

Report to Bedford Borough Safeguarding Children Board

The Learning Event for the JS Case

Facilitated By Natalie Trentham – Director of Laugharne Management Consultancy Ltd. &

Associate Consultant with

SOLACE

**Acknowledgements**

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I would like to thank all of the practitioners and managers who took part in the learning event: for giving their time so generously; for preparing information beforehand; for their honesty and openness; and their commitment to continuous improvement and learning. I would also like to thank the Learning and Improvement Standing Group panel members who helped design the day and in particular Sally Stocker and Sue Huckle for organising the event and for all of their support on the day. THANK YOU ALL - the learning would not have been possible without everyone playing their part.

**Natalie TrenthamContents**

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This report was commissioned by Bedford Borough Safeguarding Children Board, (BBSCB), following concerns raised by the Family and Children’s Early-Help Service, (FACES) about a child, JS, that they had been working with. The BBSCB Learning and Improvement Standing Group, (LISG), considered the case and agreed that it did not meet the criteria for a serious case review. However, group members agreed that lessons needed to be learned and so it was agreed that the case should be the subject of a learning event and that any learning would inform action plans for both the BBSCB and individual agencies. The following report therefore outlines how the event was designed, the findings from the day and concludes with a summary of recommendations to be considered by the LISG at its meeting on Thursday 12th February 2015.**2. Case Summary**

For confidentiality reasons it has not been possible to share the full details of this case. For those, for whom access is important, a copy of the chronology can be requested from Sally.Stocker@bedford.gov.uk

Having said this, in order to provide context for the report, particularly for those who did not attend the event, it is important to provide a short anonymous overview of the case.

***JS was born in 2008. He has never had contact with his biological Father but has a close relationship with one of his Mum’s ex-partners, who he knows as his Father. JS has three brothers aged 3 years, 2 years and six months, all of whom have different fathers. JS’s Mum and her siblings were known to Children’s Services because they suffered years of abuse in the form of neglect, sexual and emotional abuse perpetrated by their Parents.***

***For part of JS’s life he lived in Preston, initially with Mum and her partner and later, when Mum separated from the partner, JS went to live with the ex-partner for a short time. During these times there were no concerns about JS.***

***A range of agencies were involved with JS, his siblings and Mum in Bedford Borough from 2010. During this time, numerous concerns were highlighted and problems appeared to escalate. Recorded concerns included:***

* ***Mum cancelling and avoiding meetings;***
* ***Concerns about the children’s attachment to Mum;***
* ***Mum being diagnosed with depression and prescribed anti-depressant’s;***
* ***Childhood injuries and sickness (including the baby suffering from dehydration, e-coli and streptococcus);***
* ***One of the fathers and a father figure expressing concern about Mum’s care of the children;***
* ***JS exhibiting challenging behaviour;***
* ***JS not attending school;***
* ***Mum declining a nursery placement;***
* ***JS becoming very attached to professionals and distressed when they left;***
* ***Faeces smeared in the children’s bedroom;***
* ***No carpet, bedding or toys in the children’s room;***
* ***Mum appearing to withhold food and drink from the children; and***
* ***Suspicions that the children were being left unsupervised.***

***For most of the time, support was offered through early help services, a CAF (Common Assessment Framework) and Team Around the Child (TAC). For a short time in 2012 (when JS was living away from the home) the two middle children were the subject of Child Protection (CP) Plans, under the category of ’Emotional Abuse’.***

***As concerns escalated an intensive support package was provided and there was an initial CP Conference held in August 2014 when the children became the subject of CP plans under the category of ‘Neglect’. Mum agreed to JS and two of his siblings becoming looked after under S20 of the Children Act (1989) and his youngest brother was placed in the care of his Father. Mum later withdrew her consent to S20 and care proceeding began.***

In addition to this summary, an anonymised family tree can be found in **Appendix I.**

**3. Preparation for the Learning Event**

In order to design the learning event, a small group of BBSCB Learning and Improvement Standing Group members agreed to act as a reference group and undertook to:

* take the lead on ensuring the completion of their agency’s chronology of work with JS and his family;
* meet with the facilitator to agree the focus of the day, key questions to be addressed; and
* identify the key professionals involved in the case and appropriate invitees from their agency.

