Serious Case Review
Family S16

"Kate Walker"

April 2016

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1. Introduction

1.1 **Why this case was chosen to be reviewed**

Kate died in December 2014. The circumstances of her death were considered at a meeting of the Dorset Serious Case Panel where it was agreed that the criteria, outlined in statutory guidance[1] for undertaking a serious case review, had been met.

1.2 Dorset Safeguarding Children Board (DSCB) decided to review this case using The Social Care Institute for Excellence (SCIE) Learning Together Case Review methodology.

2. Methodology and Process of Review

2.1 This case has been reviewed using a systems approach, the focus of this approach is on multi-agency professional practice. The goal is to move beyond the specifics of the case – what happened and why – to identify the deeper underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case and changing them will contribute to improving practice more widely.

2.2 The data is gathered from a variety of sources, including review of existing documentation alongside data provided by frontline practitioners and their managers, who had involvement in the case during the timeline under review. Within this report, these professionals are referred to as *'The Case Group'.*

2.3 The Review has been completed by a team of senior managers who did not have line management responsibility for the case, led by two independent Lead Reviewers – being mentored by an accredited SCIE Lead Reviewer. Together, they make up *'The Review Team'.* The data, gathered during the course of this Review, the analysis and findings are the subject of scrutiny by the Review Team. Recurrent cycles of feedback and amendment by the Case Group and Review Team are inherent features of case reviews using this methodology.

2.4 A critical aspect of a Review, using this methodology, is the perspective of family members. The perspectives of both mother and stepfather are reflected within this report.

2.5 Details of the **Review process, data sources** and **structure of the Review process,** are outlined in **Appendix 1. Serious Case Review Statutory requirements and SCIE methodology** are outlined in **Appendix 2.**

[1] DFE, 'Working Together' (2013)

3. Succinct summary of case

3.1 This case involves Kate, aged 15 at the time of her death, and her older brother James, aged 17. They had been adopted: James at 18 months and Kate at 6 months by Mr and Mrs Walker. The parents subsequently divorced and Mrs Walker raised the children on her own for a considerable period of time. James went on to have significant difficulties and was unable to be educated successfully in mainstream school. At home he was verbally and physically aggressive to Mrs Walker and Kate over a number of years. This had significant impact on Kate who, through fear, began to express hatred of her brother and the strongly held view that he should live elsewhere.

3.2 Mrs Walker met and subsequently married Mr Morris; who the children came to accept within the family unit. Mr Morris was later accused of child sexual abuse by a young person outside of the family. This necessitated him having to leave the family home, causing distress to all family members.

3.3 Kate was a young person who exhibited extreme mood swings and after the break-up of her relationship with her boyfriend, she killed herself. The coroner subsequently recorded a narrative verdict. There were practitioners from a number of agencies who were involved throughout the last year of Kate's life and many worked hard to support the family and Kate.

4. Family composition

4.1

Family member	Age in December 2014
Adoptive Mother – Mrs Morris	
Stepfather – Mr Morris	
Kate	15
Sibling – James	16
Ethnic identity	White British

5. Timeframe

5.1 This Review covers the period December 2013 to December 2014. This takes into consideration the last year of Kate's life.

6. The Findings

What light has this Case Review shed on the reliability of our systems to keep children safe?

6.1 A Serious Case Review plays an important part in efforts to achieve a safer child protection system. Consequently, it is necessary to understand what happened and why in the particular case, and further to reflect on what this reveals about gaps and inadequacies in the child protection system. Using the Social Care Institute for Excellence (SCIE) Learning Together methodology, the particular case acts as a 'window on the system'.[2]

6.2 For this to happen, the outcome of the Review has to say more than what happened in this particular case and needs to provide messages to Dorset Safeguarding Children Board (DSCB) about usual practice and normal patterns of working. These messages are presented as 'findings', and provide the DSCB with an insight into the underlying patterns that influence professional practice and outcomes for children.

6.3 By responding positively to the findings, the DSCB has the opportunity to change how the child protection system operates and to make it safer. It makes sense, therefore, to prioritise the findings to identify those that need to be tackled most urgently for the benefit of the children and families, even though these may not be the issues that appeared most critical in the context of this particular case. In order to help with identification and prioritisation, the systems model that SCIE has developed includes six broad categories of these underlying patterns. The ordering of these is not fixed and will change according to which issues are felt to be most fundamental for systemic change.

6.4 The categorisation of findings is as follows:

- Tools
- Family-professional interactions
- Management systems
- Patterns of multi-agency working in response to incidents/crises
- Patterns of multi-agency working in longer-term work
- Innate human biases (cognitive and emotional biases)

[2] C. Vincent, 'Analysis of clinical incidents: a window on the system not a search for root causes' (2004)

6.5 The findings from each category convey a message to the DSCB about how that element of the child protection system was working at the time of Kate's death. They state succinctly what is, or was problematic, about the system and are therefore helpful to the reader. It is not uncommon for there to be overlap between the categories of findings.

7. In what way does this case provide a useful window into our systems?

7.1 At the start of this Serious Case Review, the DSCB identified that this tragic case held the potential to shed light on particular areas of practice and asked the Review Team to examine the following issues within the course of the Review:

- How well do we support front line multi-agency practitioners to work together with children and young people with complex mental health needs?
- How well do we use psychosocial histories to inform multi-agency assessments and planning?
- How well do we work in partnership to provide services and interventions to young people at risk of sexual abuse?
- How well do we work in multi-agency partnerships in a way that keeps the whole family, and their various needs, in mind?

7.2 These issues have provided the framework for the Review and are addressed by different Findings.

7.4 In addition, this case involves a number of challenges which safeguarding agencies, working in Dorset and nationally, encounter regularly in the following common areas of practice:

- Understanding risk when working with young people with mental health difficulties and responding to the needs of adolescents who experience fluctuating emotional health.
- Working with children whose parents are confident and knowledgeable of multi-agency systems and processes.
- Interagency information sharing and decision making when working under the 'child in need' threshold of intervention.
- Working with sibling violence.
- Partnership work and use of specialist services when a child is adopted.

8. Involvement of the family and perspectives of the parents

8.1 Kate's parents were invited to contribute to the Review and her mother and stepfather met with the Lead Reviewers. Mr and Mrs Morris's views are

reflected within the report and the Lead Reviewers are grateful for their input and openness at a time of indescribable grief.

8.2 Mr and Mrs Morris particularly commented on the professional involvement with their family and the impact of Kate's death on all family members. Mrs Morris had a long involvement with professionals since adopting the children and stated that although she had met some wonderful individuals whilst parenting Kate and James, she did not trust the services to meet the children's needs.

8.3 With regard to working with Kate's difficulties, her view was that with the support of friends, and the community around them, they were a family who could sort problems out without the need for professional involvement. When the Lead Reviewers met with Mr and Mrs Morris, it was clear that their ambivalent feelings regarding, and lack of failth in the value of professional involvement in family life impacted on their relationship with services. There is no doubt that Mrs Morris loved both her children and wanted to do what she believed was the best thing for them.

