HARINGEY LOCAL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW
CHILD Y

Born March 2006
Date of injury August 2008

EXECUTIVE SUMMARY

(September 2009)

1. Circumstances leading to the Serious Case Review (SCR)

1.1 Child Y is a black British boy, the first and only child born to his teen-age parents, Ms Y and Mr T. In mid-August 2008, Y (aged **2 ½ years**) was brought by his mother to North Middlesex Hospital (NMUH), after he suffered a fall at home. Ms Y said he had been jumping on a bed and had fallen off, apparently hurting his left leg and experiencing severe pain.

1.2 After examination in the Accident and Emergency (A&E) service, Y was admitted to Rainbow Ward for treatment for a fracture to his left femur/thigh bone. This was a serious injury which would require in-patient admission for several weeks' treatment by immobilisation and traction.

1.3 The conclusion of hospital doctors was that Y's fracture was of a type and severity which was not consistent with the fall described by Ms Y and was likely to be a non-accidental injury (NAI). His mother was arrested and interviewed (as she had been the only person present when the injury occurred).

1.4 A SCR was proposed for the following reasons:

- Y was the subject of a formal Child Protection (CP) Plan.
- He had suffered a serious injury, considered to be non-accidental.
- There were significant risk factors for this young child – and for his mother, who was until recently also a child – which appeared to have been insufficiently communicated and responded to within the professional network.
- As there were a large number of agencies working with both parents, there were likely to be important lessons to be learned from a SCR.

1.5 After some negotiation, it was agreed with Government Office for London (GOL) that an SCR should be conducted. This has now been completed, but in the meantime, two important factors emerged: DNA evidence showed that **Mr T was not the biological father of Y**, and **further medical opinion concluded that Y's injury could be consistent with Ms Y's description of its causation.**

In 2007, Mr T had raised doubt about his paternity of Y, but there was no action taken to test this out until over a year later. Because the services involved and the individuals and families themselves (generally) believed Mr T to be Y's father, and behaved accordingly, it was agreed that the Individual Management Reviews (IMRs) of each agency's involvement, and the Overview Report, should refer to Mr T as Y's father.

2. Terms of Reference

2.1 Purpose of SCR

National CP guidance, *Working Together to Safeguard Children (WT),* 2006, directs that the purpose of SCRs is to:

- Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result;
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children.

2.2 Time frame for SCR

1st June 2005 to 16th September 2008

The time frame covers the period of conception of Y and extends to granting of an Interim Care Order and transfer into Haringey's Children in Care Team.

2.3 Key Issues

IMR authors and the Overview Report author are asked to address the following key issues:

- Address the particular relevance of both the mother's and the assumed father's childhood or other experiences.

- Establish the capacity of front-line services over the time-frame covered by the review, including reference to budgets, staffing numbers and skills of the Local Safeguarding Children Board (LSCB) member agencies.

- Establish the impact of any organisational change over the period covered by the review.

- Establish and evaluate the impact of the death of Baby Peter in August 2007; what evidence is there that practice changed as a consequence of learning?

- Establish whether and how inter-agency procedures were followed throughout the period, with particular reference to:
    - The quality of multi-agency assessments
    - The quality and timeliness of decision-making
    - The quality and timeliness of child protection planning
    - The quality of supervision

- The appropriate involvement of senior managers or other organisations and professionals
- The recognition of the impact of domestic violence on children
- The recognition of domestic violence between adolescents
- The timely recognition of significant harm with particular reference to physical abuse
- The degree to which there was appropriate contact and communication with the subject child
- The degree to which there was appropriate contact with Y's mother, while she was under 18 and involved with services

- Evaluate the impact of any practice models used by staff involved in the case together with any training received and how it was evaluated; consider whether and how decision-making was affected.

- Consider how inter-agency communication affected the case and whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children.

- Establish whether there are any issues which relate to ethnicity, faith, disability or culture which may have a bearing on the review

2.4 Scope of the Review

The review is in respect of Child Y, Ms Y and Mr T. It will consider services provided to all family members within the time frame covered by the review. IMR writers shall interview professionals and staff as necessary, and shall produce a chronology of their agency's involvement with Ms Y, Mr T and Y. Their reports should include analysis under the headings listed in 2.3 above.

2.5 The Chair of the LSCB shall invite key members of the child's family as listed under family composition to contribute to the review.