Prior to the planning meeting for the day, a 63-page chronology was compiled using the BBSCB template. At the planning meeting it was agreed that the chronology showed some differences in events, it was extremely lengthy and repetitive and as result would be difficult to use for the event. Members of the group therefore undertook to do further work to clarify events and the facilitator agreed to take the chronology and summarise it into a more succinct story for JS. The summary chronology was shared with invitees prior to the event and both chronologies were available on the day as reference documents. As previously stated, these chronologies contain identifying information and so have not been included in the report but can be requested from the BBSCB Business Manager, Sally Stocker at: Sally.Stocker@bedford.gov.uk

It was agreed that the purpose of the day was to explore in detail the series of events which had led to JS and his siblings being taken into care and to ask some key questions in order to highlight learning for agencies and BBSCB.

In order to do this the reference group identified the following key questions:

* What were the challenges for you in working with this family?
* How did you capture the voice of the child and how did you use this information to inform practice?
* Did you have any concerns and if so what did you do as a result?
* Were there any key issues in your agency that impacted on the support that you were able to offer?
* Looking back now, would you have done anything differently?
* What, for you, are the key learning points and actions for partnership working?

These questions were sent to attendees beforehand. Agency representatives were asked to prepare a short overview of their involvement with JS and his family and in doing so, address these questions.

A programme for the day was then compiled which allowed key agencies to outline their involvement and learning. A copy of the programme can be found in **Appendix II.**

**4. The Learning Event**

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As previously outlined, at the learning event each agency gave an outline of their involvement and learning and attendees were invited to ask questions and discuss the events throughout the day.

Responses to the original questions posed were captured on flip charts around the room and agreed by the group through this process. In addition everyone was given ‘post it’ notes and encouraged to add comments to the sheets throughout the day. Through this process, two additional sheets were added in order to broaden the learning, these were:

* Any other relevant information that is important we capture?
* What were the warning signs from this case for professionals to be aware of in the future?

The following sections provide a summary of the learning captured.

**4.1 Challenges for Professionals in Working with this Family**

Professionals were asked to feedback the challenges that they faced in working with this family. Feedback included the following:

* There were a number of fathers and father figures in this family and so it was not always clear who had parental responsibility;
* Outcomes of legal ‘battles’ were unclear;
* Whilst one of the fathers and one of Mum’s partners raised concerns, at the time it was difficult to see what their involvement was and if these concerns were malicious;
* The Mum’s focus was often on ‘JS as a problem’ and this included him being blamed when there was concern about his younger siblings;
* FACES had received a self-referral from Mum. As a result, FACES only knew what Mum told them and it was some time before they received information from other agencies.
* There had been a self-referral made by Mum on the advice of the Health Visitor, because the Health Visitor was unable to refer directly to FACES, who did not take referrals from Health professionals because Health does not fund their service;
* School and nursery attendance was poor and so the children were not engaged on a daily basis;
* The history of the family was not fully known. E.g. Mum’s own abuse, previous CP plans for the children;
* It was difficult getting into the home – meetings and visits were often cancelled;
* It was difficult to challenge as Mum had viable reasons for not attending meetings;
* Mum was a very sympathetic character and her explanations were very plausible;
* The Police had limited awareness of this case and the issues.

**4.2 How did Professionals Capture the Voice of the Child and how did this Inform Practice?**

Professionals were asked to outline how they captured and acted on the children’s views. Responses included the following:

* There was some recorded observation made of how JS presented and responded. Professionals commented that they tailored their responses to him to meet his needs but some also acknowledged that this was not always clearly recorded;
* All professionals commented on JS being distressed when they were about to leave;
* A number of professionals had only limited contact with JS and he was often quiet with them and so his voice was often missed;
* The Education Welfare Service (EWS) does not as a rule speak directly with younger children and in this case there was no opportunity to talk to JS.

