Northamptonshire Safeguarding Children Board

Serious Case Review Report

Child Ak

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Contents

1) Introduction, background and rationale for the review – terms of reference

1.1 A Serious Case[1] Review (SCR) is one of several reviews and audits undertaken within the learning and improvement framework established by a Local Safeguarding Children Board (LSCB)[2]. A review provides an opportunity to open a 'window on the system' especially at a multi-agency/service level. Any learning, perhaps especially from a situation with the most tragic of outcomes, needs to continue to strengthen the development of the various strands of a 'safety net' (individual practice, its organisation and management, governance and quality assurance arrangements between and within each partner agency) comprising the response with, and for all children, young people and families.

1.2 Child Ak died in December 2017 just after his second birthday. Following a 999 call, ambulance crew conveyed Child Ak to the local General Hospital. Basic life support was undertaken throughout but sadly Child Ak died as a result of cardiac arrest. Child Ak was also found to have high levels of several drugs in his body and multiple injuries, bruises and other unexplained injuries of concern. Subsequently, his father was arrested, charged with and convicted of his murder.

1.3 The review concentrated in detail on a relatively brief period from 1st October 2017 – 31st December 2017.

- 1st October 2017 is the approximate time from which Child Ak's parents, who lived separately, established informal care arrangements for Child Ak.
- The end date for the review included a period following Child Ak's death, included to assist an understanding of initial steps taken to ensure that Child Ak's siblings were safeguarded.

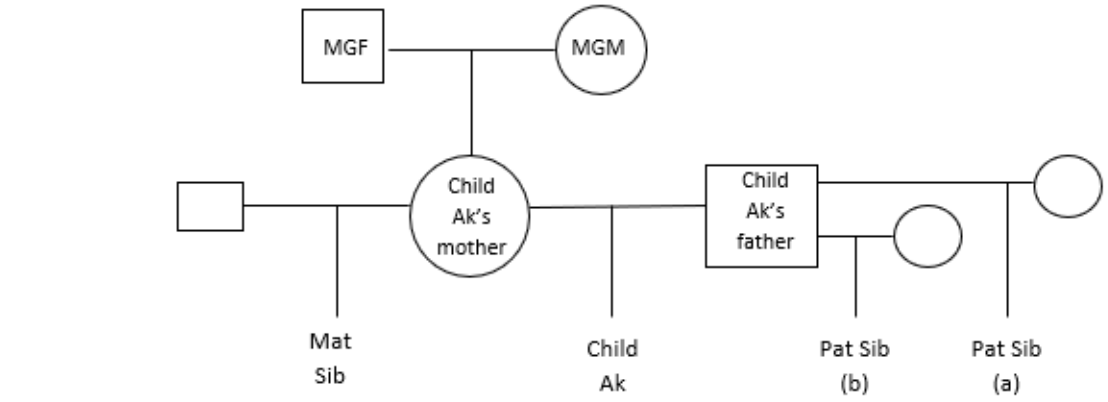
1.4 A panel was appointed to plan and manage the review comprising named and designated representatives from the local authority children's services, appropriate health services, the police and the LSCB. The panel was chaired by Malcolm Ross and a lead review report author, Phil Heasman (a qualified social worker; previously a Principal Lecturer in Social Worker; an independent training, learning and development consultant) was appointed. Both the chair and report author are independent of the case under review and of the organisations involved. Individual agencies completed Internal Management Reviews (IMR reports) and a comprehensive integrated chronology was compiled from information provided by relevant agencies and services. An event was held for relevant practitioners to identify learning and encourage reflection on their involvement, to examine the actions and decisions taken and to understand their context.

1.5 For the purpose of the report, the child who is the primary focus will be known as Child Ak. The report refers additionally to other family members and other significant people identified by their relationship to Child Ak where possible, although in some places the relationship is described in terms of the link to Child Ak's mother and father where this assists clarity.

[1] Throughout this report the word 'case' is not used to define or describe an individual child but to represent the whole of a situation, people and services or agencies involved with a particular child and her or his family or families, people known to the child and the wider context of the child's life and experience.

[2] NB: Local Safeguarding Children Board (LSCB) is the term used to describe the past and current relevant multi-agency organisation; the term Local Safeguarding Partnership is used, especially in relation to the recommendations, to indicate the prospective successor body.

A genogram of key members of Child Ak's immediate families only:



Mat Sib: maternal sibling
Pat Sib: paternal sibling
MGM: maternal grandmother
MGF: maternal grandfather

2) Background information and key events

2.1 Whilst this report concentrates primarily on a relatively brief period in late 2017, many services and agencies had contact and worked with Child Ak's mother and father (and members of their extended families) separately in preceding years including 'universal' services and agencies (e.g: health, education, police) as well as more specialist services (such as: Children's Services, Family Nurse Partnership, Youth Offending Service).

2.2 When Mother became pregnant with Child Ak, a pre-birth child protection conference was held. It was decided that Child Ak would be made the subject of a child protection plan under the category of emotional abuse. From the pre-birth conference through to October 2017, involvement with Child Ak, his mother and other family members was based on decreasing or sequentially 'stepped down' levels of formal and organised involvement, as defined in the 'levels' of response within the Children Act 1989, the statutory guidance (*Working Together 2015*) and associated guidance of the LSCB.

2.3 Child Ak's father was known in his own right to a variety of services including the police, probation and Children's Services. Consent was not given for access to Father's medical records for this review, however the police IMR report cites involvement by the police service with various members of Father's family, both as victims and offenders. Father first came to the attention of the police in 1999 with sporadic contact over the subsequent few years for offences of damage and assault until 2005 where the offences apparently became more frequent and serious. There is a record of having multiple arrests, being charged with offences (with many involving drugs) and having related convictions. The police IMR report notes a history of domestic incidents (from verbal arguments to serious assaults) involving Father, his partners and with his brother.