(A letter of invitation to participate in the SCR was sent to Ms Y, MGM and MGA, and to Mr T and PGM, offering a meeting with the Independent Overview Author and a member of Haringey's SCR Panel. They were also given the choice to participate in writing. No response was made by any family member.

The Executive Summary will be shared with both families before publication.)

2.6 The LSCB shall establish a dedicated SCR Panel with the following representatives:

- Police
- Health
- LA Children's Social Care
- LA Schools Services
- LA Legal Service
- LA Housing Service
- Probation Service
- Youth Offending Service
- Haringey Domestic Violence Co-ordinator

2.6.1 Members of the Panel will be independent of the case.

2.7 The LSCB shall appoint an independent author to write the Overview Report.

2.8 The LSCB will determine any issues relating to publication of the report, in relation to outstanding care and criminal proceedings.

3. SCR Process

3.1 Members of the SCR Panel

- Independent Chair: Alison Botham, Integrated Working Manager
- Eleanor Brazil, Deputy Director, Children and Young People's Service (HCYPS)
- Jan Doust, Head of Children's Networks
- Wendy Morgan, Acting Detective Chief Inspector, Metropolitan Police Service, Child Abuse Investigation Command (CAIC)
- Penny Thompson, Deputy Chief Executive, NHS Haringey
- Dr. David Elliman, Consultant Paediatrician/Designated Doctor for CP
- Julie Halliday, Director of Nursing, North Middlesex Hospital
- Judith Ellis, Director of Nursing, Great Ormond Street Hospital (GOSH)
- Mary Pilgrim, Assistant Chief Officer, London Probation Service (LPS)
- Linda James, Head of Service, Youth Offending Service (YOS)
- Jacqueline Longmore, Principal lawyer, Haringey Legal Services
- Denise Gandy, Head of Housing Support and Options
- Deirdre Cregan, Domestic Violence (DV) Co-ordinator
- Sarah Peel, LSCB Training and Development Officer

The Panel worked together with the Overview author to meet the requirements of the SCR process, including time scales, and to quality assure the IMRs.

3.2 SCR Panel Chair

An independent member of HCYPS was asked to chair the SCR Panel, when it became clear that the independent Board Chair would need a permanent deputy for the duration of this SCR. Unfortunately, because of holiday and sickness, she was unable to chair more than one meeting. In these circumstances, the Deputy Chief Executive, NHS Haringey, stepped into the chairing role. She had no direct or indirect management responsibility for this case.

3.3 Independent Overview author

The Overview Report was prepared by Sally Trench, an Independent Social Work Consultant, with a background of 30 years' local authority social work in the UK (never within Haringey).

3.4 Agencies contributing to the SCR

There were thirteen agencies working with Mr T, Ms Y and Y, all of whom produced IMRs. There was also a Health Overview Report. The agencies were as follows:

- Children's Social Care
- School and Support Services (Teenage Pregnancy Reintegration Project/Stepping Up and Connexions)
- Youth Offending Service
- London Probation Service
- Metropolitan Police Service
- North Middlesex University Hospital:
  Paediatric Services (GOSH@NMUH)
  Maternity Services
  Accident and Emergency Services
- Whittington Hospital:
  Accident and Emergency Services
- Community Health Services:
  School Nursing Service
  Health Visiting Service
  GP Services
- Legal Services
- Housing Services

4. The Case Story and Agencies' Involvement

4.1 Family Composition:

Y	Subject	DOB	March 2006
Ms Y	Mother		May 1990

Maternal Grandmother
Maternal Great Aunt

Mr T Father October 1987
Paternal Grandmother

4.2 Background: At the beginning of the SCR period (June 2005), Ms Y and Mr T were a teenage "couple" living (separately) in Haringey. Both were from black African-Caribbean families; Ms Y had lived in Haringey all her life, whereas Mr T had emigrated with his family to London when he was about 10 years old.

Both had experienced disturbed childhoods, with parental separation, conflict and violence in their families, including stormy relationships with their mothers. Mr T had been the victim of physical abuse within the home, and was in the care of Haringey from the age of 14.

Mr T (by now aged 17) and Ms Y (aged 15) were said to be capable young people, but they achieved poorly at secondary school. Each had at one point been permanently excluded from school, because of offending, and disruptive or aggressive behaviour. School/college was often missed because of truanting, or (in Mr T's case) of being in custody.