9. Kate's experience

9.1 Kate was described as a young person who had lots of strengths. She loved nature and would spend many hours out and about in the woods and countryside. She participated in many activities and enjoyed drama and wanted to be an actor. However, at times Kate struggled to make enduring peer relationships, she was described as ambivalent about school and found some of the requirements for uniformity a challenge, although she mostly attended and completed her academic work.

9.2 Kate's presentation was marked by significant highs and lows; she often voiced her hatred of her brother seeking to have him removed from her life. She had endured significant physical and verbal aggression from him over a considerable period of time. This, alongside the complex identity issues linked to her adoption, meant that her inner world was often marked by significant emotional struggles and at times she would ask for professional help. At other times she would appear more balanced with a more positive approach to life.

9.3 Kate struggled with some of the interventions made by Children's Services and verbalised her unhappiness, particularly in relation to the requirement that Mr Morris should not reside within the family home as, from Kate's perspective, Mr Morris was an important protective factor in her relationship with James. It was also understood that Kate had a strong attachment to her first boyfriend and this relationship was very important to her.

10. Appraisal of professional practice in this case: a synopsis

10.1 The Appraisal of Practice forms an essential component of a SCIE Review. It considers the practice in this case, but most importantly the context within which the practice occurred and supports the move to the Review Findings.

10.2 This Appraisal of Practice sets out the view of the Review Team about how timely and effective the interventions with Kate and James and their family were, including where practice fell below expected standards. It aims to provide an explanation of 'why' things happened; outlining what got in the way of professionals being as effective as they wanted to be. Any issue identified that was common across more cases in Dorset is discussed in more detail in the findings, which are cross referenced.

Professional response to disclosure of information – December 2013 to January 2014

10.3 During this period Kate was seen regularly by the School Nurse. She was felt to be in considerable distress; she spoke about a number of issues at home that were of significant concern. The School Nurse was aware that Kate was an adopted child and that some of the issues had been long standing. The School Nurse discussed these concerns with the appropriate Safeguarding Advisor within her agency and appropriately, a referral was made to the GP with the view to involving CAMHS. It was decided not to refer to Children's Social Care as it was felt that the threshold for referral had not been met. These issues are further explored in **Finding 1.**

10.4 Alongside access to a 'Safeguarding Advisor', school nurses also have formal safeguarding supervision and management supervision provided by different members of staff. It is expected practice for safeguarding concerns to be discussed within both safeguarding and management supervision, but this did not happen. Whilst it was not possible to fully ascertain the reasons behind this, it was the view of the Lead Reviewers that the accountability placed on school nurses to raise cases in these forums guided by their own discretion, and the lack of clarity within the supervision policy about the category of cases that should be raised within these forums, left the onus on the school nurse to formally raise this case without clarity being provided in order to inform this decision making. As a result of this Review, action has been taken to address these issues and so the issues do not form part of a finding instead they are addressed in the **Additional Learning** (**Appendix 3).**

10.5 The School Nurse worked within the school's 'pastoral hub', which provides services to children at the school who may need pastoral support. It was recognised as providing an excellent service to children and Kate

had been appropriately seen within this context by the school nurse. The services provided through the hub were co-ordinated by a member of staff who was supervised by the school nurse; this co-ordinator reported daily to the Designated Safeguarding Lead (DSL) who held overall responsibility for the safeguarding of children at the school. It was the coordinator's role to maintain this active communication with the DSL about children attending the hub. Confusion about how and in what circumstances information can be shared across professionals working in the hub led to limited information being shared with the 'Hub Coordinator' about Kate, and no information being shared with the DSL.

10.6 There was no information sharing protocol in place and it was the view of the Review Team that the absence of such a protocol compounded the confusion and had a significant bearing on decision making. In addition, it was understood by the Review Team that the management and supervision arrangements for both the School Nurse and the Coordinator were complex and in the view of the Lead Reviewers, the way in which the posts were structured within the service was perplexing and likely to contribute to feelings of confusion about where accountability and responsibility was held. It was the view of the Review Team that had the information been fully shared amongst these professionals, Kate's presenting needs and concerns could have been understood within a background context, the significance of these concerns better appreciated and an opportunity presented to reconsider a referral to Children's Social Care (CSC). The Review Team were informed that the learning from this Review has been taken forward and a number of changes have since been made to how this service is structured and delivered. As a result, no specific finding has been made, rather the issues are further explored in the **Additional Learning (Appendix 3).**

Referral to specialist services and responses – January 2014 to March 2014

10.7 After receiving contact from the school nurse, the GP made a timely referral to CAMHS service. On receiving the letter, CAMHS screened the case as requiring a non-urgent response and a letter was sent to Mrs Morris asking her to make contact with the service in order for an appointment to be made. After receiving no response, CAMHS closed the case and made no further contact with the family.

10.8 Although the closure of Kate's case by CAMHS, in the context of being unable to gain parental agreement to the provision of a service, was in line with expected CAMHS protocols, the Review Team questioned whether such a protocol meets the needs of children such as Kate. In addition, the referral letter stated Mrs Morris was a foster mother and whilst this information was in fact incorrect (Mrs Morris was Kate's adoptive mother), in line with an existing protocol either status should have prompted an assessment by the specialist Looked after Children(LAC)/Adoption Social Workers within CAMHS. The issues regarding access to specialist mental health support are explored further in **Finding 7.**

10.9 In recognising the need to deliver services to looked after and adopted children in a timely and targeted way, specialist workers with knowledge of attachment and loss issues are part of the CAMHS service. The provision of this specialist service within CAMHS is good practice. However, Kate did not benefit from this service as the need to pass the referral on to the specialist workers was not recognised by the screening clinician. This was contrary to an existing protocol and fell short of expected practice. The Review Team learnt that the service provided by the specialist Adoption/LAC workers was not widely understood by CAMHS clinicians, and the existing protocol was not firmly embedded within the practice of the screening clinicians. This resulted in a missed opportunity to undertake a specialist assessment in order for Kate's needs to be understood. These issues are explored further in **Finding 5.**

10.10 Professionals working with Kate were not informed of the CAMHS decision to close Kate's case and this led to understandable assumptions being made that specialist services were meeting Kate's needs. Existing practice guidance and service protocols are clear; referrers should always be informed of a CAMHS decision to close a case; the reasoning behind this is that if professionals are aware that the child is not receiving the specialist help they need, suitable adjustments can be made to the services provided to a child and their family. The Review Team heard from the Case Group that is was not uncommon for professionals to be unaware that a case had been closed to CAMHS. It was not possible to fully establish the reason for this although the Review Team were informed that this practice has now been reviewed and it is understood that a more robust screening process has now been put in place. These issues are explored further in the **Additional Learning (Appendix 3)**.

