47 (child protection) enquiries. At this stage the focus of others on supporting Mother appears to have detracted attention from a focus on the impact of her behaviour on the children.

5.10 The lack of challenge to mother by more experienced professionals meant that the student had not felt confident to query Mother's behaviour in the meeting. Due to staff sickness, there was no supervisor from the team accompanying the student social worker on this visit which would have been expected practice. The visit was observed by the student's practice educator but they did not have a background in children's services[6].

5.11 The case was immediately allocated to a qualified social worker who had responsibility for child protection enquiries and carried out a further visit with the student social worker on the same day. Mother was offered s20[7] accommodation for the children but declined this offer and the social worker arranged for all the family to stay with the local vicar and his wife over the weekend. Following the weekend, Mother's sibling (Child M's uncle) came to stay with the family on a longer term basis to support Mother. The focus of social work at this point was on helping the family to stay together with support. The risk of harm was managed through recommending that there should be a multiagency child protection conference.

[6] Practice educators are responsible for a student social workers overall learning and assessment and do have line management responsibility for specific cases.

[7] This accommodation provided with parental consent under section 20 Children Act 1989. The local authority and the parent share parental responsibility for a child accommodated under this section of the Act.

5.12 On 13th June the Home-Start volunteer was introduced and as they arrived, the social worker was leaving the home. This is indicative of many people involved in helping Mother, but little sense of a coordinated planned approach at this stage.

5.13 During this period (June 2013) Mother was living in a property owned by a housing association which was working with Mother to agree a repayment plan for rent arrears. The association were not contacted during the child protection enquiries and was unaware of any children's social care involvement. As a result there is no evidence that the implications of financial stressors including arrears were considered during assessments prior to the conference.

5.14 On 14th June 2013 the access and assessment team within the Community Mental Health Team referred Mother to the community treatment team, as her "needs appear to be complex and long-standing". It was hoped that the community treatment team would provide emotional coping skills and medical input.

5.15 GP records for 24th June 2013 note anxiety with depression, and that Mother was not allowed to be alone with the children so was staying with a volunteer with the church. Mother's brother was noted to be returning soon.

5.16 On 25th June 2013, there was a joint meeting at the home attended by the student social worker, two qualified social workers, the health visitor, two supporters from the church, the family support worker and the outreach worker from the local Children's Centre. (This meeting had been called by the student social worker to review the situation, and Mother had invited several people to the meeting herself). The student social worker recalls that a view from others at the meeting that they were not in agreement with concerns of children's social care and thought that children's social care was being negative towards Mother.

5.17 At school Child M was receiving support from the ELSA (Emotional Literary Support Assistant) and notes from this period state that Child M was worried about her Mother and that she 'cared for her sibling whilst Mum sleeps'. Child M also worried that, "her Mum was given away and hurt by people and this might happen to her. Dad can't come to the house until he stops hurting Mum".

5.18 It is clear that there were significant concerns about risks to the children at this point as on 25th June, a legal strategy meeting was held to discuss whether the threshold had been met to issue proceedings under the Public Law Outline. This meeting agreed that the threshold had been met and minutes note that a letter would be sent to Mother after the child protection conference on 4th July. The review team have not been able to understand the rationale for the letter being delayed until after the conference other than the conference was taking place nine days later and it would take longer than this for a letter to be prepared.

5.19 0n 1st July, Home-Start completed another record of concern following a visit to Mother. Child M was apparently sleeping on the floor of the bedroom so her Uncle could use the bed, and Mother commented on thoughts about hurting the children,

such as pouring hot oil on Child M's sibling when cooking. Home-Start records note that the "social worker aware of these thoughts"[8] and there is a record of the coordinator having a conversation with the social worker on 4th July 2013. During this conversation Home-Start queried why they had not received an invitation to the child protection conference (see paragraph 5.20 below).

Summary: from birth of Child M's sibling in 2012 to child protection conference in July 2013

During this period, risks to the children associated with Mother's parenting capacity were recognised and resulted in a number of organisations and individual practitioners helping Mother and her children. These included:

- the family support team
- the community mental health team
- social workers in children's social care
- the GP
- the church
- the housing association
- the health visitor
- home-start
- school (particularly the ELSA).

This was indicative of an enduring pattern of work in this case whereby a combination of Mother's vulnerability and quest for help combined with the concerns of others about the children, led to a wide range of services being involved. Almost inevitably this presented challenges in ensuring that services were coordinated in the most effective way possible. The following issues affected the overall effectiveness of work with the case.

1. There were tensions between the church/neighbours and children's social care regarding the extent to which the community should be involved in providing day to day support. This was underpinned by a lack of clarity from staff in children's social care about how far statutory services should/could involve informal networks in formal child protection processes.
2. The initial decision that this was a child in need referral resulted in allocation of the case to a student social worker who did not receive adequate case management supervision for a period of time due to the practice supervisor[9] being on extended leave. The student's practice educator[10] did not have children's experience and in any case did not have line management responsibility for work with the family. The student social worker was rightly worried about the children but lacked confidence to express these concerns in a meeting with more experienced professionals although the student did escalate once they had returned to their office.
3. The supervision of the health visitor did not provide sufficient time for individual oversight of cases and critical reflection regarding the dynamics of this case: the health visitor believes that the group format for safeguarding supervision

[8] This was the student social worker although referred to as a social worker in Home-Start records
[9] The practice supervisor is a member of the team responsible for case management
[10] The practice educator is not a member of the team but has overall responsibility for assessment of the students practice.

contributed to this issue,

Child protection conference and plans July 2013 – March 2014

5.20 An initial child protection conference was held on 4th July 2013 and both children became the subjects of a child protection plan under the category of neglect, with a second category of emotional abuse. The list of those invited to the conference did not include Home-Start, the housing association or the community mental health team (although the CMHT social worker sent a written report). The lack of attendance by Home-Start or a written report meant that significant information was not available to the conference; for example there is no record in the conference minutes of Mother's comment to the Home-Start volunteer that she had thoughts of harming the children. The Home-Start records show that Mother had asked the Home-Start volunteer to accompany her to the child protection conference, but Home-Start were informed by the "social worker"[11] that this was not possible as Home-Start had not been with the family long when the invitations were sent out. This appears to have been an individual error as the review team have received confirmation from Home-Start that they are usually appropriately invited to child protection conferences.

5.21 Members of the church also asked whether they could support Mother at the conference. Mother was supported by her sibling and sister and the conference chair recalls receiving a message that the church members were neighbours who wished to understand the conference process. In the light of this information, the decision of the chair not to agree to admit them to the conference was entirely appropriate.