From aged 14 onwards, Mr T was a serious and prolific young offender, and served three custodial sentences for violent attacks while still a minor. Ms Y received her first (of 3) criminal Supervision Orders when she was 13 years old, and continued to offend for the next 3-4 years, often in the company of Mr T. She was increasingly outside the care and control of her mother, intermittently going missing from home from the age of 14.

Both Ms Y and Mr T appeared to be healthy young people with no known disabilities. There is nothing in the records to indicate that either young person followed a religion.

4.3 Agencies' Involvement:
Ms Y's pregnancy with Y was hidden until about 22 weeks, after which she sought and received appropriate health services for herself and her unborn child.

4.4 Because of Ms Y's young age (15 years) and risk factors in her own and her family's history, her Midwife made a referral to Children's Social Care (CSC), who undertook an Initial Assessment. This led to a plan for monitoring of Ms Y's and the baby's needs (post-birth), with the understanding that Ms Y's mother and other family members would care for her and the baby.

Ms Y's family showed great commitment in their support of Ms Y, as well as in their desire to keep Y within the family network.

4.5 Ms Y was supported by, among others, the Teenage Pregnancy Reintegration Officer (TPRO), the Youth Offending Service (YOS), and Connexions, to continue her education during her pregnancy and after Y's birth.

4.6 During this same time, Mr T was similarly involved with the Leaving Care Team (within CSC), the YOS and Connexions, and was offered several training and job-preparation courses. It was rare for him to complete these, often because of his volatile and threatening behaviour. He was in prison for a good part of Ms Y's pregnancy, but was back in the community when Y was born.

4.7 Y was born in March 2006, and after some extra time spent in hospital to treat an infection, went home to his mother and maternal grandmother's home. He was seen there by Midwifery and Health Visiting Services, and Children's Social Care. Mr T was involved in visiting and at times caring for his son.

4.8 When Y was **3 months old,** Mr T severely attacked Ms Y (the first of several such incidents during 2006/07), and as a result mother and baby were placed in temporary housing in another borough. There were further moves during the next 6/7 months; as a result, services in Haringey and elsewhere struggled to make contact with Ms Y and Y (the main exception being the YOS, who met Ms Y regularly as part of her Supervision Order). Y was not seen by a Social Worker or Health Visitor for many months. Ms Y did continue to take him to their GP, and he received the required immunisations. Otherwise, Y's wellbeing was little known about at the time, and was likely to have been affected by his disrupted care, and the conflict between his parents.

4.9 The Police were regularly involved with Mr T and Ms Y, who continued to offend both singly and together. Mr T's assaults on Ms Y were noted four more times during 2006/07. Despite her wish to separate from him and protect herself and Y, she seemed unable to do so.

From November 2006 to September 2007, Mr T was subject to a Community Order, supervised by the Probation Service, which required him to attend a number of work and training activities.

4.10 In early 2007, Ms Y and Y were found to be living back with her mother in Haringey. Now over school-leaving age, she pursued her studies at college, with child care support from her extended family.

4.11 A serious attack by Mr T, including attempted rape, against Ms Y occurred in June 2007 (in the presence of Y), and led to an Initial CP Conference and a CP Plan for Y. From this point onwards, there was more intensive involvement by CSC and Health Visiting Services. Y was deemed to be principally at risk of harm from his father's violence. However, less attention was paid to the impact of his mother's erratic lifestyle, which at times included going missing from home and offending (as well as reuniting with Mr T). Ms Y's family agreed to supervise her care of Y, but the shifting shared care arrangements did not sufficiently address Y's need for settled and consistent nurturing from a primary carer.

4.12 Ms Y was also at risk of harm from Mr T; this was acknowledged by the Housing Service's commitment to rehouse her in a safe place. She was offered (but never took up) help from the Women's Support Officer within the Probation Service, a support service for victims of domestic violence.

4.13 In September 2007, Mr T went to prison for 9 months, for a wounding offence with a knife. During this period, Ms Y obtained alternative temporary accommodation, although she and Y still regularly stayed with her mother and her relatives. Y's development overall was seen to be good, apart from some language delay.

His CP Plan was intended to ensure his safety and consistent longer-term care. Several parts of the plan were not implemented, and in fact the details of who was looking after him in 2007/08 were often unclear.

4.14 Ms Y appeared to make a fresh commitment to becoming Y's main carer in the spring of 2008, a plan which was supported by the inter-agency professional network. However, the summer saw renewed pressures in the family network, including the illness of a key carer, and physical attacks against Ms Y by a new boy friend.