**4.3 Did professionals have any concerns and if so what did they do as a result?**

Some professionals (particularly those working with Mum) did not know about the concerns. However, most professionals involved in this case had concerns, which they shared at the Team Around the Child (TAC) meetings. Most professionals talked about sharing their concerns in professional supervision and being given support by their managers. Whilst initially professionals had felt concerned with what they felt was little evidence to support their feelings, concerns rapidly increased with the fast deterioration of the conditions in the home. Action then included the following:

* FACES looked at Mum’s Facebook page, which added to concerns and these were discussed in supervision;
* Referrals were made to the Multi Agency Safeguarding Hub (MASH). The first received no response and later when there was a response, the decision was that the case should remain at the CAF level. This was a decision which most professionals involved with JS felt uncomfortable with. However, they were unclear what action to take next to escalate the case;
* One of the early help workers, who had supported Mum during an assessment of JS, had concerns about the advice given by one of the health professionals. However, she felt unable to take these concerns further because she perceived the person to be more senior and knowledgeable. She discussed her concerns in supervision but the agency too did not escalate the concerns;
* Later FACES raised concerns about this family through BBSCB.

**4.4 Key issues in agencies that impacted on the support professionals were able to offer?**

The issues within agencies that front line practitioners identified as possibly having an impact on this case were as follows:

* Limited information was received by primary schools from early years providers. More could be done to strengthen the relationships between primary schools and feeder early years providers. Actually in JS’s case this was compounded because some of his early years were spent out of area;
* The group felt that the Family Support Worker in JS’s school had played a significant role in supporting JS. Not all schools have Family Support Workers and the work done in this case could be shared as good practice with all schools, to show how this role can be beneficial;
* FACES could not take referrals from Health agencies as ‘health’ does not commission this service. As a result vital information from the Health Visitor was not passed on until later;
* The FACES referral process did not include routine requests for information from other professionals. As a result of this case the referral process has now been changed;
* Because of the volume of work and professionals supporting other cases, the support around morning routines did not take place until after the TAC meeting on the 9/7/2014;
* The TAC did not include those working with Mum, although contact and discussions did take place with maternity services, who were invited to join the TAC;
* Some professionals involved in the TAC reported that despite their increasing concerns, they did not know how to escalate the case other than going through the MASH. Additionally they felt that they did not have enough evidence. The CAF coordinator was not contacted for advice and no referral to the Locality Network Panel was made because of lack of clarity about what cases could be referred and what “stuck cases” actually meant;
* MASH systems were not fit for purpose at the time that enquiries were made. Because of a backlog of cases, there were unacceptable delays, checks were limited and the information informing the decision was not good enough. MASH systems have since been changed and there is now no backlog of work;
* The Family Intervention Support Services (FISS) workers had been uncomfortable that the children had continued to remain in the home after major concerns were highlighted. These concerns included: faeces smeared across the walls in the bedroom; no carpet; no bedding or toys in the children’s room; Mum not feeding and giving the children drinks because of the mess they would make; leaving the children unsupervised or with adults where there were concerns; JS’s behaviour; Mum’s depression and lack of engagement with the children; and repeated concerns from Mum’s partners;
* Managers changing in social care and shortages of staff were felt to be important factors.

**4.5 What would professionals have done differently?**

Professionals were asked to identify what they would have done differently in hindsight. Responses included the following:

* For FACES – the referral form should have asked questions about previous involvement from other agencies;
* Many professionals felt that they should have spent time compiling a detailed chronology;
* Many professionals felt that they should have taken into consideration Mum’s own experience of being parented and how this might have impacted on her own parenting capacity because this was not considered;
* Some felt that they should have undertaken unannounced visits following telephone contact to cancel visits/ meetings.
* Some professionals felt that the child’s voice should have been more strongly sort and recorded in all visits;
* Other professionals felt that they should have responded quicker to the poor attachment between Mum and the children.

**4.6 Key Learning & Actions required, as identified by the group**

The group identified the following actions which they felt should be taken in the light of this case:

* FACES and Bedford Borough Council (BBC) to review the contract to ensure that health can refer into FACES;
* To explore FACES having access to AZEUS (BBC Children’s Services client database);
* Greater use of Locality Network Panels (or replacement in the new Early Help offer);
* BBSCB to explore further training on “listening professionals”;
* De-briefing for TAC meetings to be introduced;
* All professionals need to do chronologies at the beginning of work;
* Managers to promote and support escalation when there are concerns. Escalation procedures can be found at http://bedfordscb.proceduresonline.com/chapters/p\_reolution\_disagree.html;
* All agencies need to be clear, and ensure their staff are clear on escalation processes and when they need to be initiated;
* Education Welfare Service (EWS) to consider when and how younger children are listened to;
* BBSCB to look at the Early Help strategy in light of the learning from this case;
* The Early Help strategy should include clearer processes for TAC;
* TAC to include all professionals involved with the family and not just those working with the child – a move towards a TAF (Team Around a Family);
* To review CAFs and TACs;
* At the start of a TAC agency chronologies should be shared;
* Raising awareness of the CAF coordinators and their roles and responsibilities;
* Supervision/support for the family workers in schools should be reviewed;
* Meeting to take place between professionals involved prior to starting work with families;
* To do unannounced/ follow up meetings when visits and meetings are cancelled;
* Tools for measuring neglect, need to be shared and agreed e.g. graded care profile;
* Children’s Services to explore the learning from this case with its managers and legal department;
* BBSCB to undertake further work around Bedford Borough’s response to emotional abuse;
* BBSCB to discuss use of PLO (Public Law Outline/legal gateway;
* More awareness raising of the escalation processes and thresholds;
* Education staff should complete home visits;
* Lower/primary schools should liaise with nurseries for background information and/or concerns;
* Agencies should improve their knowledge and skills in writing referrals, particular to the MASH, in order to help ensure that referrals are responded to appropriately;
* GP’s to share information in a timely manner, if parents moves out of area;
* Bedford Borough to consider the introduction of a Family CAF;
* BBSCB should undertake a multi-agency audit of emotional abuse cases;
* Lower schools should routinely liaise with early years providers;
* Complaints policies to be reviewed in all agencies.

**4.7 Other information, which it was important for Bedford Borough agencies to know and capture.**

Besides the questions addressed in all presentations, the following information was felt by the group to be important to capture:

* Chronologies save lives and it is important that all agencies complete these;
* There is a gap in Children & Adolescent Mental Health Services (CAMHS) to meet the needs of families at an early stage;
* This case was escalated largely because of the concerns of the Education Welfare Officer (EWO) – what would have happened if JS had been attending school and EWS had not been involved?

The FISS agency chronology was not included in the overall chronologies and other agency information was received late. It was not until this event that the full circumstances and events became known. Since the event, missing information has been added to the in-depth chronology.

**4.8 Warning Signs Highlighted in this case**

There were a number of warning signs in this case, which together indicated that the case should have been escalated. The group felt that it was important that these be shared with all staff across agencies in Bedford Borough. The warning signs were as follows:

* Feeling uncomfortable about the case but without strong evidence. It is importance for professionals to recognise and discuss when they feel uncomfortable;
* Children always well covered up even in the summer;
* Children being over-affectionate to ‘professionals’ and becoming distressed when professionals leave;
* No eye contact from the children;
* Children responding to questions by looking to Mum for help with what the right answer is;
* Mum and child saying contradictory things;
* Absences from school and early years settings?
* Parents refusal to try/accept changes/solutions/help
* Lack of toys and play opportunities;
* Mum asking for help and engaging with professionals does not necessarily mean that the care of the children is improving;
* A professional providing more support than they would usually is an indication that a review of the support is needed and possible escalation.

**5. Summary of Recommendations**

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It is hoped that the whole of this report and the learning day itself, have provided learning for all professionals and agencies involved; in particular the suggestions for action made by the various professionals on the day, (in paragraph **4.6 and 4.7** of this report). It is also important that the warning signs highlighted by this case are shared and discussed more widely because they have particular relevance for professionals working in similar situations. This final section however summarises the key recommendations from the external facilitator.

**5.1 All Agencies**

* This report should be shared with all staff and discussed in team meetings across all agencies working with children in Bedford Borough, in order to further explore how the learning can inform and change practice in the future. It is particularly important that those agencies and teams not present have the opportunity to discuss the learning;
* All agencies to put together an action plan which takes account of the recommendations of this report, as well as the suggestions proposed in paragraphs 4.5 and 4.7;
* All agencies to ensure that their staff are clear about when to refer on, current thresholds for services and when and how to escalate concerns. The current thresholds for services are being reviewed in Bedford Borough. When this work is completed, it will be important that the revised arrangements are shared with staff in all agencies;
* All agencies to ensure that they complete chronologies when first becoming involved with a child and with the consent of parents (where appropriate) share all relevant information;
* This event included photographs obtained by one of the professionals involved. This triggered discussions about whether professionals should take photographs to support their work. Whilst organisations such as the Police have clear powers to take photographs, other agencies do not have clear policies. For this reason it is recommended that all BBSCB member organisations consider their position on the use of photographs and develop appropriate policies and procedures for their use;
* All managers to ensure that they are clear about processes available to them to raise concerns and make complaints about other agencies and professionals.