2.4 Children's Services were involved separately, respectively, and to differing degrees of formal involvement, with Child Ak's paternal siblings and families.

2.5 In the information available for this review, Child Ak's paternity was only definitively established in late September 2017 when Mother contacted him and informal arrangements were made to share Child Ak's care, spending half of each week with each parent.

2.6 It was not until October 2017 that services and practitioners made a link between Mother and Father and information established about the informal shared care arrangements. In mid-October Child Ak was found in Father's care during the police execution of a Crown Court warrant. Drugs were present in the property and apparently accessible to Child Ak. There was also reason to understand that Child Ak was left on his own in the flat for periods of time. Father told officers that he was looking after his son for two days. The police made a referral and information was shared with the MASH and Children's Services.

2.7 Two days after the incident, a multi-professional Strategy Discussion meeting was held. Substantial 'case history' background information was available to the meeting:

- in relation to Child Ak's health and development;
- regarding both Child Ak's parents including historic information and involvement with Children's Services and with the police in their own right, respectively;
- information about Father including the suggestion that he was dealing drugs;
- information about the current nature of contact between Father and his other children.

A summary of the information and consideration of risks and vulnerabilities at the Strategy Discussion meeting included:

- the respective age difference between Child Ak's parents
- the potential risk to Child Ak when with Father, if Father is in possession of illicit substances;
- the fact that Father only has supervised contact with his other children;
- that Father is sharing Child Ak's care even though his paternity had only recently been established;
- the degree of knowledge that Mother had of Father's criminal history and domestic abuse history.

2.8 It was decided at the meeting that the threshold was not met for a section 47 enquiry (to ascertain whether a child is 'suffering or likely to suffer significant harm') as:

- a lot of the concerns relating to Mother were not recent;
- that Child Ak had potentially been exposed to harm with Father but had not suffered harm;
- that no concerns were raised by his nursery setting; and
- that health visiting services were seeing the children as part of the 'universal service' provision.

The recorded concerns identified particularly related to Child Ak's 'mother's capacity to risk assess and protect her children and ensure that contact is safe.'

2.9 The outcome of the meeting was that referral/allocation to the Children's Services First Response Team (FRT) would be made, with action to include:

- children to be seen in their home environment and observed (in order to ascertain their wishes and feelings)
- social worker to interview both parents and/or caregivers and determine the wider social and environmental factors that might impact on them and Child Ak;
- a single assessment to be undertaken with the family as part of the current enquiry and management oversight to be completed at appropriate checkpoints;
- all professionals involved with the child/family to contribute to the assessment and provide information about the child/family;
- genogram (diagram of family details) to be updated;
- chronology to be updated

It was not a recommendation of the Strategy Discussion meeting that Child Ak should have a paediatric check or health assessment. An initial letter was sent to both parents following the Strategy Discussion meeting to inform them of the proposed assessment.

2.10 Following the allocation for assessment, information that Child Ak was in contact/staying with his Father was shared with the Multi Agency Safeguarding Hub (MASH) provided by practitioners involved in separate family proceedings that Father was a party to.

2.11 During the review process additional information was provided that concerns about Father and his (unsupervised) contact/care of Child Ak (and continuing after the incident in mid-October, the Strategy Discussion and allocation for assessment) had been reported to several Children's Services practitioners on, it would seem, up to eight occasions by three different members of the extended maternal family of paternal sibling (a) (including one report from before the incident in mid-October) - and some were reported further within MASH and Children's Services by the practitioners involved with this child.

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2.12 In early December, the social worker allocated to undertake the assessment attempted to contact Mother by telephone but was unsuccessful.

2.13 Two days before the incident in mid-December that led to this review being undertaken, further information was sent directly by an independent reviewing officer (IRO) - involved in the separate family legal proceedings unconnected with Child Ak - to the allocated social worker and manager reporting that it appeared that Child Ak was being cared for still by Father. It was also reported that the court had requested a parenting assessment of Father relating to concerns about potential emotional or physical harm linked to incidents of domestic violence and potential harm due to his apparent lifestyle, drug use and dealing. The IRO noted that no observations were recorded on Child Ak's file since October.

2.14 The following day the allocated social worker succeeded in speaking on the phone to Mother who said that her son did not need a social worker and put the phone down on the worker. Following the call, the social worker planned to send Child Ak's mother a letter explaining the social care concerns, the possible outcome of non-engagement, and proposed actions to be taken by social care if she continued to decline to discuss the situation.

2.15 The next day the emergency services were contacted by Father. A paramedic crew attended, and Child Ak was taken to the local hospital where, sadly, his death was confirmed. Child Ak had experienced traumatic cardiac arrest and apparently had unexplained injuries, multiple bruises and other injuries of concern inconsistent with the account given. Father was arrested on suspicion of murder.

3) Practice, its organisation and management – terms of reference: questions, issues, and themes

3.1 The review sought to develop an holistic and systemic perspective in understanding Child Ak's life and the circumstances of his life and death; in considering the impact of his parents and carers, his wider family and those associated with them on his development and wellbeing; and in understanding the work with Child Ak and his family by practitioners and their services and organisations, individually and together, focussing especially on a number of themes

3.2 **Child Ak:** what was like life for him; was his 'voice' heard, listened to and understood. Following the concerns that led to the Strategy Discussion meeting and the subsequent information about Child Ak's continuing care by Father, the formal assessment (including an expectation that Child Ak's wishes and feelings would be ascertained) and the recommended interview with both Child Ak's parents may have provided a picture of what life was like for Child Ak. However, the Children's Services IMR report suggests that there was a significant missed opportunity: '(Child Ak) was never seen from the period (of the incident leading to the strategy meeting) up to the time of his death… and therefore his voice was not heard. Consequently, Child Ak's safety was seriously undermined with lost opportunities to place him at the centre of any analysis of risk.' Additional Children's Services information concludes that 'Through the history of the case…' there was 'insufficient focus on the actual day to day experience of the children.'