10.11 In February 2014, a 'Children of Concern' meeting was held at the school. This meeting was held on a termly basis and was an opportunity to discuss children where there are concerns about how a child's behaviour may be impacting on their attendance or learning. Kate's needs were appropriately raised at this meeting and in line with routine practice, the school's allocated educational psychologist attended. The educational psychologist agreed to meet with Kate and made a number of attempts to contact Mrs Morris in order to gain parental permission to carry out an assessment of Kate's needs. The psychologist was unable to gain a response from Mrs Morris and as a result this specialist assessment could not be progressed; Kate's case was closed to this service. Although this complied with expected practice and protocol, it was the view of the Review Team that this does not place the needs of the child as paramount, and left Kate without the specialist assessment and provision she needed. The relevant issues are explored further in **Finding 7** and in the **Additional Learning.**

10.12 In the context of the lack of any referral to CSC, the Review Team were further perplexed by the absence of services considering the need for a Common Assessment Framework (CAF) or a Team Around the Child (TAC) meeting, both of which provide an opportunity for services to share

information, assess need, co-ordinate and plan service provision, benchmark progress, and review the success of intervention. Had this been done it was the view of the Review Team that Kate's needs would have become clearer to the professionals involved and services better co-ordinated. In addition, the possibility that a pattern of Mrs Morris not agreeing services on Kate's behalf was having a significant impact on the services Kate was receiving, was not recognised. The issues in relation to the use of CAFs are explored further in **Finding 2,** and the issues in relation to working with 'disguised compliance' are explored further in **Finding 8.**

Coordination of Early Help services – March 2014 to June 2014

10.13 In June 2014, James was preparing to leave a residential school placement. He had been at this school for some time, the placement had managed and met many of his needs, and he had made progress in a number of areas of his learning and development. Staff at the school were concerned about his return home; James still had considerable needs and there were remaining concerns about how he related to female staff, which was often characterised by an aggressive and hostile manner. His key worker had a good relationship with the family and understood that Mrs Morris was very worried about James' return to the family because of his history of violence towards herself and Kate. A decision was taken to refer James to the locality team in his home county and in line with routine practice a Pre-CAF form was used to make this referral.

10.14 The Pre-CAF was received by the early help service (EHS). The name of the form suggests that it was a pre-curser to a CAF, but this was not the case; it is a form that is routinely used as a referral form to access local resources through the EHS based within the county council. The form in use followed a tick box format of information sharing and as a result there was limited information contained within this referral on which to base decision making.

10.15 Staff within the education department learnt of the plans for James to return home from the residential school and subsequently were contacted a number of times by Mrs Morris. Mrs Morris was deeply concerned about James' return to the family, she expressed her concerns in relation to his history of violence towards herself and Kate and asked for James to be placed in the care of the county council. Staff understood the nature of Mrs Morris' distress, they had knowledge of previous involvement with the family before James went to the school, and the tensions and the significant distress within the family in relation to James' aggressive and violent behaviour were documented within records. This led to a series of emails between staff members within education and with the EHS, and the decision taken by the EHS was for James to be provided with a 1:1 worker on his return to the family home.

10.16 It was the view of the Review Team that the information available strongly suggested that the needs of the family were at such a level that as a

minimum a CAF should have been completed. This would have allowed the information held in agency records to come together within a formal assessment and planning process, but this did not happen. The limitations of the Pre-CAF and the use of email exchanges to share information led to a fragmentation of the information, and the absence of a CAF in respect to Kate's needs restricted the limited multi-agency view of the needs within the family and contributed to this decision making. Of equal significance appeared to be the status and understanding of the value of a CAF within the local area, and confusions about who held responsibility for completion. The Review Team learnt that the coordination of early help services and use of a CAF was not embedded, and there was a lack of training and support for all agency partners in its use and application. It was understood that these confusions had not been successfully addressed at a strategic level and this led to a vacuum. These issues are explored further in **Finding 2.**

10.17 The Review Team analysed the email exchanges that took place in relation to James' return to the family. Within this email exchange was vital information that suggested the needs and risks within the family were at such a level that at a minimum these needs met a threshold for intervention under sc17; further it was the view of the Review Team that the risk of violence to Kate and to Mrs Morris posed by the return of James was significant enough to warrant consideration as to whether the threshold for a child protection referral had been met.

10.18 The Review Team sought to understand why the needs of this family had not been considered under the required threshold, and why there had been no assessment of need. It seemed that practitioners across the services did not recognise sibling violence as a safeguarding risk that potentially met the threshold of significant harm in posing a risk to both the physical and emotional wellbeing of a child. The Review Team sought to understand why, and found that the impact of sibling violence is not well researched and is commonly unrecognised as a source of significant harm. **Finding 1** explores the issues in relation to perceptions of thresholds for referral to Children's Social Care, and **Finding 4** explores issues in relation to sibling violence.

Agencies response to the allegation of sexual abuse against Mr Morris – July 2014 to August 2014

10.19 In July 2014, Children's Social Care (CSC) received a referral from the local police. It was reported that a young woman had alleged Mr Morris sexually abused her when she was a teenager, and this was now the subject of a police investigation. In line with expected practice, a joint investigation was initiated with the local police Child Abuse Investigation Team (CAIT) and Kate was interviewed at school. During this interview Kate spoke of her hatred of James, but made no allegations in respect to Mr Morris. This was a timely interview and appropriately conducted by a social worker and a police officer.

10.20 At this point a decision was taken that CSC would conduct a single agency investigation into the safety of Kate and James. In line with expected practice, the social worker commenced an assessment of the family circumstances in order to make an immediate assessment of the children's safety at home. The practice manager and social worker appropriately met to discuss the family circumstances and to plan the assessment before the first home visit was made. It was agreed that Mr Morris would be asked to leave the family home until an assessment could be completed, and that this arrangement would be formalised under a Contract of Expectations. This approach follows the principles of best practice when working to safeguard children in these circumstances, and the use of a written agreement, such as a Contract of Expectations, was common practice.

10.21 The social worker made a timely visit to the family where she dealt with the understandable distress of all family members relating to recent events. Both Mr and Mrs Morris were clear that the allegations were untrue, but reluctantly agreed that Mr Morris would not reside in the family home. The Contract of Expectations was negotiated and agreed; Mr Morris worked from home and so by necessity this contained detailed arrangements. However, the contract did not sufficiently take into account or appreciate the perspectives of both parents in relation to the terms that had been set, the very real difficulties the family would have in keeping to its terms or the values held by the couple in relation to the involvement of professionals in family life.