4.15 In August 2008, Y sustained the injury to his femur. Because he was the subject of a CP Plan, and because his fracture was initially believed to be NAI, hospital staff acted promptly to inform and involve the appropriate protection agencies (Police and CSC).

A CP investigation was carried out, and legal action was taken: by the Police (in relation to Ms Y) and by the local authority, to secure Y's protection – via an Emergency Protection Order and Interim Care Order (ICO).

4.16 Y made a good physical recovery. He remained in hospital for a month, after which time he was discharged to the care of a maternal relative, still under an ICO. Plans for his future care were explored via a Family Group

Conference; at the same time, a parenting assessment of his mother was commenced.

5. Analysis and Conclusions

5.1 The main findings from this case reflect those identified in SCRs nationally over several years. For professionals and public alike, it remains perplexing that practitioners, managers and professional networks, apparently, make the same mistakes over and over again.

The fact is that **CP work is intrinsically complex, difficult and demanding**. Brandon et al (2009)[1] declared that:

"Practitioners who are overwhelmed, not just by the volume of work but also by its nature, may not be able to do even the simple things well. Good support, supervision and a fully staffed workforce are crucial".

In many local authorities, achieving effective and high quality CP practice, within and across agencies, remains extremely challenging. The learning from this SCR is intended to help meet these challenges within all the agencies working with children in Haringey.

Basic Practice Areas

5.2 **<u>Assessment:</u> The response by Haringey CSC to Ms Y's pregnancy in 2005/06 and Y's birth was insufficient – based on an inadequate assessment of vulnerability and risk for both parents as individuals, and as teenage parents. The mistaken view of the case as "low level" continued to influence the professional network until Y's injury.**

- Assessments need to consider family history of both sides of the family, and individual psycho-social history, as well as previous agency involvements (among all relevant agencies).
- The <u>culture</u> of child care/child rearing in an individual family needs to be explored, including the impact of ethnicity, faith, and areas of ill health or disability.
- The IMRs generally commented that there were no issues of ethnicity, faith, disability, or culture which affected the services provided to the child, his parents, and extended family. There was an acknowledgement that the <u>culture</u> in Ms Y's family was to "look after their own".
- In this case, a Core Assessment/pre-birth parenting assessment should have been undertaken, as both parents were high vulnerability/high risk.
- The ability of Ms Y's family to offer supportive or substitute care for Y was largely assumed, not carefully assessed. As a result, many areas of family conflict, family ill health, and risks from criminal behaviour remained unexplored.

- The elements of good comprehensive assessments should include:
  ~Proper use of the assessment model in the *Framework for the Assessment of Children in Need and their Families* (DH, 2000) (AF) to achieve a comprehensive and inter-actional understanding of parents/children
  ~ use of chronologies for family history and agency involvement
  ~ thorough examination of old records, especially key documents (e.g., court reports, CP Conference minutes, previous assessments)
  ~ Reviewing an assessment in the light of any significant changes or new information.
- Given the response to this case, the threshold for a Core Assessment, a pre-birth parenting assessment, and an Initial CP Conference in CSC needs to be reviewed.

5.3 **<u>Communication and Information sharing</u>: Not all relevant agencies were included in meetings and information-sharing. When information was shared, it was not always rigorous and comprehensive.**

- Agencies generally worked in "silos", making it difficult to achieve a full picture of the needs and risks for mother, father and child. The lack of a <u>full</u> professional network continued to affect the work and outcomes in this case throughout.
- Agencies involved with father were frequently left out of meetings and information sharing, despite his ongoing involvement with Y and Ms Y.
- Information sharing tended to underplay areas of risk, especially for Y.
- Police MERLIN reports (notifications of children coming to the notice of police) were not consistently completed and/or provided to other agencies when Ms Y was encountered by the police, either as a victim or an offender.
- CP Conferences and Core Groups had limited invitation lists and attendance, so that there were severe constraints on getting a full picture of the circumstances of the parents and Y. The circulation of minutes missed out those who did not attend as well as those who should have been invited but were not, thus limiting the sharing of important information from the Conference.
- Agencies struggled to work effectively in the face of confused and inconsistent information from parents and family members.