5.22 It is of note that there is no reference in the conference minutes to the fact that children's social care had started legal proceedings. Whilst the detail of actions taken in this regard would not be appropriate to share at the conference, the multi-agency group would expect to be informed that a legal strategy meeting had taken place which deemed the threshold for proceedings to be met.

5.23 Following the conference, social work responsibility for Child M and her sibling was transferred from the referral and assessment team to a social worker in the child in need team. This new social worker had responsibility for working with the multi-agency group to develop and implement the child protection plan.

5.24 The child protection plan is set out in detail below as an illustration of the wide range of services that were involved with the family. The plan included:

- contact with the mental health social worker,
- a psychiatric assessment,

[11] It is not clear whether this was the student or the allocated qualified worker

- attendance at the emotional coping skills programme,
- referral to Home-Start (although this was already in place),
- referral to Art Therapy for Child M,
- a referral to Child and Adolescent Mental Health Services for family therapy,
- ELSA support for Child M to continue,
- Child M's sibling to attend toddler group,
- nursery nurse involvement to support Mother with learning how to play appropriately and
- social work visits to focus on stopping the 'neighbour's involvement'.

5.25 The multi-agency child protection plan did recognise that there should be no contact with the family member who Mother had alleged had previously abused her but no practitioner raised any queries about risks this person may pose to other children. Another problem with the plan is that the emotional coping skills six week programme provided by mental health services was linked with a planned outcome of "children being provided with long term stability". This was potentially a rather ambitious undertaking for a six week teaching based skills programme when Mother's problems were deep and long-standing. The aspect of the plan linked to accessing counselling/therapy to address her past issues was linked with engaging with a psychiatric assessment, but this assessment was a one-off consultation that did not provide the therapeutic input needed to achieve this outcome.

5.26 Following the conference in July 2013 Public Law Outline[12] letter was issued to Mother. Due to an error the letter was not sent to Father who also had parental responsibility. There is no evidence of any structured plan linked to the PLO process and the next legal strategy meeting was not held until November 2013. The lack of focused work linked to the PLO is noted as being due to Mother failing to instruct a solicitor; this is not an acceptable reason and contributed to drift in the management of the case.

5.27 As a result of the child protection intervention during the summer of 2013, the intensive support from the church stopped, including the daily rotas to allow Mother to show her ability to parent independently. This was perceived by the church to be because the social worker wished them to reduce their involvement although there was less clarity from the church's point of view that this was part of a positive plan.

5.28 On 5th August 2013, Mother was seen for an assessment by the consultant psychiatrist. The plan from this consultation was continue with medication, attend the emotional coping skills group and consider the possibility of continuing long term

[12] The first stage of legal proceedings

therapy from a local counselling service if Mother could pay for it. Mother was to continue seeing the social worker from CMHT.

5.29 During August a range of services continued to be involved with the family. Mother attended a "Stay and Play" session at the children's centre, and the community nursery nurse visited at home. At a core group meeting in August Mother referred to contact with a private psychiatrist. Regular visits from the social worker from CMHT and Home-Start continued.

5.30 The emotional coping skills group started in September. Mother attended the first three sessions, missed the fourth session due to a child protection conference, missed the fifth session and only attended 20 minutes of the sixth session.

5.31 In September 2013 the vicar from the church spoke to the head teacher of the local village school about concerns at a residential weekend which indicated that Child M was adopting the role of young carer for her sibling. When Mother became aware of this discussion Mother stopped attending church and the vicar spoke to the Diocesan Safeguarding Officer whose advice was that the church should report the situation to children's social care if there was "immediate danger" to the children. The minister didn't feel that there was immediate danger, and believed that the neglect was being dealt with by children's social care. Following this, Mother began attending a group run by a free church nearby.

5.32 The role of churches in the safeguarding system is explored further in paragraph 6.11. At this point the issue related to the interpretation of "immediate danger". It would have been good practice for the concerns of the church to be shared with children's social care and the failure to do so indicates a lack of clarity within the church community regarding their role in relation to families where there are concerns about ongoing neglect.

5.33 At the beginning of September, Child M's sibling started at a private nursery. Mother had told the initial conference that she hoped to send Child M's sibling to nursery but at that stage this was no longer certain and the nursery were not aware of the existence of the child protection plan. Staff at the nursery immediately began to record concerns about Mother's physical care of Child M's sibling and apparent disinterest when issues were raised with her. Concerns were discussed in supervision including the possibility that Mother's disinterest was shyness and/or influenced by her cultural background. At this stage it was the view of the nursery manager that records should be kept and reviewed but the threshold had not been reached for a discussion with children's services. This was a reasonable decision at that time.

5.34 Home-Start visits continued during September 2013 and notes for one visit on 27th September identified concerns regarding Child M's sibling playing at the cooker, Mother opening the front door so he could play outside, dirty pots and pans, a sieve with mouldy kidney beans. The Home-Start coordinator followed these concerns up

with a report to a forthcoming core group meeting and review child protection conference.

5.35 During September there were further concerns regarding rent arrears which were only known to the income team in the Housing Association. At this stage the housing officer who had responsibility for tenancy management was unaware of the arrears and the Housing Association have identified during discussions for this review that internal communication systems need to be reviewed. Even if the housing officer had been aware of the arrears it is unlikely that direct contact would have been made with children's social care unless Mother had informed the housing officer of their involvement. At that stage plans were being made to manage the debt and there were no other causes for concern.

5.36 On 20th October 2013 a review child protection conference took place and the decision was that the children should remain on the child protection plan. The chronology indicates that the minutes of the meeting were not received by attendees until 27th November. The private nursery is noted to be part of the core group but they were not contacted and continued to be unaware of the existence of the plan.

5.37 During October, Mother and Child M's sibling twice attended a speech and language group at the children's centre. Health visitor contact continued as did regular visits from the community CMHT social worker and the children's social worker. There is a note on the children's social care file that the "PLO/CPP continues to be tracked. Core and parenting assessments are underway and other written evidence being collated."

5.38 The outcome of a second legal strategy meeting was that a parenting assessment should be completed by a family support worker as well as a psychological assessment by mental health services. The parenting assessment began but no psychological assessment took place which could have assisted practitioners in assessing Mother's psychological capacity to parent. This omission might have been less likely had the approach been formalised through a commissioned psychological assessment from a court recognised expert working to a clear letter of instruction. Practice in relation to expert reports was reviewed by Hampshire in 2014/15 and resulted in guidance being issued to clarify expected practice. The review has had sight of evidence which shows that current practice would include an expert report in similar cases.

5.39 On 12th November, notes of the core group comment that the PLO outline was proceeding alongside the child protection plan and work with the community nursery nurse had been completed. The ELSA expressed concerns about Mother's emotional availability for Child M and that she was often the last to be picked up after school.