3.3 **Child Ak's care by Mother and wider maternal family.** The assessment proposed at the Strategy Discussion meeting in October 2017 was essentially to establish potential levels of support (for a 'child in need', as opposed to a child in need of protection) and focused primarily on Mother's capacity to appreciate and manage the potential risk to Child Ak given that '(Child Ak) has potentially been exposed to harm with dad but has not suffered harm… The concern is around mother's capacity to risk assess and protect her children and ensure the contact is safe.'

3.4 It is hoped that, but not known whether, the assessment would have:

- addressed Mother's understanding of and response to the potential risk to her son in light of the incident in mid-October, especially in relation to her attitude towards contact and shared care between Child Ak and Father (and whether contact or shared care had continued or was planned);
- reviewed and analysed Mother's history and the potential impact on her current parenting capacity or general level of vulnerability, resilience, capacity to protect, and sense of agency - or how her own experiences may have affected her capacity to recognise and manage risk and manage the relationship with Father that led to agreeing or allowing the shared care arrangement to continue.

Although there was no formal involvement with the family by October 2017, there may have been an over-optimism on the part of practitioners at the Strategy Discussion meeting about Mother's capacity, and those of others involved in his care, to recognise and manage risk even if *they* were not seen as a direct source of risk or vulnerability at that time.

3.5 Despite the fact that there was extensive information in the chronology and IMR reports about Child Ak's maternal family and their extended involvement with many services, and Children's Services identified 'aspects of the family' as a contributory factor, it is important to note that the level of formal involvement by practitioners and services in Child Ak life was 'stepped down' or decreased over Child Ak's life up until October 2017. Information available to the review suggests that the injuries that led to Child Ak's death did not apparently occur while he was in the care of his mother or maternal grandparents or in their home, but in the care and home of his father.

3.6 **Father and involvement with fathers.** Some information was known by some agencies about Father's own background and family; about police involvement, offences and criminal convictions including for drug offences; and his parenting capacity in relation to his other children. There is a record of various expectations that parenting assessments would be carried out (including linked to concerns and decisions about contact or other arrangements and in family proceedings matters), reference to work relating to anger management and in relation to perpetrating domestic abuse.

3.7 The recommendations at the Strategy Discussion meeting in mid-October 2017 included that both Child Ak's parents should be interviewed and that a single assessment should be undertaken with the family (but not famili*es*) and it is hoped that relatively recent information about concerns regarding drug use and contact in relation to the paternal siblings would have been considered further. It is suggested in the Children's Services IMR report that the Strategy Discussion meeting in mid-October 'failed to fully appreciate the significance of (Father's) chronic history of domestic abuse and extensive history with the police for drug related offences.'

3.8 Following allocation (after the Strategy Discussion meeting), the fact that direct contact was not made with Father to undertake the assessment meant that information was not obtained or analysed in relation to:

- Child Ak's experience in Father's care;
- questions about the quality of care (especially care that involved Child Ak staying with him for several days at a time);
- Child Ak's health, development and wellbeing when with Father;
- what his needs were – both generic and specific (what Child Ak needed from his Father) and whether those needs were being met - and if so, how?; whether those needs were not being met – and if not, why not?

3.9 Finally, it seems deeply significant that despite all the information and analysis in the IMR review reports, the combined chronology or as a result of the criminal trial following Child Ak's death, it has not been possible to establish a clear picture of the circumstances that caused or can explain

the assault/s that resulted in the number, nature and great severity of the injuries leading to Child Ak's death or the type and magnitude of the levels of drugs found in Child Ak's body, post-mortem.

3.10 **Working with interconnected families and related children and young people.** The issue of working with interconnected families and the children and young people within them is highlighted by this review given the many individuals, households and extended families connected to Child Ak. Many people across the families that Child Ak was considered to be part of at different times of his life were actively involved with statutory services including Children's Services where there was work within the requirements and provisions of statutory guidance (e.g: where children were considered 'in need' or in need of protection or where there were legal proceedings).

3.11 **Agency practice, processes, organisation and management.** The review considered the involvement of the individual agencies and their practitioners who had contact with or responsibilities in respect of Child Ak and his respective parents during the period of the review, primarily October to December 2017.

3.12 **Health services.** Child Ak and his maternal family were the subject of regular 'multi-disciplinary' safeguarding meetings at the GP practice and perhaps this raises an issue about one agency or service designating concerns as 'safeguarding' when there is no formal involvement as defined by the *Working Together* 2015/2018 'levels' of 'early help', 'child in need' and 'child protection'. It is not known how formally managed these meetings were and the way that information was shared - or how discussions and any proposed action was recorded and then made available to other practitioners who may have contact with members of the families on the practice's register. It is not known whether families were informed of the fact that they are discussed at these meetings.

3.13 Also consideration might be given to what constitutes a 'single agency' when, under the umbrella term 'health', there may be many practitioners, from several professional groups with different contractual arrangements, perhaps working in different teams, certainly located in various places and with different organisational, support and administrative arrangements (including IT systems) – all of which could perhaps be construed as multi-organisation/-agency working. This may be important given the expectations in *Working Together 2015/2018* about the requirements for formal management of multi-agency 'early help' (where 'early help' is a term used to describe the level of concern rather than a description of a 'targeted' service) and the associated expectations of an inter-agency assessment undertaken by a 'lead professional who should provide support to the child and family, act as an advocate on their behalf and coordinate the delivery of support services.'

3.14 **Police service.** The police IMR report provides several key learning points and emerging issues including the importance of maintaining a 'safeguarding' focus whatever the task or incident attended to. The recommendation in the police IMR report that: 'Planned operations to identify an officer responsible for any safeguarding action needed' is welcome and this may enhance the consistency and quality of information shared with other services when required. Similarly, the recommendation to undertake 'a process of 'dip sampling' of engagement of officers attending

DVs (domestic violence) with children present. To ensure that the voice of the child is heard' is also welcome.