5.4 **<u>Risk Management:</u> As a consequence of 5.2 and 5.3 (above), there was a lack of multi-agency assessment and risk management planning – until Y's injury in August 2008.**

- Individual agencies generally made assessments according to their primary function, e.g. risk of re-offending, throughout the case. Their safeguarding responsibilities (for Y and Ms Y) were not adequately acknowledged and acted upon. "*Safeguarding is everybody's business*" needs to be reinforced in all agencies working with parents and children.

- Mr T was not referred to Multi-Agency Public Protection Arrangements (MAPPA), the appropriate inter-agency forum for assessing and managing risk from Mr T to Ms Y and Y.
- Detailed information about both parents, held by YOS, the Police and Probation was rarely sought by those working with Ms Y and Mr T. Police and offending services need to be consulted fully, where they are known to be involved with parents.
- CP investigations (S47 investigations) should be carried out in line with the London CP Procedures – in this instance, in response to the several episodes of DV which occurred in Y's first 12 months.
- On a positive note, the S47 investigation after Y's injury was effective in its inclusion of all relevant agencies, the level of communication, and the appropriate decision-making and planning to protect Y.

5.5 **<u>Ms Y's needs as a child in her own right</u>: Agencies were not sufficiently protective of Ms Y as a child (she was 15 years and 10 months when Y was born).**

- Agencies often struggle to focus on the protection needs of adolescents, who, like Ms Y, engage in risk-taking activities, including offending and running away from home.
- Agencies did not sufficiently recognise and respond to Ms Y's vulnerability as a young person with a troubled family history and a turbulent adolescence, who was contending with the care of an infant and risk of violence from her partner.
- Instead, Ms Y was generally seen as "a young mother". Where there were offers from a targeted service (for a child/young person) such as the Teenage Pregnancy Reintegration Officer, she used these minimally.
- There was no recorded risk assessment of Mr T's and Ms Y's under-age sexual activity, in line with the Bichard recommendations[2].
- A pre-birth or residential post-birth parenting assessment might have offered Ms Y the opportunity to successfully parent her child, or at least to carefully consider their future.

5.6 **<u>Case Planning and Review</u>: The impact of having no formal plan pre-birth and during Y's first 15 months meant that the inter-agency work was unfocussed. The CP Plan was poorly implemented.**

- Without a formal plan – whether Child in Need, Child Protection or Child in Care Plan – the purpose of the work, the expectations of professionals and family members, and the desired outcomes may remain unclear (as in this case). Even after there was a CP Plan for Y, this lack of clarity continued.
- In several agencies, there was good continuity of the key worker (HV1, YOS Case Worker for Ms Y, GP1). However, in CSC, the several

changes in SWs and Managers contributed to the failure to implement the CP Plan.

- There was an insufficient level of CP supervision available in the HV Service. In CSC, supervision sessions were held, but largely failed to bring an objective rigour to the task.
- **Structure** and **Good Supervision** are the keys to improving children and families work in all agencies. This is vital in CSC, where there may be ongoing staff turnover. Thus, all cases remaining open in CSC after an Initial Assessment or Core Assessment should adhere to the structure of **APIR**: **A**ssessment, **P**lanning, **I**ntervention, **R**eview.

Specific Practice Areas

5.7 **<u>Response to Domestic Violence</u>: DV towards Ms Y as a young person, and in particular the risk of violence to Y as a vulnerable infant and toddler, were given insufficient weight and response.**

- The known violence between the parents (mostly by Mr T against Ms Y) did not trigger a CP Investigation, despite the fact that there were two children (Ms Y and Y) at considerable risk. There was no CP Conference until Y was 15 months old, after 6 reported incidents of DV between his parents (Y being present on 4 of the occasions).
- It is likely there were other incidents of DV which did not come to light. (Research suggests that there is evidence of significant under-reporting of DV[3]).
- The risk to infants from exposure to angry conflict and violence needs to be understood in relation to both physical harm and emotional harm.
- The history of violence towards others – principally by Mr T, but also by Ms Y – should have been regarded as a significant risk factor for familial violence, including to children.
- Neither Mr T nor Ms Y co-operated with the services which might have addressed the violence in their relationship.

5.8 **<u>Involving fathers</u>: This case illustrated the common practice of "sidelining" male parents/fathers and the agencies involved with them.**

- Mr T's history and involvement with the child were not given enough attention at various points, including the beginning of the case – despite the fact that he was a Care Leaver, and well known to CSC, YOS and the Police.
- These agencies involved with Mr T were not included in the first planning meeting and most of the CP Conferences. As a result, the danger from Mr T's level of violence and therefore risk to any child were not properly addressed.