5.40 On 13th November Child M presented at school with a wobbly tooth and stated that she had done it herself because she had taken her uncle's laptop without permission and thought he was going to hit her, so she moved away and banged her tooth

herself. The school passed this information to the social worker. A telephone strategy discussion took place between the social worker and the police child protection team and it was agreed that the allegation would be managed as a single agency s47 enquiry. Whilst usual expected practice as set out in procedures was for a strategy discussion *"ordinarily be coordinated and chaired by the team manager/first line manager"*[13] the review was informed that since within procedures allowance was made for the discussion to be led by others. At that time, a discussion led by a social worker would not have been uncommon. This is why there is no evidence on file of management oversight of the decision, or the involvement of health professionals, as would be practice today within the Multi Agency Safeguarding Hub.[14]

5.41 The social worker visited Child M at school and Child M spoke about her uncle hitting her and taking pictures of her that made her cry. Talking to the child is a crucial element of social work assessments and it is to the social worker's credit that this was a central aspect of the child protection enquiries. The possibility of consulting a paediatrician as a result of the wobbly tooth and allegation about being hit was not considered at this stage and further more detailed examination of the circumstances surrounding these events may have provided additional opportunity for Child M's voice to be heard.

5.42 The social worker visited the family home and challenged Uncle with this information and recorded that he seemed genuinely shocked, did not realise the impact of his actions on Child M and apologised to her. The social worker also challenged Mother who seemed unaware of the incident. After this the social worker discussed the home visit with the team manager and it was agreed that there would be no further child protection action but the family were aware that there would be consequences if anything like this should occur again. Although there was appropriate management oversight at this stage, there is no recorded discussion with the team manager prompted any further consideration of whether relying on Uncle as the main source of support to the family was in the children's best interests.

5.43 This incident is illustrative of an approach to work with the family which at times was insufficiently rigorous in using procedures which are designed to support a coordinated multi-agency approach including a systematic gathering and analysis of all available information. Although there had been a core group meeting the previous day, section 47 enquires should still have included contact with other professionals who knew the family[15]. This was particularly important where a child was subject of a child protection plan and would have informed them of the allegation as well as

[13] 4 LSCB procedures
[14] Current practice is that strategy discussions would be managed within MASH and all decisions would include management sign off.
[15] 4LSCB procedures state that "The social worker must contact the other agencies involved with the child to inform them that a Section 47 Enquiry has been initiated and to seek their views. The checks should be undertaken directly with involved professionals and not through messages with intermediaries".

gathering any further relevant information. There is no record in the chronology that any contact was made with other agencies or that anyone other than the school was aware of the allegation. More extensive enquiries may have gathered information regarding rent arrears and the concerns recorded by the private nursery about Mother's care of Child M's sibling which at that stage in isolation had not reached the threshold for a referral to children's services. The day nursery remained unaware of the child protection plan or the recent s47 enquiries.

5.44 During November three of the support services working with the family ceased their involvement for various reasons:

- the case was closed to the local family centre because at that time the process was that once the family had been escalated to children's services the case was closed to the centre.
- Mother and Child M's sibling attended their last session of the Speech and Language Group as there was a new group leader who did not run the group in the same way as the previous leader and the group no longer met their needs. The Children's Centre (where the group took place) did not know that the children were on a child protection plan,
- Home-Start finished their involvement as Mother cancelled the volunteer visits as she had obtained a part time job.

5.45 In December 2013, because of continued non-payment a Notice of Seeking Possession was sought by the housing association. There was an internal communication issue at this point, as the housing officer responsible for tenancy management was unaware of the arrears which meant that even if the social worker had made contact as part of the s47 enquiries the information about the arrears may not have informed social work decision making. The Notice of Seeking Possession was hand delivered, but Mother was not at home. The officer delivering the letter was quite surprised at how "scruffy" the property was but it was not bad enough to raise concerns with the housing officer.

5.46 Through December to March the child protection plan continued although the chronology suggests that contact with professionals was less frequent.

5.47 In January 2014 Mother started weekly counselling at a Rape and Sexual Abuse Counselling Service.

5.48 During January and February records suggest that Mother was struggling financially had significant debts and asked for support from the housing association financial inclusion officer. An indicator was added to the housing association debt advice section that Mother was vulnerable due to being a parent alone with mental health issues. The extent of these debts would not have been known to the social worker and at this point a referral should have been made to children's social care by the Housing Association. The role of housing in the child protection system is discussed further in paragraphs 6.9 -10.

5.49 A third legal strategy meeting was held in January 2014. It was noted that the parenting assessment had been completed but no conclusion could be reached as it had not been shared with Mother. There is no review of the absence of a psychological assessment.

5.50 The review team sought to understand the reason why the assessment could not reach a conclusion at this stage but was not able to do so as the final assessment document could not be found within children's social care records. This raises an additional issue regarding efficient storage of records that may be important in informing future work with the family.

5.51 A further legal strategy meeting on 6th February 2014 heard that adult mental health services were reporting good progress (she was soon to be discharged) and there was an all-round improvement in Mother's capacity to cope. It was agreed that the threshold for legal action was no longer met.

5.52 On 14th February 2014 the private nursery school received an invitation to a review child protection conference. They had not known that Child M's sibling was subject to a child protection plan and they therefore contacted the social worker for more information. Concerns in the nursery had started to increase at this point with nursery records in February noting concern about Mother's care of Child M's sibling including Mother being distant and unaffectionate, being late arriving and Child M's sibling often smelling of stale urine. These concerns were conveyed to the social worker.

5.53 On 6th March 2014, there was a review child protection conference and both children were removed from the child protection plan and this was stepped down to a child in need plan. This was the first child protection conference that the nursery manager had attended. They had not been part of the core group and when conference members were describing considerable improvements in the home they did not feel able to challenge the prevailing view that both children should be removed from a plan, even though they had concerns about Mother's care of Child M's sibling. Although the nursery manager had received training relating to the child protection conference process, this serves as a reminder that colleagues who are not frequent attenders may find the process daunting.

Summary: Child protection conference and plans July 2013 – March 2014

This period started with significant concerns about Mother's ability to care for her children, mainly linked to her own mental health issues and emotional vulnerability. By the end of the period there was a unanimous view expressed by the professional community who were part of the child protection conference process that progress had been made and the children no longer needed to be subject to child protection plans. It is significant that the nursery manager still had concerns during the conference but did not feel able to challenge the prevailing view that there had been considerable improvements. This stemmed from lack of confidence within the meeting but they also found it hard to measure their current concerns against the knowledge of others who were describing

considerable progress. The positive changes in the family were clearly identified by the professionals involved but there was also information that was not available to the conference.
The practice issues that may have affected the decision making at this point were:

- the lack of involvement of the housing association in the conference and core group process, due in part to the fact that they had not referred to children's social care. Information from the housing association would have confirmed the potential for stress associated with a high level of debt,
- aspects of the child protection plan being overly optimistic about outcomes from specific actions (e.g. the emotional coping skills group) and lack of clarity about how Mother's capacity to sustain change over time would be assessed,
- a misunderstanding by some professionals about the therapeutic input from the CMHT (the health visitor referred to her having "intensive therapy with the CMHT")
- insufficient liaison and supervision of the safeguarding work of the CMHT by their specialist safeguarding professionals,
- a lack of understanding within statutory agencies of the importance of working positively with the church community,
- a fragmented approach to the delivery of support services with key agencies being either unaware of the child protection plan (the children's centre and private nursery) or having a remit that ended at the point that a case reached the child protection threshold (the family centre).