3.15 **Multi/inter-agency practice, process, organisation and management including the Multi-Agency Safeguarding Hub (MASH)** The main focus of multi-professional/multi-agency work during the period October to December 2017 relates to the response to the incident when Child Ak was found in Father's care when concerns were raised about drugs in the flat and the level of supervision that Child Ak was given, especially in relation to the Strategy Discussion meeting held two days after – and the related decision making. The Children's Services IMR report highlighted 'a lack of a systematic and consistent approach in the threshold decision making', suggesting that the 'application of the Children's Services Threshold pathway was at best ineffectual and at worst obscure in the decision making process'. Of note in the Children's Services' IMR report is the apparent emphasis on 'imminence' with additional Children's Services information concluding that making threshold decisions in respect of section 47 enquiries based on the premise of 'imminent danger' is not an accurate reflection of how judgements should be made within the framework of risk, significant harm and likelihood of harm as set out in the Children Act 1989 and *Working Together.*

3.16 In the Children's Services IMR report and in views expressed by panel members it is acknowledged that, on further reflection and with hindsight, the decision at the Strategy Discussion meeting should have been made to proceed to a 'single 47[3] and ICPC (Initial Child Protection Conference) with legal advice; …there were certainly more risk factors than protective factors.'

3.17 A further issue relates to the management of information within the MASH service – especially in respect of any information received and then further shared regarding Child Ak's contact and continuing contact with, and care by, his Father.

3.18 **Children's Services.** Child Ak was allocated to a social worker in the First Response Team for assessment on the same day as the Strategy Discussion meeting, with notification letters sent to both parents. The review panel heard of continuing work to develop the response to parents or carers following referral and it is hoped that this might include setting out clearly the rationale (including the details of cause for concern and related statutory basis for the work) and process for an assessment; the timescale; the areas to be addressed in the assessment; any expectations (for example in relation to contact, etc); the details of the lead practitioner who will be undertaking the assessment – and the opportunities for support and service pathways that may follow. This immediate allocation and sending a letter would appear to be good practice - not least given the fact that, even during the time that the review was being undertaken Children's Services were seeking to manage a situation where there were many unallocated cases (Ofsted Inspection Report October 2018).

[3] Section 47 Children Act 1989: the duty to investigate whether a child is suffering or likely to suffer significant harm - where a local authority have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

3.19 It is important to understand more about the circumstances affecting the practice and management of Child Ak's 'case' in the period from October to December 2017

3.20 Problematic contributory factors are highlighted from information available to the review panel, including:

- delay
- insufficient consideration and follow up on the 'high risks which had been identified for Child Ak from his father'
- ineffective communication between and within professionals in Children's Services
- concerns were not escalated.

Secondly, 'local strategic level factors' are identified - potentially impacting on the effectiveness of work at the time:

- high turnover of staff
- large numbers of agency staff
- significant levels of management sick leave
- ineffective case management and priority monitoring systems which compounded problems and resulted in a lack of accuracy in identifying high risks or the need for urgency
- high caseloads
- a focus on 'imminent danger'
- lack of appropriate escalation

3.21 According to the Children's Services IMR report, active steps were apparently being taken to address the issue of high workloads with a 'recovery plan' in place and discussions held about creating opportunities for staff to complete outstanding work, including work over the weekend.

3.22 There does not seem to have been an effective process for management oversight or a process to review the decision of the Strategy Discussion meeting in the event of additional information - or continued risk being identified. It is not entirely clear how notice of new or additional information is actually given once there is an allocated worker. If this is via email or telephone message, then 'notice' may be *given* or information 'passed on' but the information may well not have been meaningfully 'shared' or obviously *received* by the person with allocated responsibility. In information from Children's Services it was concluded that: 'The case management and priority monitoring systems do not seem to have worked well enough in this case. The impact of this was a lack of appropriate escalation… during October 2017 and resultant delay in taking the appropriate action at the right time to ensure (Child Ak's) safety and protection.'

3.23 There were also apparently issues about the IT systems and their reliability at a crucial point in early December 2017. It was agreed that the allocation of all cases should be reviewed by the Service Managers. This would have included his case - where the information and concerns about continuing contact between Child Ak and Father 'would have been seen and should have led to an escalation to a higher level of action to safeguard him. However, IT systems issues prevented this from taking place and this further delay in being identified and responded to occurred during the emerging crisis of (Child Ak) being cared for by (Father) who was known to be a very risky adult.'

3.24 A question could be asked about the messages that may have been unwittingly given to or received by Child Ak's respective parents about the level of concern or perceived risk to Child Ak as a result of the delayed follow up to the letter following the Strategy Discussion meeting informing them that an assessment would be undertaken.

4) Learning lessons; developing practice, its organisation and management; recommendations

4.1 Most of the IMR reports included sections on 'lessons learnt' and areas for development or recommendations of relevance to the specific practice, teams and service arrangements within the relevant agency itself.

4.2 The following, taken from the IMR reports, seem of particular note and of wider, multi-agency relevance:

- developing an organisational culture that is child centred and child focused; that ensures that the child/young person is 'seen' (or considered, when working with parents, even if absent – and referrals made if parents' presentation gives cause for concern); that ensures that the child or young person's 'voice' is heard; that safeguarding is considered in all circumstances including identifying an officer responsible for any safeguarding action needed in all police operations;

- clarifying, understanding and applying thresholds across frontline teams, within the MASH and for statutory intervention;

- ensuring effective systems to assist management accessibility and oversight, workload management (individuals and teams) and reflective, direct and recorded supervision of 'cases'; ensuring that 'high-risk' cases are identified and prioritised;

- ensuring that assessments are child focused, follow a consistent framework to promote analysis and include a 'Think Family' perspective, ensuring that information about relations between adults and children in their care (including parental responsibility) is clear and accurate;

- developing an organisational culture that enables professional curiosity, professional judgement and professional challenge;

- ensure that expectations regarding multi-agency information sharing is clearly understood across all levels of involvement and that information and updates (e.g: records and minutes of meetings) are available and shared appropriately within each service or agency, that MASH Strategy Discussion minutes and decisions are available on the police information system;

- ensure that practitioners are trained to be able to fulfil their safeguarding roles and responsibilities at all levels of practice;

- ensure that procedures and protocols are understood and followed (e.g: record keeping, the 'voice' of the child).