- The case demonstrated a general tendency towards "mother-focused" services in pregnancy and neo-natal period, with men/fathers receiving less attention.
- Mr T was referred for parenting groups by Connexions and his Probation Officer, although it was not apparent that he attended. .
- Improving practice in this area would be assisted by engaging with the Family Rights Group's "Fathers Matter" work, and the material in Mary Ryan's report *Working with Fathers* (DH, 2000).

5.9 **Families who get lost: Cross-borough moves created difficulties for the work, and there were significant periods when Ms Y and Y's circumstances were not known.**

- The transfer of the case to Enfield Children's Services (July 2006) from CSC was ineffective, and the case was apparently "lost" and not worked with for a number of months – despite the fact that Y was regarded as approaching the threshold for an ICPC. Haringey CSC should have kept the case open until another LA agreed to the transfer.
- The HV Services in 4 boroughs made ongoing attempts in 2006 to locate Y and Ms Y, without success.
- It was not always clear whether Police reports were reaching the appropriate Children's Service, thus placing Y and Ms Y at greater risk.
- Ms Y did not always stay at her "official" placements by the Housing Department. All this meant that there were significant periods when Y was not seen and his whereabouts unknown.

5.10 **Children from birth to 12 months: A better understanding and sharing of the safeguarding risks related to the vulnerability and developmental needs of children in their first year is needed.**

- The requirements for a baby's growth and positive development depend not just on physical nurturing and safety (though that is of primary importance), but must include warmth and affection, stimulation, and consistency of care.
- There is need for a clearer definition and understanding of the "basic care needs" of infants and toddlers, which can be shared among the agencies working with such cases.
- The extreme vulnerability of babies is reflected in the national SCR reviews: in 05/06, 44% of SCRs related to under-1s (though they formed 6% of the under-18 population); in 06/07, it was 47%. This too should form part of the understanding of their care needs.
- Y was inevitably affected by the increasingly chaotic circumstances of his first year, spent largely in the full-time care of his 16-year old mother, and in his second year with a variety of carers. It seems clear that Y was witnessing conflict and violence.

- All this reinforces the importance of the safeguarding role for Health staff (especially Midwives and HVs) working with young babies and their families, as noted by Lord Laming (2009)[4].

6. Summary

6.1 This SCR was undertaken under unusual circumstances, in that a) the original judgement about Y's NAI was subsequently amended, following receipt of independent medical advice, and b) it was discovered that Mr T was not Y's father after all.

6.2 Nonetheless, it was rightly believed by the LSCB that, in a case where so many agencies were involved, undertaking a SCR would lead to significant learning points. This has proved to be the case, both in several aspects of basic practice, and for specific areas of work.

6.3 This SCR has highlighted the challenges of working with some teenage parents with considerable needs. Both Mr T and Ms Y were vulnerable young people, with complex personal histories. Apart from becoming parents, they exhibited a large number of adolescent anti-social and risk-taking behaviours, including a resistance to (some) helping services and interventions.

6.4 It proved challenging for professionals to consider both Ms Y and Y as children, and properly to assess, plan for and protect them both.

6.5 Good practice would suggest that a young mother in these circumstances would receive a comprehensive pre-and post-birth parenting assessment; that the baby's father would be part of this assessment; and a future Y would, as early as possible, be protected by a clear plan for his care needs to be met.

7. Recommendations

7.1 This SCR has several key issues in common with the those of recent Haringey SCRs, which resulted in recommendations which are applicable to the learning here. Previous recommendations/actions which are most relevant to this SCR include the following:

- Actions in relation to the content and effectiveness of CP Plans and to compliance with CP Plans; ensuring that CP Conference decisions are child-focused.
- The establishment of a sub-group to identify best practice models for working with fathers, including the use of materials from the Family Rights Group and from the Department for Education and Skills (DfES) and Department for Children, Schools and Families (DCSF). The aim will be

to improve fathers' participation in safeguarding processes and decision-making
- Regularising the contributions of those with Parental Responsibility to CP meetings
- Improvements in protocols (via the London Safeguarding Children Board) for tracking families who move across borough boundaries
- Haringey LSCB audit of "*all CP and safeguarding interventions*"
- Training in the principles and values of "*authoritative practice*"
- General review and evaluation of all training in safeguarding
- Embedding the safeguarding responsibility via single, multi-agency and specialist training for all staff who have contact with children
- Mandatory social history training programme for HVs and SW staff, linked to a Parenting Assessment Capacity Project
- Training on conducting "*high quality assessments*" and "*using them to inform decision-making in safeguarding practice"; " improving the quality of information and analysis within Initial Assessments and Core Assessments, S47s (CP Investigations), and Conference Reports…."*
- The LSCB satisfies itself that there is in place in all agencies effective and skilled supervision, which supports and appropriately challenges staff.