During this period, concerns were sufficient to consider legal proceedings and these were spelt out clearly to Mother in writing. The review team had heard that it is possible that Mother did not fully understood the level of concern, the actions that needed to be taken to improve the wellbeing of both children as well as the consequences of changes not taking place. Although the decision to stop the PLO process was understandable given the reported progress, the absence of a psychological assessment meant that there was only a partial understanding of Mother's capacity to sustain change.

March 2014 – fatal accident on 9th December 2014

5.54 From March through to October 2014 a child in need plan was in place although records suggest that although there continued to be concerns, particularly following visits by the health visitor and housing officials these were not shared in a timely and systematic way with children's social care .

5.55 At the start of June the notes from the community nursery nurse and health visitor indicate deterioration in home conditions, with safety hazards and limited space for the children to play. There is no evidence that these concerns were shared with the social worker and the health visitor could not attend the child in need meetings in either June or July. There appear to be two factors affecting health visiting practice at that time, firstly, a lack of named supervisor who was familiar with the health visitors caseload, who could be contacted for a discussion where concerns were increasing,

and secondly, no mechanism within Southern Health to alert managers when practitioners could not attend key meetings.

5.56 There were further concerns about rent arrears and in June 2014 Mother was informed that court was pending. This was averted by a weekly payment plan being agreed with the housing association. On 16th July the housing association income officer referred Mother to the financial tenancy sustainment officer noting concerns about the condition of the property, Mother's mental health and lack of local family support. The income officer asked the tenancy sustainment officer to contact relevant agencies as Mother had said she was under the child in need team.

5.57 There was an unacceptable delay in the tenancy sustainment officer making contact with children's social care. It was not until 2nd September 2014 a safeguarding enquiry was made to the social work team by the housing association tenancy support officer. The children's social care file noted that a notice seeking possession was likely. This is the first significant contact between housing and children's social care that indicated the severity of Mother's financial situation.

5.58 On 26th September 2014, S47 (child protection) enquiries commenced as a result of concerns raised by the school. Child M had disclosed caring for her sibling, and that Mother had threatened to kill herself. A home visit by the social worker three days later noted that the home conditions had deteriorated to a point where they were hazardous.

5.59 An initial child protection conference was held on 17th October 2014. No one from the housing association was invited. The nursery did receive an invitation but the manager was on holiday and there was no other member of staff trained to a sufficient level who could prepare a report and attend. Nursery information was therefore conveyed verbally via the preschool inclusion officer. It was noted that Mother had been unable to maintain the home in a state of cleanliness and safety, she continued to fail to prioritise her children's needs, and there were concerns about her mental health. It was agreed that both children should be placed on a child protection plan under the category of neglect and a core group of professionals were to work with Mother consisting of the social worker, health visitor, head teacher of Child M's school and the nursery manager.

5.60 On 21st October a legal strategy meeting took place. At this stage it was decided that the threshold for legal proceedings had not been met as Mother was reporting to be doing more for Child M who was noted to be doing well at school. The chair was concerned about Mother's psychological wellbeing and suggested that a report should be obtained from Mother's private counsellor in London.

5.61 Around this time the partner of the vicar at the local church started to get more frequent texts from Mother saying that things were getting difficult, she wanted a divorce and she had money issues. The vicar's partner had heard via other members of the church that the children were back on a child protection plan.

Mother asked the vicar and his partner to have Child M to stay for two nights while she went to London to sort out selling her house there prior to the divorce.

5.62 During early December, records relating to Child's M's sibling refer to him being quiet, poor language, poor attendance at nursery and withdrawn.

5.63 The vicar's partner has told this review that the week before Child M's death was "very intense" and there were lots of texts. Mother was having regular contact with her husband, which she found very difficult. Mother also said that the social workers were visiting on 4th or 5th December and she needed to sort the house out. She later said that this visit didn't happen as "someone was away".

5.64 The vicar's partner told this review that the weekend was particularly stressful and when Child M was collected from home to be taken to church she (unusually) described problems at home and said that her father had been on the phone to her mother all day. Mother went to bed with a headache and Child M looked after her sibling. After church that day, the vicar's partner offered to have Child M for the day and she was returned home at 8.30 p.m.

5.65 On 8th December records show that "a neighbour" contacted children's social care concerned about Mother's high level of stress following a phone call from Father. This call had been made by the vicar's partner who gave her name and left a message.

5.66 It was on the evening of 8th December that the fatal car accident took place. Information at the inquest confirmed that there were no other vehicles involved and Mother and Child M were not wearing seatbelts. Mother told the inquest that she cannot recall anything from the two months prior to the accident and the coroner recorded cause of death as a road traffic accident.

Summary: March 2014 – fatal accident on 9th December 2014

From March to October 2014 Child M and her sibling were subject of a child in need plan. Given the lack of clarity about Mother's capacity to sustain change at the point that their names were removed from a child protection plan, it was important that this was tested via a child in need plan. There is little evidence that this happened and that concerns noted by the health visitor appear not to have been relayed to the child in need meetings. The lack of timely referral from housing continued to be particularly significant as it is now clear that there were ongoing stresses associated with financial difficulties.

Swift action was taken when other concerns came to light resulting in a further child protection conference and a child protection plan that recognised that legal action would be considered if changes were not sustained. A legal strategy meeting also took place. However, given the previous steps towards legal action were not all followed through completely and within timescales, it is unclear whether this aspect of the plan would have seemed significant to Mother.

The church continued to be very significant in the lives of Mother and the children but again did not feature within the plan. As the church became aware of increasing stress within the family, a stronger relationship with children's social care would have been beneficial in discussing their concerns.

Another service which had been very significant to Mother was rape crisis. This had ended on 6th October 2014 yet the child protection plan developed at the conference on 17the October continued to refer to "Mother is accessing counselling/therapy to address her past issues and counselling is listed as a protective factor". It is not apparent from the plan who would be delivering this.