10.22 The practice manager and social worker remained concerned about Kate's safety; they were not convinced that the arrangements in place would provide robust enough safeguards for Kate, they agreed that an Initial Child Protection Conference should be convened and a date was set. This decision was later challenged by a more senior manager who took the view that the Contract of Expectations offered sufficient safeguards within the family and that the case should be worked with under a lower threshold of intervention, as a 'child in need'. The practice wisdom that informs this approach is that if the family are engaged with services, willing and able to put in place sufficient safeguards, then intervention at a higher threshold is unnecessarily intrusive and can interfere with achieving positive partnerships with families. This is a justifiable position to take, but it was a position that was based on a false belief that the family were engaged and compliant. Mr and Mrs Morris's commitment and ability to comply had not formed part of the Sc47 investigation or initial enquiries. In addition, although written agreements were in common use and an established part of working with families to safeguard children, compliance with the terms of the contract could not be realistically monitored and the use of this tool in safeguarding children had not been the subject of audit as to their efficacy. The issues regarding the use of such contracts are further explored in **Finding 9** and the issues in relation to the categorization of cases are discussed further in **Finding 3.**

Child in Need Meeting – September 2014

10.23 In September 2014, a timely 'child in need' meeting was held, and appropriately chaired by an experienced manager. In line with routine practice, when working within this threshold of intervention, a representative from the police CAIT was not invited, Kate's school were invited but did not attend as the school were busy dealing with a number of child protection cases and it was expected practice that these would be prioritised. The decision to work the case as a 'child in need' case rather than a child protection case resulted in unintended consequences. Although the Review Team were informed that it had been decided the case should be worked as a 'robust' 'child in need' case (and so the service response from CSC was no different than a child protection case), the fundamental difference in how multi-agency partners viewed and responded to a case categorised as 'child in need' as opposed to child protection was not realised; this had a detrimental impact on how Kate's needs were understood and met by the multi-agency network. The issues in relation to disguised compliance are explored further in **Finding 3.**

10.24 Kate's fluctuating emotional presentation and negative views about James were shared at the meeting and there was an appropriate recommendation that the School Nurse re-refer Kate to CAMHS. However, the depth of Kate's despair was not comprehensively recognised or understood, the impact presented by James were not explored and this resulted in only a surface understanding of each. The Review Team learnt that practitioners often struggle to recognise the difference between normal teenage behaviour and young people with significant emotional problems, and the lack of understanding about the impact of sibling violence compounded the way in which Kate's emotional wellbeing was normalised as being broadly characteristic of her stage of adolescent development. The issues in relation to sibling violence are explored in **Finding 4** and the issues in relation to how the emotional needs adolescents are understood are explored further in **Finding 6**.

10.25 A decision of the meeting was to refer Kate to the Adolescent Support Team within Children's Services, which had a remit to work with teenagers in order to address issues around intra-familial and peer relationships. Whilst this referral was well intended, the involvement of specialist professionals from the Adoption Support Service, who had an in depth understanding of attachment loss and the challenges presented to children and their families during adolescence, was not considered. Had the adoption records been checked, it would have been clear that the case was allocated within the Adoption Support Service to a professional who knew the history of the family and had provided services to family in the past. This was a significant oversight and resulted in a missed opportunity to gain an in depth understanding of Kate's needs and provide specialist input. The Review Team learnt that the work of the Adoption Support Service was not routinely understood or recognised, and the work of the team was not sufficiently embedded within front line services. In addition, case recording was held in separate recording systems and the fact that a

professional from within the team was already allocated to a child was not clearly identifiable within the recording system used by front line services. **Finding 5** explores the integration of adoption support within front line services.

Second CAMHS referral – September 2014

10.26 The School Nurse referral to CAMHS did not contain relevant information about Kate being an adopted child, which was an oversight (**Finding 5**).

10.27 The referral was screened through the usual CAMHS processes and, in line with normal practice and existing protocols, an "Opt-in" letter was sent to Mrs Morris. After receiving no response, a decision was made to close the case. This was the second time a referral had been made to CAMHS, the referral was made in line with Kate's expressed wishes to receive help from this service and represented a further occasion where an opportunity to provide Kate with the specialist help she needed was missed. Issues in relation to specialist mental health provision are explored further in **Finding 7.**

10.28 Given that Mrs Morris had been present at the meeting and had agreed to the CAMHS referral, it was not surprising that the general expectation amongst the practitioners was that she would 'opt in' to the services. However, the complexity of Mrs Morris' relationship with professionals and her willingness to engage them in the life of her family was not understood. Mrs Morris had experienced a long history of professional involvement in her family's life, she had found much of their involvement overly intrusive and at times unhelpful, especially when coping with the level of violence perpetrated by James. Mrs Morris was open in telling the Lead Reviewers that in her experience it was family and friends that could help - not professionals, and she held onto to a belief that the love she showed to her children would ultimately win through.

10.29 The values held by the family in relation to the involvement of professionals in family life were not explored and as a result the possibility that practitioners were dealing with a form of 'disguised compliance' was not thought about, supervision and training did not support practitioners to recognise and address these subtleties. Although a perfectly understandable perspective, the result was that whilst Mrs Morris may have seemed compliant and engaged, her belief system meant that well-meaning plans made by professionals were unlikely to get the response they expected; it was a subtle form of non-engagement that was not understood. This left Mrs Morris without the support she needed in understanding how her experiences may be impacting on the services her family received, This ultimately left Kate without the specialist support she required. These issues are explored further in **Finding 8.**

Investigation into the allegation of inappropriate sexual advances – October 2014

10.30 In October 2014, Mrs Morris told the social worker that two weeks previously she had bought 'alcohol pops' for James and Kate; she had been struggling without the support of Mr Morris in meeting the demands of caring for Kate and James, particularly since James had returned from school, and that on this occasion she had given them these alcohol pops in an attempt to reduce the possibility of conflict between the siblings whilst she was out of the home.

10.31 The social worker responded appropriately by visiting the next day and in line with expected practice spoke to Kate alone. Kate alleged that whilst her mother was out of the home, James had asked if he could touch her intimately, she told the social worker she wanted him removed from the family home. The social worker formed the view that on balance, James was not a sexual risk to Kate but believed that this was Kate's way of having James removed. This was a timely response which recognised the presenting sexual risk issues and of the antipathy Kate felt towards James. Mrs Morris was requested to ensure that Kate and James were not left unsupervised. This attempt by the social worker to manage the situation illustrates just how difficult front line practice can be when intervening proportionately in family life. However, the competing demands now present in the family, and the particular relevance of the entrenched difficulties and complexities within the sibling relationship were not realised. The lack of input from specialist services, the lack of multi-agency recognition and guidance in relation to the complex problems the family were now facing left the social worker to 'go it alone' in trying to support the family. This left both them and the family in an untenable situation. **Finding 4** explores the issues in relation to sibling violence, and **Findings 5 and 7** are particularly relevant to the issues in relation to the lack of involvement by specialist services.

Contravening the Contract of Expectations – November 2014

10.32 As part of a routine visit to the family, Mr Morris was found to be in the family home and appeared to have been settled there for some time. This was in contravention of the Contract of Expectations. He was asked to leave and he agreed. At a much later point it became clear that the contract was often breached, and that both Kate and James were complicit in keeping this from CSC.