7.2 It will be for Haringey LSCB to ensure that learning and actions are cross-referenced, and that the most recent lessons from this SCR support and complement other actions being taken to improve safeguarding for Haringey's children and young people.

Recommendations for the LSCB

7.3 <u>Domestic Violence (DV)</u>

- An audit of the content of DV training courses is needed, and these should be updated with recent research, including material about violence between teenagers.
- An audit of agencies' staff who have received DV training is needed, and consideration given to where this training should be mandatory.
- The LSCB should monitor compliance with the requirement in the London CP Procedures (para 5.11.35) that "*Where there is DV in families with a child under 12 months old (including an unborn child), even if the child was not present, any single incident of DV should trigger a CP investigation".*
- The Board should explore DV "filter question" opportunities – Ante-natal booking visit, New Birth Visit, A&E (with particular care taken for children who present without an adult).
- The LSCB member agencies should share and disseminate good practice materials in this area – e.g., *Working Together to Safeguard Children and their Families (2006),* pp 2002-05; *Responding to Domestic Abuse: A*

Handbook for Health Professionals (DH, 2006); and, published very recently by DH, *Improving Safety, Reducing Harm – Children, Young People and Domestic Violence, A Practical Toolkit for front-line Practitioners.*

7.4 Meeting the needs of babies in their first year of life

- The LSCB should sponsor a multi-agency learning event to raise awareness, to cover the following:

  a) Child development and the criticality of the first year of life
  b) Agreed definitions of good enough care for this age group, and agreed desired outcomes for infants, and how to promote and measure these
  c) Pre-birth parenting assessments for mothers under 16

7.5 Involving fathers

- A multi-agency learning event using material available from the Family Rights Group, the Family Nurse Partnership, and other research sources.

7.6 Information-sharing

- Local procedures should include the following: where an agency is offering a targeted service to a young person or adult who becomes a parent, contact should be made with CSC to give and receive information.
- All agencies should be pro-active in exchange of information where there is a child involved (including a teenage child).

7.7 Core Groups

- The LSCB should review the operation of Core Groups, to ensure that they are functioning effectively, and are compliant with the *London CP Procedures* (2006). In particular, the following should be noted:

  a) Organising and chairing/leading the Core Group
  b) Appropriate membership
  c) Implementation of the CP Plan
  d) Action to be taken when a plan is drifting or parts of it cannot be implemented, or there is a significant change in the risk to the child

Recommendations for individual agencies

7.8 Child in Need and CP Plans - CSC

- These plans should be expressed in terms of measurable outcomes for the child, time scales for action and contingency plans.

7.9 Assessments - CSC

- A prompt sheet for making contact with all agencies should be provided and used when undertaking an IA or a CA.

- Team managers should be targeted as key players for improving practice, based on the recommendations in this and recent SCRs, including the use of **APIR**, and best practice in specific areas such as DV, etc. CSC senior managers should consider how best to do this – e.g., via regular workshops or "learning sets" for Team Managers.

7.10 Inclusion of teenage fathers – Teenage Pregnancy Reintegration Project, Stepping Up

- The TPR, Stepping Up need to ensure that teenage fathers are included in their service, and their needs addressed.

References

1) Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C., and Black, J., *Understanding Serious Case Reviews and their Impact – A Biennial Analysis of Serious Case Reviews 2005-07*, 2009, DCSF

2) Sir Michael Bichard, *The Bichard Inquiry Report, A Public Inquiry Report on child protection Procedures in Humberside Police and Cambridgeshire Constabulary, particularly the effectiveness of relevant intelligence-based record keeping, vetting practices since 1995 and information sharing with other agencies. This report makes recommendations on matters of local and national relevance*, Home Office, 2004.

3) www.womensaid.org.uk/press_releases/health_services.htm, and *Crime in England and Wales 2001/2002*, Home Office, July 2002.

4) The Lord Laming, *The Protection of Children in England: A Progress Report,* House of Commons, 2009.