6. FINDINGS AND RECOMMENDATIONS

6.1 The inquest into the death of Child M concluded that the cause of death was a road traffic accident and it was noted that Child M and Mother were not wearing seatbelts at the time of the accident. It is the conclusion of this serious case review, that although Child M was subject of a child protection plan at the time of death, it could not have been predicted by professionals that a fatal accident would occur.

6.2 Many people worked hard to help Child M's family over a number of years and as in most reviews, there are lessons to learn about how practice could be improved. In this case help to the family could have been more focused, better coordinated and the impact of plans scrutinised and reviewed more thoroughly; particularly in relation to the link between Mother's emotional well-being and parenting capacity. There is also evidence of over optimism regarding Mother's capacity to sustain the changes required to provide safe consistent care for both children.

6.3 The main factors driving an over optimistic approaches during the period under review were:

- The complexity of the support network surrounding Mother which resulted in significant information not being known by all the relevant people at the right time.
- The challenges of working with neglect where significant improvements in practical parenting can mask a longer term ability to sustain change.
- A lack of management oversight and opportunities for supervision which kept plans on track and challenged biases, beliefs and "groupthink" in a number of agencies.
- A lack of systematic use of multi-professional whole family assessments in order to gain a full understanding of the interaction between parental psychological wellbeing and child development and safety.

6.4 Several of the findings of this review echo those of other recent reviews covering a similarly historic timeframe. This suggests that the issues were not specific to this case and that there is an opportunity, through this review and the Hampshire Safeguarding Children Board response, to understand more fully the underlying factors that were affecting practice at that time and the impact of current practice improvements since the period under review. Specifically:

- working effectively with neglect and in particular assessing parental capacity to sustain change,
- ensuring that the voice of the child is heard and there is careful consideration of the lived experience of children within the family,
- recognition for the potential for children to become young carers where neglect is an issue within the family,
- ensuring the vital role of early years settings in the safeguarding system is understood by all involved,
- ensuring that housing providers discharge their safeguarding responsibilities effectively and their role in the safeguarding system is clear and unambiguous,
- providing effective supervision opportunities to all practitioners and volunteers who come in regular contact with children and families.

Finding 1
Child protection assessments conferences and plans did not include all relevant organisations and engage positively with community support systems.

6.5 There was a complicated network of people /agencies working with Child M and the family. This complex network was in part the result of Mother's own quest for support from a wide range of sources and as a result, social workers needed to engage with a significant number of people in order to make sure that all relevant information was understood and plans to help the family were effectively coordinated. Although there was involvement from core organisations such as schools and health professionals, other community based services including Home-Start, the private day nursery, housing and the church community were not always invited to child protection conferences or other forums such as core groups or child in need meetings.

6.6 Home-Start had significant information that they recorded within their own records as concerns and discussed with social workers, but they were not invited to the child protection conference. This is not usual practice and appears to have been a misunderstanding by an individual social worker regarding the correct criteria that should be used when issuing invitations. Home-Start was invited to subsequent conferences.

6.7 Child M's sibling was known by the time of the second review conference in October 2013 to be attending the private day nursery and they were named as part of the core group. However, they were not informed of the child protection plan until they received an invitation to the review conference in March 2013. The concerns that

were being recorded by the nursery did not influence the generally positive view that developed by March 2014 and it is significant that the manager of the nursery did not feel able to challenge this within the conference. Even where training on child protection conferences has been received, attending an actual child protection conferences for the first time can be intimidating and in this case, lack of familiarity with the process alongside a strong view by those who had been involved with the core group, that substantial progress had been made, inhibited the nursery manager from disagreeing with the decision to discontinue the child protection plan.

6.8 With the benefit of hindsight, the decision to discontinue the plan at the first may have been based on an overly optimistic understanding of Mother's capacity to sustain change. An element of "groupthink"[16] may have been present and contributed to the consensus within the conference but at the time, with the information available, it is understandable why this decision was made.

6.9 Full participation by the day nursery in the second initial child protection conference was inhibited by the fact that only one member of staff was trained to prepare child protection conference reports or attend conferences and they were on holiday. This situation has now been remedied with additional staff members trained to take this role, but it is an issue that may need to be considered by other providers.

6.10 The housing association was notably absent from mainstream planning and they did not refer important information about Mother's financial situation and potential stress as a result of arrears. Another recent serious case review within Hampshire[17] found that the role that housing plays in safeguarding children may be underestimated. Although the circumstances of that review were different (the housing issues related to bed and breakfast accommodation) the underlying issue of housing providers being a key partner in the safeguarding system is relevant and their role in this regard should be fully understood by them.

6.11 An added complicating factor affecting full involvement of housing issues was fragmentation within the housing association itself as the housing officer with responsibility for tenancy and community management (who would often be the liaison point for children's social care) was unaware of the work being undertaken by colleagues managing arrears.

6.12 Of particular significance was the role of the church community in providing support and a lack of clarity about their role. Statutory agencies were concerned that the high level of help provided by church members masked any concerns and did not allow for a proper assessment of Mother's capacity to parent the children. However, rather than looking at how to work positively with the church community and harness their resources in a planned way, the approach set out in the child protection plan was to stop their involvement. This was not only a waste of valuable resources but also left

[16] Groupthink (Janis 1982) is a group process whereby there is a reluctance by group members to challenge the group consensus and has been found to occur within the child protection system.
[17] Child L Published January 2016

the church community unsure about what to do when faced with worries about the children. This was exacerbated by the diocesan safeguarding team being perceived by the local church community as being focused primarily on abuse within the church, rather than providing support where there were families causing general concern.

6.13 Other issues include:

- the children's centre involved in delivering parenting support services not being aware of the child protection plan (this was reported to be usual practice at that time but different under current structures and arrangements)
- the practice in that area at that time which involved the family centre closing a case once it became allocated with the social work team.

6.14 One consequence of a lack of full coordination of professional input to the family was that it was much harder to assess any issues relating to Mother's engagement with services. For the majority of the time, no one was aware of the full range of people that Mother and the children were in contact with and therefore did not have the full picture of what seemed to work best in providing help. It was also not possible to consider the impact of any non-engagement with services over time. The one consistent pattern of attendance was Mother's contact with the rape and sexual abuse counselling service and it is not clear what sense was made of this in relation to Mother's own needs.

6.15 One final issue raised by this review is the role of multi-agency information checks during section 47 enquiries. Following the strategy discussion regarding alleged abuse by Child M's uncle the social worker was proactive in following up the allegations with Child M, Mother and Uncle but other organisations were not advised of the allegation or that section 47 enquiries were taking place. This is not in line with current procedures which are clear that other agencies should be informed and asked for their assessment in the light of the information presented.