4.3 The 2018 LSCB Annual Report (2018) expects that each agency will track and audit the implementation of lessons and recommendations from agency reports and from SCR reports respectively. It is also expected that the appropriate LSCB/Local Safeguarding Partnership sub-group will review and evaluate information on action plans, progress and outcomes.

4.4 In addition to the learning points and recommendations in the individual IMR reports, the review considered several specific relevant themes. Some contextual commentary is followed by recommendations. Many of the themes that have been identified seem linked - with a degree of interactive dynamic overlap or common elements. They may also resonate with themes in other serious case reviews published by the LSCB and in national reports.

4.5 Seeing and hearing children.

4.5.1 This is definitely a theme that has been identified in many previous SCRs, overview analyses (the DfE biennial and triennial publications) and other reviews (e.g: Ofsted thematic review *The voice of the child* 2011) and was referred to across all the IMR reports, the practitioner event and the panel discussions. *Pathways to harm; pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 Final Report* (2016), notes that an active effort must be made to actually see children in their families – a lesson 'so important that it must be re-emphasised and potentially re-learnt as people, organisations and culture change.'

4.5.2 In the Ofsted review *The voice of the child* (2011) several aspects of practice that may inhibit children being heard and seen are identified – the first two perhaps being of direct relevance in this situation:

'In too many cases...

1) the child/young person was not seen frequently enough by the professionals involved, or was not asked about their views and feelings
2) agencies did not listen to adults who tried to speak on behalf of the child/young person and who had important information to contribute
3) parents and carers prevented professionals from seeing and listening to the child/young person
4) practitioners focused too much on the needs of parents, especially on vulnerable parents, and overlooked the implications for the child
5) agencies did not interpret their findings well enough to protect the child.'

4.5.3 The following messages or lessons from *this* review relating to seeing and hearing children seem of particular significance:

- seeing and recognising a child and their experience in all situations and in all relationships, families and home/household or care settings that he or she may be part of;
- seeing the child within the information (the 'data') in increasingly IT systems driven processes; recognising the risk of a child becoming 'virtual', an identifying name linked to a process or task;
- recognising the value of imagining the 'voice' of the child (one panel discussion included reflection on the question of what a child or young person might want from an SCR process and related recommendations);
- thinking about a child's experience, beyond the immediate presentation;

- listening and responding effectively (including rigorous recording and timely and appropriate sharing of information with other practitioners) to people (including other extended family members and practitioners involved with other children) who may raise concerns and who may have important information about potential risks posed to a child;
- consider the message that a child or young person might take about the regard for their safety or welfare from the response of practitioners and managers.

Recommendation 1:

That:

- each agency is required to review guidance, procedures and training for practitioners and managers and ensure that: a) the fundamental message to 'think child or young person' is understood; b) any duty and expectation is fulfilled that a child/young person will be seen and that her/his views, wishes and feelings will be ascertained, taken into account and given due regard; c) the expectation is met that *anyone* who may contribute to an understanding of the child or young person's experience is heard and their views (and especially any reports of concerns) are recorded and shared with other practitioners as necessary and taken into account in assessments and responses;
- the Local Safeguarding Partnership requires evidence from each agency that they are meeting this recommendation and that the effectiveness of direct work with children and young people and the ability to understand the experience of a child/young person (informed by all available sources of information) is measured as part of key performance indicators.

4.6 Young people in need of protection who may also be parents

4.6.1 Whilst this review has focused primarily on a short period of time (October to December 2017), the IMR reports and the combined chronology covered a period when Mother and significant others were young and legally considered children in their own right.

4.6.2 Perhaps the dominant language and ideas about effective safeguarding of *children* does not translate sufficiently when working with young people. A publication in 2018 *Safeguarding during adolescence – the relationship between Contextual Safeguarding, Complex Safeguarding and Transitional Safeguarding* (Firmin et al, Research in Practice) is helpful. However, additional consideration may be required when working with young people/adolescents in need of protection but who are *also* parents - ensuring that *their* need for protection or services in their own right is not lost. Additional consideration might also be given to young people in this situation where they are ostensibly being supported or are living with *their* parents – perhaps in whose care the young parent's protection needs had arisen.

Recommendation 2:

a) That the Local Safeguarding Partnership and all partner agencies develop or review existing guidance and procedures for effective work with *young people who are parents* where safeguarding or the provision of services is required for both a young parent and her/his child - including the need for separate plans and appropriately differentiated services, resources and allocation of practitioners.

b) That the guidance and procedures also consider the need for the careful assessment of the protective and parenting capacity of *the parents of young parents* especially where there are, or have been, concerns relating to the young parent's own experience in their care; where a household is shared; where *the parents of young parents* may be considered part of the caring, support or protective arrangements for a baby/child and her/his young parent.

4.7 Parents and the potential impact of abuse including exploitation and domestic abuse

4.7.1 It seems of note that considerable information was available to the review about the experiences of several parents (but especially mothers) in both the immediate and extended families related to Child Ak – in relation to the potential legacy and impact of abuse, particularly domestic abuse. This may have relevance to an understanding of a parent's vulnerability and potential capacity to recognise risk, to have a sense of agency and capacity for assertion and a degree of control within relationships to appropriately safeguard a child. This is not to seek to excuse attitudes or actions that could or should have been more protective, but it may form part of an explanation – and therefore contribute to practitioners' analysis of risk and capacity to protect, especially including in relation to contact between a child and his/her father.