10.33 The extent to which the terms of this contract was breached was not known to professionals who were working with the family at the time. Indeed, it was not possible for practitioners to be aware of whether the contract was being complied with or not, as it was not possible to monitor compliance with this contract with any degree of certainty (This is explored further in **Finding 9**). Of critical importance was the question of whether the family were working in an open and honest way with the professionals, and whether the family were engaged in meaningful co-operation. In order

to answer this, the values and belief systems of the family needed to be unpacked and explored; for reasons identified earlier, this did not happen. The issues in relation to disguised compliance are explored further in **Finding 8.**

Involvement of Advocacy Services and The Child in Need meeting – November 2014

10.34 Mrs Morris had requested an independent advocate for Kate at the 'child in need' meeting in September 2014, in order for her wishes and feelings to be represented. There was a high volume of demand for advocacy services at this time and in line with the terms of their commission, the timing of provision was dictated by prioritising child protection cases over cases that were categorised as children in need. This meant that Kate was not provided with an advocate until November, just before the next scheduled 'child in need' meeting. The categorisation of cases and the prioritisation that follows is explored further in **Finding 3.**

10.35 On meeting Kate at home the advocate was concerned by her presentation, by the strength of her wishes and feelings in relation to her negative feelings towards James, and her openly expressed wish to die. Kate gave her permission for her views to be shared at the 'child in need' meeting, but stated that "no-one listens anyway". The advocate was so concerned that she made immediate contact with CSC; this was in line with expected practice.

10.36 Both Mr and Mrs Morris attended the 'child in need' meeting. It was unclear to the Review Team why Mr Morris was present; he was believed to present a risk to the children and the nature of the alleged offense (which included alleged grooming) was not considered, both in respect to the possible connotations in the meeting itself but also in respect to how this may manifest within the family. It was understood that in line with working with the family as a 'child in need' case, his inclusion was not questioned as the emphasis on working collaboratively and openly with parents and carers under this categorisation was underpinned by national guidance and good practice values. These issues are explored further in **Finding 3.**

10.37 In November 2014, the second 'child in need' meeting took place. The meeting included the same attendees as previously outlined. The issues in relation to categorisation of cases and the way this is responded to by multi-agency partners is detailed in 10.23 and explored further in **Finding 3**.

10.38 The Advocacy Manager represented Kate's wishes and feelings to the meeting. This was a powerful expression of Kate's feelings when she was at her most negative. The professional response was to rationalise these powerful messages within the context of Kate's presentation that was characterised by up and down moods. This denied her reality, and meant that no risk assessment was undertaken. It was the view of the Review

Team that this demonstrated how difficult it is for practitioners within the constraints of their work and resources to differentiate between the normal moods swings of adolescents and behaviours that indicate significant psychological trauma. In the continued absence of CAMHS involvement and in the absence of specialist advice from the Adoption Support Service the weight of Kate's acute and ongoing distress was not understood. Issues in relation to how troubled teenagers are responded to are explored further in **Finding 6.**

10.39 In response to Kate's expressed wishes and feelings Mrs Morris became understandably distressed, and this dominated much of the meeting. The contravention of the Contract of Expectations was not discussed, nor the lack of response to the CAMHS letter by Mrs Morris. Mrs Morris was actively encouraged to support the CAMHS work, however the issues raised previously about how compliance was understood was not recognised or addressed. These issues are explored further in **Finding's 7, 8 and 9.**

Kate's break-up with her boyfriend – late November 2014

10.40 Towards the end of November Kate's boyfriend, Justin, told her that he wanted to break up with her. Kate was very attached to Justin and became very distressed. Justin took her to the school office. The Pastoral Support Hub Coordinator was involved with another student. Mrs Morris was asked to collect Kate from school, but was not able to do so. The teachers responded in a caring and supportive manner. They recognised that the extreme nature of Kate's distress was unusual and they effectively supported both young people through the crisis, but they could not contain Kate's distress within the school and arrangements were made for Kate to return home.

10.41 Staff at the school were unaware of the involvement of CSC or of the complex issues at home, both in relation to recent events and in relation to Kate's adoptive status. Staff at the school were not represented at the 'child in need' meetings, and there had been no effective information sharing between the school nurse and the school in respect to Kate's needs. As a result, the incident was not reported to CSC. This fell below expected practice standards and was contrary to existing procedural guidance. The issues in relation to how the categorisation of a case impacts on multi-agency work are explored further in **Finding 3.** The issues in relation to information sharing, roles and responsibilities between staff working at the school's pastoral hub have been addressed during the course of this Review and are explored further in the **Additional Learning**.

10.42 Consequently, when the social worker visited the family home a few days later, she was not aware of Kate and Justin's relationship breakup. She appropriately acknowledged Kate's distress and spent considerable time talking to Kate giving consolation, advice and guidance, which was good practice.

10.43 The impact on Kate's psychological wellbeing of the ending of this significant relationship was not recognised by the practitioners involved. Attempts to get a psychological assessment had been unsuccessful, the lack of involvement of specialist adoption services meant that the significance of this loss for Kate, who had a history of unresolved loss and separation, was not understood, and a belief that an experience such as this was part and parcel of adolescent life and learning (and that ultimately the upbeat Kate would win through) underestimated the extent of her distress. **Findings 5 and 7** explore relevant issues in relation to the involvement of specialist services and **Finding 6** explores the issues in relation to how the emotional needs of adolescents are understood.

11. Summary of findings

11.1 The Review Team have prioritised 9 findings for the DSCB to consider. They relate to five categories of underlying patterns. The reader will observe many of the findings are interlinked; this is the nature of the systemic patterning found within interacting/overlapping systems.

Findings	Category
Finding 1: There is a perception in the multi-agency system that Children's Services Social Care will only accept referrals where there are immediate Child Protection concerns. This means that children living with significant family difficulties and complex emotional needs are not appropriately referred.	Patterns of multi-agency working in longer term work
Finding 2: The limited use of a CAF in Dorset is resulting in a lack of awareness about its value by multi-agency professionals, this leaves Early Support Services uncoordinated.	Patterns of multi-agency working in short term work
Finding 3: Professional response to children and families is led by categorisation of the case rather than the needs of the child and family, this increases the likelihood that children and families are not provided with the services they need.	Management systems
Finding 4: There is insufficient recognition, knowledge or understanding of the impact of living with sibling violence on the psychosocial development of children, this means limited action is taken to protect them or address their needs.	Patterns of multi-agency working in longer term work
Finding 5: The knowledge and skills of specialist adoption services are poorly integrated into first response services, this detrimentally impacts on	Management Systems

the services provided to adopted children and their families.	
Finding 6: There is a tendency for practitioners across all agencies to be desensitized to teenage crises and their impact where extreme highs and lows are commonplace making it difficult to distinguish between 'normal' adolescent development and those requiring specialist input.	Human bias
Finding 7: As the system is set up access to specialist adolescent mental health services requires parental permission before they can engage with the child. This means that some children are denied access to services they desperately need if a parent will not consent to opt in.	Management systems
Finding 8: Practitioners struggle to work with 'disguised compliance' when parents have good knowledge of and are confident in dealing with the system. The families appear engaged and use reasoned argument to convince practitioners of their compliance. The result is that children continue to be at risk and potentially become complicit in the deceit.	Family-professional interactions
Finding 9: The routine use of Contracts of Expectations where family compliance is unreliable, with no clear sanction should the contract be broken renders them meaningless for the family, ineffective in protecting children and impossible to successfully monitor.	Tools