Recommendation 1a
Hampshire Safeguarding Children Board should work with local faith and community groups and children's social care to agree and promote a positive role for community faith groups where a child is subject of a child in need or child protection plan and ensure there is an understanding of Hampshire Safeguarding Children Board's information sharing protocol.

Recommendation 1b
The diocesan safeguarding team should work with local church communities to promote and clarify their role in providing support and assistance in situations where there are concerns about abuse and neglect within the family.

Recommendation 1c

Hampshire Safeguarding Children Board should work with partner agencies to ensure that all relevant professionals (including those working in private and voluntary organisations) are included in child protection conferences and that the conference process encourages full participation by those unfamiliar with the process.

Recommendation 1d
Hampshire County Council Early Years Team should seek assurance from all early years providers that they have a full understanding of the child protection conference process and have their own safeguarding procedures in place.

Recommendation 1e
Hampshire Safeguarding Children Board should ask the housing association to:

- review internal communication pathways where a family is in arrears, ensuring that all staff with responsibility for tenant welfare are informed,
- ensure that all staff are aware of their safeguarding responsibilities and that referral processes into children's social care are fit for purpose.

Recommendation 1f
Hampshire Safeguarding Children Board should ask children's social care to remind staff that where section 47 enquires take place on open cases the same procedures should be followed as for new referrals and it is particularly important to notify colleagues across the professional network.

Finding 2
Although Mother was in receipt of a wide range of services, there was insufficient understanding of her capacity to sustain change through a shared understanding of what constituted neglectful parenting, focused assessments and use of the Public Law Outline process.

6.16 The complexity of the network providing help to Mother has been commented on in Finding One and the first child protection plan was based on an assessment that too much help might mask an assessment of whether Mother was able to provide care on her own; hence the focus on asking the support from the church community to cease. The approach would have benefited from a clearer understanding of the underlying causes of Mother's emotionally and physically neglectful parenting style, what help was needed to improve outcomes for the children and whether change could be sustained without a continuing planned package of support.

6.17 Across the partnership at that time there was a lack of shared understanding of what constitutes neglect and/or risky parenting which had the potential to affect positive working relationships. For example, following the first referral the student social worker believed that some people felt that the approach of children's social care was punitive and at the third child protection conference the nursery manager was reluctant to challenge a multi-agency decision to discontinue the plan even though they did not agree. The school and the day nursery have also raised the issue as to

whether there were added challenges because of the family's culture leading to Child M being seen to be "different" rather than "vulnerable" in a predominantly white middle class area. This is likely to have added to the complexity of developing a shared understanding of the children's situation. It is noticeable that the perception of Child M's vulnerability increased with a change of head teacher who had considerable safeguarding experience, highlighting the very individual responses of professionals when faced with the less tangible forms of safeguarding concerns.

6.18 There was an opportunity to have a clearer understanding of Mother's psychological vulnerability at the point that the legal strategy meeting recommended a psychological assessment. Within the PLO framework this could have been commissioned from a recognised expert and provided a basis for understanding her needs and capacity for change. Instead there was an overreliance on a parenting assessment completed by a family support worker and no follow up as to why the psychological assessment had not been completed.

6.19 Overall, the approach to the PLO process at that time lacked sufficient rigour. As a result of a more general recognition that more structure was needed, children's social care developed new frameworks for tracking the process and the Safeguarding Children Board will need to be assured that these are making a difference in practice.

6.20 An additional issue is the storage of assessments. It is of concern that the parenting assessment cannot be found on the electronic system and a paper copy cannot be located. This not only raises issues regarding safe storage of records but also means that if assessments are not readily available they cannot be used effectively to inform future work and measure change. Children's social care have commissioned a new IT system which will improve the storage and retrieval of records and there is therefore no recommendation in relation to this issue.

Recommendation 2a
The response of the recommendation in the serious case review relating to child E (developing a shared evidence based strategy for working with neglect) should be informed by the findings of this review. This work should include community and faith groups.

Recommendation 2b
Hampshire Safeguarding Children Board should ask children's social care for evidence that the current process for tracking progress within the Public Law Outline process is having a positive impact on outcomes.

Finding 3
Practitioners working with complex families, professional networks and relationships, both within statutory and community organisations, need management and/or supervision arrangements that promote critical reflection and

analysis, clarify roles and responsibilities and keep plans on track. This was not consistently provided.

6.21 Although a large number of people worked hard to provide support to the family, the case history highlights the potential for practitioners to be "drawn into Mother's world"[18] and lose their capacity to stand back and see the whole picture. Additionally, as highlighted above, a dominant group view can inhibit individual challenge. In such situations time to stop, think and reflect on how assumptions and biases may be affecting thinking is of the utmost importance. Supervision is one place where this can happen and there were gaps in the supervision and management systems across the partnership which at times contributed to drift, loss of focus on assessing Mother's capacity to change and the lack of coordination across the system discussed above. The main supervision gaps were:

- Case management supervision for the social work student.
- Management and supervision of social work practice in a long term case
- The effectiveness of group supervision within health visiting
- Safeguarding supervision within mental health services.

6.22 The management of the original referral as a child in need resulted in allocation to a student. Asking a student to carry out a child in need assessment is not unreasonable but ultimate case management responsibility should have sat with a qualified worker. The problem at this stage was that allocation seems to have been wrongly assigned to the student and additionally there was insufficient specialist case management supervision available. Students' overall development is managed and assessed by a practice educator, but day to day case management responsibility lies with a practice supervisor in the team and in this case the practice supervisor was on sick leave. The team manager took over case supervision but the student concerned does not recall detailed management oversight and at times lacked confidence in dealing with other experienced professionals. At this stage best practice would have been for the case to be formally allocated to another qualified worker in the team as it was for child protection purposes.

6.23 The student's practice educator did not have a child care background but, as a result of the lack of clarity over case allocation, was the only qualified social work professional at a complex multi-agency meeting in Mother's home. This situation is not dissimilar to another recently published serious case review elsewhere[19] and highlights the need to make sure that where a practice educator is observing practice assumptions must not be made about their role in identifying risks linked to case management.

6.24 The chronology suggests that once this case became "long term" and on the caseload of an experienced social worker there was an assumption that the issues in

[18] Quote from a practitioner involved in the case.
[19] Hertfordshire Safeguarding Children Board Serious Care Review "Sophie" (published May 2016)

the case were “known” and risks were managed. It is likely that this contributed to the minimal evidence within the records of scrutiny, challenge and oversight within supervision. For example, Mother was allowed to delay the Public Law Outline process citing a lack of solicitor and the process drifted for three months. This should have been challenged as the message could have been conveyed to Mother that the legal process was not being taken seriously within children's social care. As explored in paragraphs 5.48-49 above, the request from a later legal strategy meeting for a psychological assessment was also not actioned and there is no evidence that the decision not to go ahead with the assessment was a fully thought through decision agreed by the manager.