Recommendation 3:
That practitioners working with a parent who may have experienced abuse (especially including domestic abuse and/or exploitation) analyse and take into account the potential impact of those experiences on a parent's own understanding of risk and any assessment of her or his protective capacity.

4.8 Fathers, partners, secondary and other carers and their families, connected families and networks.

4.8.1 This is another theme of other SCRs and an area highlighted for further research in a Department for Education evidence review (Wilkinson. J and Bowyer. S, 2017). It is acknowledged that there was only a relatively short period of time from Father being identified to the incidents that led to this review – but further development of work with fathers, partners and secondary carers would be beneficial, especially when assessing and analysing potential risks to a child.

Recommendation 4:
That where there is statutory involvement, all practitioners are expected and required:

- to establish and update information (sharing with other practitioners and agencies where appropriate) about a child's or young person's parents and carers, wider family/families' members, associates and people of significance to the child (using genograms and ecomaps in all cases) - especially in relation to anyone who has parental responsibility and/or who is playing a part in caring for the child (formal, informal, regular, occasional – for shorter or longer periods of time, but especially where there is 'staying care');
- to establish information relating to the level of care or contact that a parent or carer has with a child (including any restrictions on, or conditions regarding, care or contact with any *other* children of that parent/carer);

- to include fathers or partners (including those who have contact) actively in all processes (especially in parenting assessments, meetings and plans).

That the Local Safeguarding Partnership and partner agencies identify and promote approaches and resources relating to engagement and effective work with fathers or partners of parents.

Recommendation 5:

That the Local Safeguarding Partnership and all partner agencies actively develop strategies, procedures, guidance and systems (including in relation to information management and recording) to enhance practitioners' and agencies' capacity to work effectively where there may be:

- complex parenting arrangements, for example involving different parents – especially fathers/father figures - for several children within a single household;
- parents, perhaps especially fathers, who have several children but where the children live primarily in several different households – but where there may be unsupervised, supervised or even staying contact;
- several connected individuals or families (including those who may share a household) involved with statutory services and known to many different practitioners and services and who may have different allocated lead practitioners.

4.9 Engagement and compliance and the impact on children.

4.9.1 There was evidence of persistent engagement with Child Ak and his maternal family over an extended period: by the Family Nurse partnership practitioners, health visitors, social workers and others and the value of work within the context of relationships has been identified in SCR reports and other research. In a 2011 review Munro notes: 'A recent overview of the evidence about effective interventions for complex families… showed the importance of providing 'a dependable professional relationship' for parents and children, in particular with those families who conceal or minimise their difficulties. …it was the quality of the therapeutic bond established between the social worker and client that was the basis for what was conceived of as a positive intervention.'

4.9.2 However, the question of the capacity to influence and help effect lasting and sustained change was raised in some of the IMR reports with sporadic engagement in meetings and formal decision processes and with missed appointments at times. The theme of 'disguised' or 'false' compliance' is mentioned in some of the IMR report information and has been referred to in previous analyses of SCRs. However, it may be important to recognise that a lack of engagement or compliance may not be deliberate, planned or part of a strategy but possibly a reflection of an individual's organisation and functioning, her/his stage of life (especially perhaps with young parents), priorities, capacity or recognition of responsibilities. Again, it may be very important for practitioners also to recognise factors that could impact on parents' and carers' capacity and a personal sense of agency more generally – especially the possibility of coercion and control in domestically abusive relations and in family functioning, or where there may have been experience of exploitation.

4.9.3 An emerging key message from discussions of compliance/non-compliance seems to be the importance of a primary and unrelenting focus on the child/young person and the impact of care arrangements (across the full range of carers who may be involved in her/his life) and outcomes for her or him in terms of health, development and wellbeing - rather than on parental activity per se. Learning from reviews analysed by the NSPCC[4] highlights that 'professionals need to establish the facts and gather evidence about what is actually happening, rather than accepting parent's presenting behaviour and assertions. By focusing on outcomes (for the child/young person) rather than processes, professionals can keep the focus of their work on the child.'

4.9.4 Parents may choose not to engage but it is important that practitioners consider carefully the point at which this choice denies a child or young person access to an assessment or service to protect or meet her/his needs - and follow the local multi-agency guidance: *Resistant Families – Working with Refusal to Consent or Engage,* where appropriate.

Recommendation 6:

That practitioners, supervisors and managers are guided and required through advice, procedures, practice supervision and related training to:

- maintain a clear focus on the impact on the child/young person (measured in terms of health, development and wellbeing) of parents' or carers' willingness and capacity to engage – both in assessments and in plans for work;
- to 'Recognise that noncompliance may be a parent's choice, but that does not mean it is the child's choice.' (*Pathways to harm, pathways to protection 2016 p.143)*;
- to be aware that 'Where child welfare concerns are identified, poor engagement by families should heighten concern and should not prompt case closure unless there has been a thorough risk appraisal.' *(p.147)*;
- to follow established single and multi-agency safeguarding arrangements and procedures to address any harm or risk of harm where required and escalate continuing concerns – including where services cannot be provided.

This recommendation links to learning identified in another current SCR (Ref 070).

4.10 Assessments, thresholds and pathways including formalising multi-agency work (especially 'non-targeted' early help)

4.10.1 *Working Together 2018* (p.16) expects that 'safeguarding partners should publish a threshold document, which sets out the local criteria for action…' including in relation to local arrangements agreeing 'the levels for the different types of assessment and services to be commissioned and delivered. This should include services for children who have suffered or are likely to suffer abuse and neglect whether from within the family of from external threats' (what *Working Together 2018* newly refers to as 'contextual safeguarding' p.23). Information from Children's Services suggests that there was 'difficulty in being able to evidence a systematic and consistent approach in the threshold decision-making in relation to Child Ak and his half-sibling' – and – that 'inconsistent application of the thresholds to determine the right level of intervention led to incoherent management of the case.'