12. Findings

12.1 This section represents the main learning from this Case Review for Dorset Safeguarding Children Board and partner agencies. Each finding is set out in a way that illustrates:

- How does this issue feature in this particular case?
- How do we know it is not peculiar to this case? What can the Case Group and Review Team tell us about how this issue plays out in other similar cases/scenarios and/or ways that the pattern is embedded in usual practice?
- How widespread and prevalent is the pattern? What evidence have we gathered about how many cases are actually or potentially affected by the pattern? Is it found in a specific team, local area, district, county, region, national?
- What are the implications for the reliability of the multi-agency child protection system?

12.2 The evidence for the different 'layers' of the findings comes from the knowledge and experience of the Review Team and the Case Group, from the records relating to this case, and other relevant documentation and from relevant research evidence.

12.3 Nine priority findings were chosen because they represented areas of practice which were significant in how this case was managed, but which also reflected wider patterns of practice and the systems which underpin that practice.

The remainder of this section explores the 9 Findings.

13. The Findings in detail

Finding 1: There is a perception in the multi-agency system that Children's Services Social Care will only accept referrals where there are immediate Child Protection concerns. This means that children living with significant family difficulties and complex emotional needs are not appropriately referred.

13.1 Statutory guidance describes the circumstances in which children who are in need of services from Children's Social Care or who are in need of protection, require a referral to the relevant statutory services in order for their needs to be assessed and for services to be provided to meet these needs. This finding has shown that in circumstances where a child has been visibly harmed or has made a clear disclosure of harm, the need to make a referral is understood by multi-agency partners. In circumstances where there are significant family difficulties and complex emotional needs, or where the harm a child may be experiencing is less obvious, there is a

perception that Children's Social Care will not accept such a referral and so in these circumstances referrals are not made.

How did it feature in this case?

13.2 Kate told a number of practitioners in late 2013-2014 how unhappy she was at home. She included information to suggest she may have been physically harmed at home, she spoke about wanting to come into care and of spending a night alone in a tent in the wood after running away from home. The practitioners involved formed the view that this did not reach the threshold for a referral to Children's Services Social Care. Information about Kate's adoption and the sibling violence from her brother James was available to these practitioners.

13.3 By spring 2014 James was preparing to leave his residential school. At this time Mrs Morris stated that she would not have James home due to his history of violence and the ongoing risks he posed to her and Kate.

13.4 There was information held by the school to suggest that James continued to have difficulties in his relationships with women, these relationships were often characterised by aggression and hostility. As a result, there was a great deal of information known that suggested that James' return to the family home was likely to have a significant impact on the health and wellbeing of both James and Kate. Despite this, no referral was made to Children's Social Care.

How do we know it is not peculiar to this case?

13.5 The Case Group gave many examples where they had made referrals to Children's Services Social Care that had not been accepted. There was a considered discussion about whether to refer an allegation of assault when there was no injury to be seen. The discussion concentrated on issues such as these, rather than taking into account the context within which the alleged or potential assault had occurred. The Review Team commented that the DSCB threshold tool that was in place at the time was unclear. In one instance it advocated using the CAF if there were no urgent concerns and in another, providing a tool to support agencies to understand mild, moderate and high risk and consequent referrals to Social Care. Along with this the Review Team was also able to give a number of examples when they had supported staff who were unclear about whether to make a referral.

13.6 It is important to note that when reflecting on the services that were offered to Kate and her family, both the Review Team and the Case Group recognised that information that was knowable should have prompted a referral to Children's Services Social Care under the category of 'moderate to high family dysfunction'.

13.7 Practitioners within the multi-agency Child Protection system are aware

that when there are immediate concerns about significant harm that they should make a referral to Children's Services Social Care as the lead agency.

13.8 Knowing when other referrals should be made is more complex, and many practitioners have had experience of making referrals before when they have not been accepted and may not have understood the reasons why. All of this impacts on future decisions about making referrals particularly when harm may not be immediate or there is risk of family breakdown.

How widespread and prevalent is the issue?

13.9 A search of national serious case reviews indicates that this issue of thresholds comes up on numerous occasions. An example of this is in the Liverpool review 'Maisie' where Finding 3 states:

> *"Thresholds for intervention are perceived differently by professionals within a safeguarding system"*

> *"Whilst there is a commonly held recognition amongst professionals of the need to work to thresholds, these are felt by professionals to be at a too high level of risk."* [3]

13.10 Children's Society in its research 'Safeguarding Young People: Responding to Young People aged 11-17 who are maltreated'[4] refers to this very issue:

> *"A key barrier to professionals making a referral to young people who have been maltreated to Children's Social Care Services was the perception that thresholds and resource constraints would mean they were unable to respond"*

13.11 In an article, published in September 2015, 'Are Child Protection thresholds too high?'[5] Community Care undertook an analysis of 59 Ofsted inspections. They reported that they found confusion around thresholds in 26 inspections, or 44% of Local Authorities:

> *"Often the understanding of thresholds in partner agencies and within Children's Services was not consistent."*

[3] Liverpool Safeguarding Children Board, Final Overview Report 'Maisie' (January 2015)
[4] Children's Society: 'Safeguarding Young People: Responding to Young People aged 11-17 who are maltreated' (2010)
[5] 'Are Child Protection thresholds too high?' (September 2015)

What are the implications for the reliability of the multi-agency Child Protection system?

13.12 In a safe system there is a common understanding of when agencies should refer to Children's Services Social Care. This is agreed at strategic level and there is joint ownership of the LSCB published threshold document that is clear and easy to understand. All practitioners are suitably trained and supported to work within the threshold document and thresholds do not change as a result of variables such as location and resource availability. Practitioners therefore develop and become confident in their practice around making referrals.

13.13 In a safe system there is a culture of debate, challenge and dialogue that assists practitioners to feel confident about referring and seeking advice and challenging when needed.

13.14 Systems are unsafe when practitioners lack confidence in their judgement around making a referral to Children's Services Social Care; they are not aware of the threshold tool or find it unhelpful. When referrals are not made children are not provided with the right level of intervention and this can lead to the child believing that no-one is listening

13.15 In a system where agencies are left confused about which children they should refer to Children's Social Care this can lead to a lack of intervention at the right level, and children remaining at risk of future harm.