6.25 Similarly more active management involvement in decision making should have been evident at the strategy discussion between the social worker and Hampshire police in November 2013. Scrutiny of the subsequent section 47 process would have highlighted that the outcome of “no further action” had not been informed by full agency checks. This point in the case history could also have provided an opportunity to reflect on whether assumptions were being made about Uncle’s capacity to cope with the responsibilities being placed on him and and whether sufficient checks had been carried out in relation to his background.

6.26 It has not been possible to fully discuss the reason for apparent gaps in the role that supervision could have played within children's social care as key personnel have been on sick leave. However the review has been informed by senior managers that, based on the finding from audits, it is likely that the issues identified by the review are local rather than systemic. The Safeguarding Children Board will need to be assured that this is the case.

6.27 In relation to the health visiting and nursery nurse service, the review was told that although the health visitor and nursery nurse were both aware that this was a complicated case, supervision did not provide the opportunity to consider the role of the health visitor and nursery nurse in any depth. Safeguarding supervision was (and is) provided in groups and at the time it was usual for a different supervisor to lead each session. It was possible to ask for an individual session from the safeguarding team but this was not accessed in this case; the most likely reason was that at no one point was it deemed urgent but was rather continuing concerns of a similar nature over a long time period.

6.28 Within the CMHT arrangements for specialist safeguarding supervision are not well established. Discussion of safeguarding issues is integrated into the generic supervision provided by team leaders, the quality of which depends on the level of safeguarding expertise within the team. No practitioner was aware of any role for named doctors for safeguarding in supporting psychiatrists within adult mental health although there was an awareness that the safeguarding team can be contacted on an ad hoc basis as the need arises. In this case, although there was involvement from a number of team members and extensive involvement from the team social

worker, the opportunity for any practitioner to reflect on their role within the children's safeguarding system was limited.

6.29 The head teacher at Child M's school has reflected on the important role that the ELSA had in relation to providing continuity and emotional support to Child M. With hindsight the ELSA had a great deal of responsibility and did not always receive the support that was needed. ELSAs do receive group supervision outside the school but this would not have provided the individual input that would have been needed in this case. In addition, within the school the ELSA held their own confidential records and as a result the head teacher could not have the oversight that was needed to make connections between the various aspects of work with Child M within the school.

6.30 The church community worked hard to provide support but at times felt unsure about the boundaries of their roles and responsibilities. The diocesan safeguarding team was not perceived as the place to go for advice and support with non-urgent issues relating to families in the parish and as a consequence the local church community were not supported in managing their concerns.

Recommendation 3
In the light of the lack of child focus in this case and a potential for over optimism in parental capacity sustain long term change, Hampshire Safeguarding Children Board should develop with partners and the Adult Safeguarding Board a statement of expectation regarding safeguarding supervision and undertake a multi-agency audit of the quality of supervision practice.

In addition, specific actions required by individual organisations are as follows.

Recommendation 3a
Hampshire children's social care should ensure that its policy of not allocating responsibility for casework to student social workers and the respective roles and responsibilities of practice educators, practice supervisors and team managers is better understood throughout the workforce.

Recommendation 3b
Southern Health should be asked to review arrangements for safeguarding supervision for health visitors and nursery nurses in order to ensure that each practitioner has sufficient access to the individual support and critical reflection that is necessary for effective safeguarding practice.

Recommendation 3c
Safeguarding supervision systems within the community mental health team should be developed in order to ensure that all practitioners are receiving supervision from supervisors with sufficient specialist knowledge and skill.

Recommendation 3d
Schools should be asked to review their supervision and management arrangements for

ELSAs in order to ensure that there is management oversight of their work that ensures links with other aspects of school life and that they all have sufficient individual emotional support as required.

Recommendation 3e
The Diocesan Safeguarding Team should develop and communicate with churches the process for obtaining advice and consultation where there are safeguarding concerns relating to members of the local church community.

Finding 4:
Although the psychological vulnerability of Mother was recognised, plans to address this were not always located within a whole family approach which understood and addressed the interface between parental wellbeing, parent/child relationships and the lived experience of children within the family.

6.31 One of the challenges of this case was achieving a balance between the needs of the adult and focusing on the impact of their behaviour on the children. It has been noticeable that during this review it has been hard to gain a picture of Child M, mainly because responding to Mother's needs was the focus of the work of many of the practitioners in the child protection system. Practitioners were aware of the danger of becoming adult focused and sustained efforts were made to provide emotional support to Child M at school, although there is less clarity about how far the impact of family life on Child M's sibling was understood. It was positive that Child M's allegations about Uncle were followed up directly with her by the social worker but there could have been further exploration regarding her injuries through discussion with others in the network including a paediatrician. This would have given a clear message to Child M that her voice had been heard.

6.32 Mother's long standing, deep seated psychological issues were recognised and the child protection plan did provide a focus on Mother's mental health but there was a lack of precision in the overall approach in relation to understanding the exact nature of her psychological difficulties and their impact on her capacity to provide safe consistent parenting.

6.33 The psychological assessment requested at the third legal planning meeting did not take place. The review has been assured that the revised arrangement for the public law outline mean that current practice includes commissioning assessments as required.

6.34 A consequence of no psychological assessment was that plans made assumptions about the impact of services, whereas it is questionable whether services that were provided as part of the child protection plan could produce the depth of change that was assumed. For example, a short term input such as the emotional coping skills group was unlikely to address long term problems. The impact of the private counselling services accessed by Mother was unknown and the local service that

Mother did engage with (rape counselling service) sits outside the child protection system and due to the confidential nature of the service there was no feedback regarding the depth of progress being made. The challenge is therefore to make sure that child protection plans adequately address the depth and complexity of parent's psychological needs and assess change beyond surface presentation.

6.35 A potential feature of families where parental mental ill health and/or psychological vulnerability is present is for children to take on the role of carer for others in the family. Information suggests that Child M took on this role in relation to her sibling but it was not addressed explicitly in assessments or plans. This has been a feature of a recent review in Hampshire[20], suggesting that this in an area that needs further practice development. Practice guidance in relation to young carers was issued in July 2011 and is now due for review[21]. This will provide an opportunity to work across the partnership to promote work with young carers as an important aspect of safeguarding practice.

6.36 There is no evidence within the documentation that practitioners during the period under review worked across adult mental health and children's services using an established whole family assessment framework[22] to help them understand the impact of Mother's wellbeing on her relationship with her children. Hampshire children's social care are now piloting a whole family approach via the establishment of a family intervention team and the findings from this pilot and plans to embed whole family approaches in practice will form part of the response to this review.