[4] (https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/disguised-compliance/

4.10.2 The formal arrangements for multi-agency work may be clearly understood at 'child in need' and 'child protection' levels, for work with 'looked after children' (where the local authority identify a social worker as the 'lead practitioner') and '*targeted* early help' (especially where this essentially involves a local authority provided or commissioned service). However, there may be less clarity about the statutory expectations (*in Working Together 2015/2018*) for the management of multi-agency work across the whole undifferentiated spectrum of 'early help' (where 'early help' is considered a *status* – of concern about a child's wellbeing and potential unmet need - rather than a *service*).

Recommendation 7:

That:

- the Local Safeguarding Partnership completes the current work to review and revise the multi-agency *Thresholds and Pathways* guidance (referred to as 'local protocols for assessment' in *Working Together 2018)* for work with children, young people and families at all levels – including, especially, at the locally-defined 'non-targeted early help level' and in relation to the role of the lead practitioner and related co-ordination of a single, shared assessment; a co-ordinated plan; and the promotion of child/young person and family engagement;
- the Local Safeguarding Partnership updates guidance to reflect any *future* changes in operational arrangements and related processes – at the time that any changes are made;
- that *partner agencies* similarly revise and update their own related agency-/service-specific guidance – at the time that any changes are made;
- that promotion and compliance with the guidance is evidenced through training and supervision;
- that the application of the guidance and its impact is monitored, especially in relation to: the appropriateness and quality of referrals; decisions relating to section 47 enquiries made at Strategy Discussion meetings; the start and completion of assessments (including within statutory required timescales and in relation to the principles and parameters of effective and 'high-quality' assessments as set out in *Working Together 2018*); on plans, pathways and outcomes of service provision - so that children, young people and families receive the right help at the right time.

4.10.3 The incident that led to the Strategy Discussion in mid-October in relation to Child Ak included concerns that Child Ak had been found in the proximity of drugs, therefore it is also recommended:

Recommendation 8:

That where there is a concern that a child may have been in a situation where drugs were accessible to them, there must be a comprehensive risk assessment which will consider information or evidence of the accessibility of drugs within the household, and supervision of the child. A paediatric assessment should always be considered as part of an initial response or as part of all further enquiries or assessments.

4.11 Practitioner and manager roles and responsibilities

4.11.1 *Working Together (2015/2018)* and related statutory guidance sets out the legislative context and related responsibilities, duties, powers and rights - for practice and its management. For social workers, the expectations are published in the Department for Education's (DfE) *Post-qualifying standard: knowledge and skills statement for child and family practitioners (May 2018).*

4.11.2 Issues relating to management oversight and supervision of workers' practice were reported in some of the IMR reports, significantly in relation to Children's Services. The DfE's expectations for Children's Services/social work managers at the time of work with Child Ak were outlined in the *Knowledge and Skills Statements for Practice Leaders and Practice Supervisors (2015)*[5] . Areas of competence in the current guidance for practice supervisors include: promoting and governing excellent practice; confident analysis and decision-making; practice supervision; shaping and influencing the practice system; and performance management and improvement. The recommendations reported to the panel from Children's Services address several areas of practice and management: 'to develop', 'to make clear', 'to ensure' etc., but there are no apparent explicit recommendations about training and development for managers, supervisors and practice leaders to help achieve the proposed developments and then support and maintain the associated anticipated improvements for children and young people. Thus:

Recommendation 9:

That the Local Safeguarding Partnership requires assurance:

- from Children's Services about the arrangements for managers', supervisors' and practice leaders' training and support in the First Response (or equivalent) teams; and
- in relation to arrangements for management and quality assurance within the MASH service.

It is expected that this will be monitored through reports to the Local Safeguarding Partnership and, within the local authority, as part of the Improvement Plan.

4.11.3 A further area relating to practitioner roles and responsibilities has been highlighted in this review: the importance of recognising that practitioners from *all* agencies have responsibilities across the safeguarding spectrum in relation to information sharing, raising concerns, challenging and escalating matters where concerns are not shared by others, or when new concerns arise. It is important that 'professional challenge' is seen as a positive step to present confidently an assessment and analysis relating to the wellbeing of a child and potential action, rather than as a way of gatekeeping and managing finite and potentially stretched resources.

4.11.4 Thus a substantial learning point is that practitioners from all agencies recognise that they have a responsibility to identify, raise and continue to raise safeguarding concerns that they have about children and young people's wellbeing using the appropriate procedures (including the processes to manage differences of opinion, disagreements and conflict) and to escalate concerns (again using the established processes and procedures) where necessary.

[5] Now republished as*: Post-qualifying standard knowledge and skills statement for child and family practice supervisors* (May 2018) and *Post-qualifying standard knowledge and skills statement for practice leaders* (March 2018)

4.11.5 Similar may be suggested in relation to managers where they may have concerns about organisational arrangements, resource management and related practices that could impact on the effectiveness of response to children and young people, parents and carers. Panel members reported that the *current* culture in the local authority is now one where managers and supervisors are enabled and encouraged to identify and raise concerns when workload exceeds capacity and may, therefore, impact on the capacity to respond effectively to child in need or at risk - and if there is a risk that decisions may be resource-led and not children's/young people's needs-led. This is to be welcomed but will need monitoring in line with recommendation 11 (below).