Finding 1: There is a perception in the multi-agency system that Children's Services Social Care will only accept referrals where there are immediate Child Protection concerns. This means that children living with significant family difficulties and complex emotional needs are not appropriately referred.

Summary

A solid understanding of which circumstances meet a threshold for referral to statutory CSC services allows children and families to receive the correct level of support at the earliest possible opportunity. In the absence of such an understanding, confusions and misconceptions have the potential of leaving families without the correct level of support they need, and children vulnerable to harm.

Issues for the Board and member agencies to consider:

- The Board to take steps to improve understanding and application of the threshold document across partner agencies. Data regarding the number and appropriateness of referrals, and the response from Children's Services Social Care should be analysed to ensure young people are receiving the interventions they require.
- The Board should consider monitoring the use of the escalation

policy when agencies do not agree with the response from Family Support when a referral is made.

- Can the Board satisfy itself that practitioners are taking cases to supervision where they have attempted to refer to Children's Services and have been told they do not reach the threshold?
- The Board should consider whether the availability of resources impacts on both the referral rate and the referral take up.
- Does innovative practice exist elsewhere that can be built on in Dorset?
- DSCB to decide where accountability will be held for maintaining detailed monitoring and evaluation of the learning that has emerged from this finding.
- The DSCB should consider how they will be best informed of progress and consider how challenge will be provided.
- Finding and planned improvements to be included in respective agency learning and development plans and in the DSCB learning and development plan.
- Given the implications for the protection of children in Dorset, the Board should consider taking the above actions as a matter of urgency.

Finding 2: The limited use of a CAF in Dorset is resulting in a lack of awareness about its value by multi-agency professionals, this leaves Early Support Services uncoordinated.

13.16 The Common Assessment Framework (CAF) is an assessment tool that can be used when a child or family require input from several agencies in order to support and help them promote change. It ensures that intervention is based upon assessment and coordinated through the multi-agency network. Families have to agree to participate in a CAF and there will always be a lead professional from the multi-agency network who will take prime responsibility for moving the work forward. This case has shown that in Dorset there is limited use of the CAF and a lack of awareness about the value it holds in meeting a child's needs, this results in a lack of coordination of early help services.

How did it feature in this case?

13.17 In spring 2014 Kate was discussed at the Children of Concern meeting at the school. The fact that she was adopted, was showing signs of emotional distress and was beginning to exhibit some behaviour problems at school was referenced. It was decided to approach Mrs Morris to ask permission for an assessment by the Educational Psychologist. At the same time, and running in parallel, James' residential school referred him to Early

Intervention using the Pre-CAF document and there was considerable email correspondence between Early Intervention and Special Educational Needs and the referring school. This correspondence referenced Mrs Morris's expressed wish that James did not return home and that another residential school be sought. The information about James's violence towards Kate was known about but not explicitly referred to. None of the practitioners involved thought to implement a CAF and therefore information about the two siblings was not shared across the multi-agency network.

How do we know it is not peculiar to this case?

13.18 Review Team members reported that during the time under the Review, training in CAFs had been suspended and consequently all agencies were confused as to its status.

13.19 Another Serious Case Review in Dorset, Family S18[6], which was running concurrent to this Review, found that Early Intervention services were piecemeal and not coordinated through a CAF:

> *"The most obvious missed opportunity in this case was the failure to take advantage of the systems which were in place in order to enable agencies to work together, analyse and assess risk, think creatively and plan interventions."*

13.20 In Dorset there has been inconsistent messages given to practitioners about the use and implementation of CAF which practitioners spoke about during Case Group meetings. This has caused confusion and in some instances established working relationships have led to local practice that does not involve formal CAF use. It was understood that generally, there is a lack of clarity about the CAF and referral process, there are challenges in information sharing between different colleagues and different agencies, confusion about the purpose of CAF and when they should be used.

How widespread and prevalent is the issue?

13.21 The data about CAF is limited, but it is known that most CAFs are undertaken by social workers in Dorset as part of a step-down process to access Early Intervention services on behalf of families. The Review stated that agencies outside of Social Care rarely initiate CAFs or provide a lead practitioner.

13.22 Claire Easton, Marian Morris and Geoff Gee undertook some research in 2010[7] that involved 24 Local Authorities and included work around what

[6] Karen Tudor, Serious Case Review S18, Dorset Safeguarding Children's Board in conjunction with Hampshire Safeguarding Children's Board (as yet unpublished)

[7] Clare Easton et al, Local Authorities Research Consortium: Integrated Children's Services and the Common Assessment Framework Process (Slough National Foundation for Educational Research, 2010)

the key factors were that promote the effectiveness of CAF in different contexts. The research noted positive outcomes where CAF was used. The research also found:

> *"A steadily improving but still somewhat inconsistent implementation of the CAF with significant variations and approach in different authorities."*

What are the implications for the reliability of the multi-agency Child Protection system?

13.23 In a safe system strategic leadership in respect to Early Intervention leads to clarity for practitioners enabling them to judge how best to meet children's needs at the earliest opportunity, and what services and resources should be used.

13.24 When families are provided with this early help through an assessment of need and a carefully coordinated plan, problems are dealt with before they become entrenched and resources are used most efficiently.

13.25 Early Help practitioners are able to effectively assess children and bring together information from a wide range of services. There is an accessible and understood assessment tool, with all practitioners trained and confident in using it. All assessments are properly completed with relevant information, and there is clarity about which resources, services and interventions should be used. At times these early assessments will support onward referral to specialist services, and CAF is one such assessment tool.

13.26 In an unsafe system there is no strategic ownership of Early Intervention and this leads to lack of clarity for multiagency partners, no joint training or supporting IT systems. The additional resource demands will not be recognised and practitioners will be unsupported with the implementation of early help assessments such as CAF. The consequent lack of clarity within the process leads to practitioners failing to undertake CAFs even when situations demand it.

13.27 If there are no quality assurance mechanisms in place, such as data collection about how a CAF is used, there is little ability to monitor progress or to take action to remedy any weaknesses in the multi-agency system, this has the potential of leaving children without the help they need.

Finding 2: The limited use of a CAF in Dorset is resulting in a lack of awareness about its value by multi-agency professionals, this leaves Early Support Services uncoordinated.

Summary

When there are a number of practitioners working with children a coordinated multi-agency response through appropriate assessment,

planning and intervention improves outcomes and effectively supports referral onto specialist service when required. When this does not happen, children and families are not provided with the support they need, problems can become entrenched and services may then struggle to meet these needs.

Issues for the Board and member agencies to consider:

- The Board should take steps to achieve a strategic oversight for Early Intervention and implementation of the Common Assessment Framework (CAF) that is well informed and effective in delivering required changes.
- The Board should actively monitor the use of CAFs in Dorset and make enquiries as to whether they improve the outcomes for children.
- Does innovative practice exist elsewhere that can be built on in Dorset?
- The DSCB should decide where accountability will be held for maintaining detailed monitoring and evaluation of the learning from this finding.
- The DSCB should consider how they will be best informed of progress and consider how challenge will be provided.
- Finding and planned improvements to be included in respective agency learning and development plans, and in the DSCB learning and development plan.