**5.2 Early Help**

* FACES to change its referral process. This work has already begun;
* Referral routes should be separated from funding routes where possible. Families do not belong to agencies. (See Children’s Services recommendation 5.4);
* The current review of Early Help and the new strategy should include:
	+ A review of how information processes work in practice;
	+ A review of the CAF;
	+ Clear processes and support for the TAC – including consideration of a Team Around the Family (TAF) approach;
	+ Clear guidance on the role and responsibilities of the CAF co-coordinator;
	+ The provision of support to TACs through the network panels or replacement processes; and
	+ Clear tools for professionals to help them to recognise neglect and emotional abuse.

**5.3 Health**

* Bedfordshire Clinical Commissioning Group (BCCG) and South Essex Partnership Trust (SEPT) to take forward the concerns raised about the health professional mentioned in this case. This has already taken place.
* BCCG to reiterate to all GPs the importance of sharing records/information in a timely manner, when families de-register and re-register with another GP.

**5.4 Children’s Services**

* To discuss with schools the role of Family Support Workers and highlight the work undertaken in this case. To also review supervision and support for the Family Support Workers in schools;
* The report and the learning from the day should be discussed with the MASH manager, (who was not present), in order to ensure that the problems experienced have now been addressed and that any further changes to practice are explored, in the light of this case;
* Children’s Services to review its current contract with FACES to ensure that it includes the expectation that Health referrals to FACES are accepted;
* EWS to consider when and how younger children are listened to;
* Children’s Services to consider with its managers and legal department whether, in the light of this case, action could and should be taken earlier and if so what needs to change to make this possible.

**5.5 BBSCB**

* BBSCB to monitor and review all action plans that have been developed from this audit and agreed by agencies;
* BBSCB to review how chronologies are compiled for future events of this kind;
* BBSCB to explore further training on “listening professionals”;
* BBSCB to promote procedures around thresholds and escalation, following concerns;
* BBSCB to consider undertaking a multi-agency audit of emotional abuse cases.

**Natalie Trentham**

**Independent Consultant**

**Amended on 27/02/15**

**Appendix I – Anonymised Family Tree**

Maternal Grandfather

Maternal Grandmother

Child JS Aged 6

Child B

Aged 3

Father

Child JS

ils A A

Mother

Aged 23

Child D

Aged 6 months

Child C

Aged 2

Mother’s ex partner who was a full time carer for Child JS

Father Child B

Father Child C

Father

Child D

Aged 28

**Appendix II – Programme**

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 **Learning Event**

**To be held on 8th January 2015 9am - 4pm– at**

**Lakeview Village Hall Brooklands Avenue, Wixams Bedford MK42 6AB**

**Re: JS Case**

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| 9 - 10 | Panel Discussion and clarification of the process |
| 10 - 10.20  | Introduction to the day – Natalie Trentham |
| 10.20 - 11.20  | **FACES** Presentation |
| 10.50 -11.20 | **Smarteez Nursery** Presentation |
| 11.20 - 11.50 | **Putnoe Primary School** Presentation |
| 11.50 -12.20 | **Family Intervention Support Services (FISS**) Presentation |
| 12.20 -12.50 | **Lunch** |
| 12.50 – 1pm | A reminder of the details of this case – Natalie Trentham |
| 1pm -1.30 | **Bedford Hospital** Presentation |
| 1.30 – 2pm | **Education Welfare Service** Presentation |
| 2pm - 2.30 | **SEPT 0 – 19 Team** Presentation |
| 2.30 – 3pm | **Children Social Care** Presentation |
| 3pm – 3.30 | Group Discussion - Learning from the Day |
| 3.30 – 4pm | Panel Discussion – Recommendations |