4.12 Information sharing, information management and related systems

4.12.1 Information sharing and management has been a consistent theme of SCRs, public inquires and similar reports for decades (see Galilee 2010, report for the Scottish Parliament – a review of such reports dating back to the 1940s). In the IMR reports and at the practitioner event for this review, matters relating to information sharing, information management and related systems were similarly highlighted including, specifically:

- 'systems that do not speak to each other';
- the sharing of strategy meeting minutes and decisions to the police NICHE system;
- different IT systems across health services;
- the absence of a national 'ContactPoint'-style or local 'one-stop' record of children or young people who are, or have been, the subject of child protection plans; or are identified as children 'in need' (CA'89 sn.17); or where there is involvement because of a child or young person's legal status (e.g: accommodated under CA'89 sn. 20, subject of a Supervision or Care Order, CA'89 sn.31); where there may be specific contact arrangements as a result of past, present or prospective risk of harm, etc.;
- the accuracy of information gathered and shared;
- the potential challenge of having to 'effectively navigate multiple domains and sources of information held both internally and across partner agencies' (from the Children's Services IMR report);
- the management of information coming in to and out of the MASH, for example: additional information, and what it means to *notify* or share information with an allocated worker or team;
- the absence of a co-ordinated system for tracking and monitoring cases.

4.12.2 Undoubtedly, information technology has a considerable potential: for assisting with the identification of risk of harm, and associated need and provision of services and support; for laterally linking information about children and their families when new connections are identified (a newly-identified father, for example, or a father who may be the parent of several children in different households); for ensuring that information is available to all relevant practitioners (e.g: in a GP surgery following a multi-disciplinary team safeguarding meeting); for assisting processes and management oversight such as 'flagging' timescales and the completion of tasks (e.g: appropriate allocation, seeing a child within three days of a decision to assess, completing an assessment within 45 days, etc).

4.12.3 It is also recognised that practitioner uncertainty about appropriate information sharing can potentially hinder the process, perhaps especially with the new General Data Protection Regulation requirements.

Recommendation 10:

That the Local Safeguarding Partnership:

- review the all-agency guidance on information sharing to ensure that it is compliant with GDPR requirements, and promotes the principles for sharing information in safeguarding work set out in *Working Together 2018* (especially the guide on p.20);
- evidence awareness of, and compliance with, the guidance across teams and services, in supervision and in training;
- ensure that minutes from multi-agency meetings are shared with all relevant partner agencies, especially MASH Strategy Discussion minutes with health agencies and the police;
- monitor instances when information sharing and management may have hindered or, equally, assisted effective responses to children and families.

That all partner agencies review their own related guidance on sharing information both internally and with other agencies.

4.12.4 It is recognised that the challenge of communication between agencies' and services' separate information systems is a national issue but it is a learning point from this review that the Local Safeguarding Partnership should continue its work to promote and enhance the integration (where possible and appropriate) of local information systems and their capacity and functionality to enhance safeguarding practice and its management with children and families within and across services - and within and across work with individuals and families where necessary and appropriate.

4.13 Resources, services' configuration and quality assurance.

4.13.1 The strategic work of partner agencies to develop and appropriately configure effective services, to manage the operational and practice implications and to assure the effectiveness and quality of services for children, young people and families, continues (especially for the local authority and Children's Services within it). Thus, it is recommended

Recommendation 11:

That the Local Safeguarding Partnership will:

- monitor and evaluate the impact of strategic, operational, organisational and practice developments – including multi-agency arrangements and those of key safeguarding partners (particularly the local authority) - through a clear, open and transparent audit process identifying key indicators and relevant qualitative information and data to assist in the assurance of safe practice; and
- champion appropriate resource allocation.

This should be monitored through reports to the Local Safeguarding Partnership and the Social Care Improvement Board.

Recommendation 12:
That the Local Safeguarding Partnership (through the Quality Assurance Sub Group or equivalent, as appropriate) monitors and tracks the implementation and impact of all the specific agency recommendations from the IMR (Individual Management Review) reports and related action plans, as well as the recommendations and action plan relating to this overview report.

5) Conclusion

5.1 Many people have contributed to this review and their time and expertise is appreciated greatly, especially as this helped in the development of an understanding of agencies' and practitioners' involvement with Child Ak, his families, significant other people in his life and the issues identified following his tragic death.

5.2 Two quotations from reports separated by nearly thirty years perhaps have relevance for this review:

The inquiry report following the death of Liam Johnson London Borough of Islington (1989) included the following:

> 'It was said to us before we started hearing evidence that if we could suggest ways in which families like this… could somehow be identified before the tragedy occurs it would be an enormous help. It will be clear from the pages that follow that although we suggest ways in which practice might be improved, we have been unable to suggest any infallible method of spotting potential child killers.'

Although, significantly, the reference at the time was not to the man identified in September 2017 as Child Ak's actual biological father, a terribly tragic irony in this situation is that before his birth, at the pre-birth child protection conference, a key reason recorded for the need for Child Ak to be made the subject of a child protection plan was the 'unknown risk his/her father poses.'

Secondly, the triennial analysis of serious case reviews (2016) embraces the idea of 'pathways' to harm and protection recognising that:

> 'children are harmed within contexts of risk and vulnerability and that there are many opportunities for prevention and protection, even without being able to predict which children may be harmed, when or in what manner. It affirms the very positive work being done by professionals working with families to support and challenge, and acknowledges the need for an authoritative approach, combining authority, empathy and humility… …and taking hold of the opportunities to learn and improve.'

5.3 It is perhaps impossible to say whether the developments identified in practice and its organisation and management that have been implemented already; that comprise the recommendations for individual services and agencies; or that may follow in line with the recommendations of this report – could have had an impact on the outcome for Child Ak, who was tragically killed by his father and in relation to whom it has not been possible to establish a clear picture of the circumstances that caused or can explain the assault/s that resulted in the

number, nature and great severity of the injuries leading to Child Ak's death or the type and magnitude of the levels of drugs found in Child Ak's body, post-mortem.

5.4 It is hoped sincerely that the lessons and recommendations from this review (along with learning from audits of practice where positive outcomes may be highlighted for the children, young people and families with whom agencies work day in and day out) will enhance the vital ongoing work to further strengthen and develop practice, its organisation and management, quality assurance and governance - and strengthen the provision of effective services and responses to all children, young people and families.

May 2019