6.37 Part of a whole family approach includes understanding stressors and support systems within the family network. In this case an assumption was made about the positive role of Uncle but there is little evidence that full background checks were carried out and time was taken to consider his relationship with the family. This was particularly significant at the time that Child M made allegations against him and a DBS check should have been carried out at this point.

Recommendation 4a

Hampshire Safeguarding Children Board should work with partner agencies and the Adult Safeguarding Children Board to progress an agreed approach to whole family approaches to work with children and their families with a particular focus on:

- The effectiveness of recognition and coordinated responses where neglect is leading to a young person taking on a caring role.
- The impact of the 4lscb joint working protocol on practice

[20] For example SCR Child E

[21] HCC (2011) *Hampshire Practice Guidance for Adult and Children's Services in supporting Young Carers within a Whole Family working model.* (was due for review March 2012)

[22] For example:
Falcov, A (2012) *The Family Model Handbook. An integrated approach to supporting mentally ill parents and their children.* Brighton: Pavilion.
Mainstone F (2014) *Mastering whole family assessment in social work.* London: JKP

Recommendation 4b
Hampshire Safeguarding Children Board should consider whether the voice of the child is adequately heard within assessments, particularly where these relate to safeguarding concerns.

Finding 5
There was a lack of consistency and clarity regarding how to respond to Mother's allegation regarding sexual abuse by another family member.

6.38 Mother's allegation of previous sexual abuse by a close family member currently living in the UK was common knowledge within the professional and community network although not all were aware to what extent others knew. The church community were unsure how to respond, confidentiality prevented the rape counselling service from disclosing this without Mother's permission and the implications were not fully explored within the child protection arena. It was good practice that steps were taken to advise Mother against Child M and her sibling having contact with the family member concerned but there was no consideration as to whether checks should be undertaken with the relevant police force regarding the alleged perpetrators potential access to children or whether there had been other allegations.

6.39 The challenge professionals' face in responding to allegations of child sexual abuse within the family has been confirmed by a recent report by the children's commissioner.[23] There are very specific challenges about how to respond when a parent discloses sexual abuse by a family member as a child and it is important that members of professional and community networks within Hampshire have clear, well publicised messages as to how best to respond.

Recommendation 5

Hampshire Safeguarding Children Board should ensure that professional and community networks have access to clear well publicised guidance as to how to respond when a parent discloses abuse as a child within their family.

[23] Children's Commissioner (2015) *Protecting Children from Harm: a critical assessment of child sexual abuse in the family network in England and priorities for action.*

7. APPENDIX ONE: THE REVIEW PROCESS

7.1 Following the death of Child M on 8th December 2014, the serious case review subcommittee of Hampshire Safeguarding Children Board agreed on 19th January 2015 that the case met the criteria for a serious case review. This decision was confirmed by the Chair of the Safeguarding Children Board on 3rd February 2015.

7.2 The review was led by the independent reviewer and the review group. The review group were supported by the Hampshire Safeguarding Children Board's administrator who attended meetings and took notes.

7.3 The independent lead reviewer was Jane Wonnacott. Jane qualified as a social worker in 1979. She has an MSc in social work practice, the Advanced Award in Social Work and an MPhil as a result of researching the impact of supervision on supervision practice. She has published two books on supervision and co-wrote with Tony Morrison the national training programme for social work supervisors. Since 1994 she has been the author or chair of many serious case reviews and in 2010 completed the Tavistock Clinic and Government Office London nine day training programme for panel chairs and authors. She has also attended the 2012 Department for Education serious case review training programme.

7.4 The review group consisted of:

- Jane Wonnacott: Lead Reviewer
- Learning Reviews and Stakeholder Engagement Coordinator
- Area Manager, Children's Services
- Team Manager, Children's Services
- Designated Nurse
- Designated Doctor,
- Reviewer, Hampshire Constabulary serious case review team
- Inclusion Service Manager, Children's Services
- Safeguarding Lead, Portsmouth Anglican Diocese

7.5 In considering the process for this review, account was taken of the principles set out within Working Together to Safeguard Children (2015) which specifies that:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works to promote good practice.
- The approach taken to reviews should be proportionate to the scale and complexity of the issues being examined.
- Reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being

reviewed.

- Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- Families including surviving children should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring the child is at the centre of the process.
- The final report must be published, including the LSCBs response to the review findings.
- Improvement must be sustained through regular monitoring and follow up.

7.6 Agencies who had been involved with Child M's family were asked to provide a chronology as well as a narrative report of their involvement including any significant information outside the timescales. These reports also highlighted any emerging practice issues.

7.7 No specific terms of reference were set for the review beyond establishing the scope of the review as it was recognised that this was a complex network with many "unknowns" and the questions that needed to be considered would become apparent as the review progressed.

7.8 The agency reports were considered by the review group and practitioners were identified who would be most able to help the review group understand the detail of what happened and the influences on practice at that time.

7.9 The independent reviewer met practitioners either individually or in small groups with the member of the review panel who had professional expertise in their area of practice. This approach allowed the lead reviewer to gain an overview of practice and cross reference information whilst ensuring that practice issues specific to one staff group were fully explored. A full list of practitioners is set out in Appendix Two.

7.10 All practitioners were invited to a meeting with the review group to discuss the emerging themes from the review. This provided an opportunity to check the review group's initial analysis with practitioners who had been directly involved and share ideas about potential practice improvements.

7.11 Mother and Father were offered an opportunity to contribute to the review. Neither responded to correspondence relating to the review. Both were again invited to participate after the inquest had concluded but at time of writing no response has been received.

7.12 The lead reviewer met on six occasions with the review team to discuss the emerging information and the draft report. The report was received by serious case review subcommittee and amendments made prior to presentation to the Hampshire Safeguarding Children Board on 28th September 2016.

7.13 A response to this review has been prepared by Hampshire Safeguarding Children Board.

8. APPRENDIX TWO: PRCTITIONER DISCUSSIONS

Childrens Social Care

- Student Social Worker referral and assessment team
- Social worker children in need team
- District manager children in need team
- Child Protection Conference Chair

Early Years services

- Children's centre leader
- Senior family support worker
- Manager private day nursery

School

- Class teachers
- Student teacher
- Learning Support Assistant
- Special Educational Needs Coordinator
- Head teacher.

Home Start

- Coordinator
- Volunteer

Community Mental Health

- Consultant Psychiatrist
- Team Leader community treatment team
- Mental health practitioner

Community Health

- Health visitor
- Student health visitor

- Community nursery nurse
- GPs
- Specialist safeguarding nurse

Housing Association

- Housing Officer
- Resident services manager
- Lead financial inclusion advisor
- Income officers
- Income team leader

Church

- Vicar
- Vicar's partner

Telephone conversations were held with:

- Rape Crisis service
- Assistant head of workforce development children's services
- Workforce development manager