Finding 3: Professional response to children and families is led by categorisation of the case rather than the needs of the child and family, this increases the likelihood that children and families are not provided with the services they need.

13.28 All work with vulnerable children and families is governed by the 1989 Children Act which defines when a child is in need of services and when a child is in need of protection. These categorisations are based upon risk and levels of need. Children in need require services to promote their health and development, children subject to child protection enquiries and plans receive services aimed at safeguarding children at risk of significant harm. Social workers only work with children in need and child protection cases and are required to be the lead agency for child protection cases. This Review has found that the categorisation of whether a child is in need of protection or in need of services has a profound impact on the multi-agency response.

How did it feature in this case?

13.29 Kate was deemed to be a child in need of services by Children's Services Social Care and this categorisation was not challenged by other agencies. This decision was taken because the family were believed to be cooperating with a plan that kept the stepfather, who was under investigation for abuse, out of the house, only having supervised contact with the children. This meant that some agencies were not routinely joined into the information sharing processes.

13.30 The case was approached with significant rigor, but without the child protection constructs there were 'child in need' meetings rather than Child Protection Conferences; therefore, the GP and Police were not invited and did not receive subsequent minutes, and the school did not prioritise their involvement because of their need to prioritise those children who were in need of protection. The consequence was that important members of the multi-agency network had no knowledge of the assessed needs within the family or the plans to meet these needs.

How do we know it is not peculiar to this case?

13.31 The Case Group explained that the different status of cases warrants a different response from agencies. Children's Services Social Care stated that 'child in need' cases are worked in a similar way to child protection cases and in this case visiting was at the same frequency with the same levels of Children's Services input. However, agency partners were clear that 'child in need' cases are not given the same priority and they would not feel the same responsibility to attend meetings, share information or join in the multi-agency planning. Responses depend on the categorisation of the case rather than the identified needs.

13.32 The Review Team learned of another Serious Case Review in Dorset regarding an adolescent that died, Family S11[8], the report makes a relevant comment:

> *"Although the Child in Need Plan should have been the focus of the multi-agency team to agree objectives, clarify who was doing what and measure progress…for this case multi-agency partners did not prioritise attendance at meetings and did not effectively sign up to the Child in Need Plan."*

13.33 A multi-agency case audit in November 2014 concentrated on child protection cases, but a message that came through in respect of 'child in need' cases was that multi-agency partners lacked confidence in this process and did not participate in the same way that they would in child protection cases.

13.34 The Review Team learned that the Advocacy Service always prioritised

[8] Karen Tudor, Serious Case Review, Overview Report S11 (February 2014)

cases according to status and this is accepted practice.

How widespread and prevalent is the issue?

13.35 A Department of Education (DFE) statistic, published February 2015, shows that the number of children subject to Child in Need status during the period practitioners were working with Kate was 378,600 nationally. This was a slight increase when compared to the previous year. In Dorset, on the 1st of December 2014 there were 1705 children in need.

13.36 These statistics however do not separate children who are being assessed and do not go on to receive services by a multi-agency network within a Child in Need Plan. Traditionally, data and statistical information has been collected on children subject to Child Protection Plans, there is far less known about the cohort of children subject to Child in Need Plans and the nature of multi-agency engagement in the provision of services.

13.37 In 2012 the Department for Education published new learning from Serious Case Reviews: a two-year report for 2009 to 2011[9]. This overview of 184 Serious Case Reviews noted the theme in respect of how workers approached 'child in need' and child protection cases:

> *"There appears to be some confusion engendered by the perceived distinction between Child in Need procedures and Child Protection procedures. Indeed, rather than being seen as a continuum this distinction leads to a substantial gulf in practitioners' approaches."*

What are the implications for the reliability of the multi-agency Child Protection system?

13.38 A safe system is based on the principle that children's needs do not fit neatly into a categorization box, services provided to the child and family will recognise that their needs will vary over time and will be different according to age and development, life transitions and life events that may impact on these needs and how these needs are met.

13.39 When services are able to be responsive to the dynamic nature of need their response will not be governed by how a particular service area may have categorized the child's needs, rather their response will be governed by the principle that the child is at the centre of their decision making. In addition, a position will be taken that the needs of the child cannot ever be successfully addressed without the involvement of the multi-agency network who know the child and family best. When this happens, the holistic needs of a child can be seen from a multi-agency perspective, important information will be shared and assessments and service

[9] Brandon et al,' Serious Case Reviews: a two-year report for 2009 to 2011', Department for Education (22 April 2013)

provision will place the child as central to decision making.

13.40 However, viewing a child's needs from the perspective of a categorisation leads to their needs being prioritised according to the weight placed on the categorisation used.

13.41 The involvement of the multi-agency network in providing services will be led, not by the needs of the child but by considerations such as prioritisation of resources according to the status of need. This can lead to confusions over role and responsibility, important information will be lost, and the network around the child will be fragmented. This risks an approach to the child and family characterised by limited multi-agency agency decision making and silo working. Within this construct the needs and safety of a child will be compromised.

Finding 3: Professional response to children and families is led by categorisation of the case rather than the needs of the child and family, this increases the likelihood that children and families are not provided with the services they need.

Summary

Statutory guidance requires children's needs to be categorised by Children's Social Care as either 'child protection' or 'child in need'. There are well developed embedded processes for all partners when working with cases categorised as 'child protection'. Interagency working with children in need are given less priority by some, and therefore information sharing and involvement in planning and service delivery can be less robust, this has a detrimental impact on children's outcomes.

Issues for the Board and member agencies to consider:

- The Board should consider how and in what way the threshold document published by the Board in 2015 has improved multi-agency work and outcomes for children in need.
- The Board should consider whether the demands on resources are playing a significant part in how children in need are provided with a multi-agency service, and further consider how any gaps can be addressed within the finite resources available.
- The Board should consider how to promote confidence within the multi-agency network to strengthen their role in providing services to children in need.
- Does innovative practice exist elsewhere that can be built on in Dorset?
- The DSCB should decide where accountability will be held for maintaining detailed monitoring and evaluation of how the learning from this finding is embedded within multi-agency systems to the

benefit of children and families.

- ❖ The DSCB should consider how they will be best informed of progress and consider how challenge will be provided
- ❖ Finding and planned improvements to be included in respective agency learning and development plans and in the DSCB learning and development plan.

Finding 4: There is insufficient recognition, knowledge or understanding of the impact of sibling violence on the psychosocial development of children, this means that limited action is taken to protect them or address their needs.

13.42 Sibling violence can have a profound impact on the psychological and emotional development of the victim and perpetrator and can result in long term emotional and psychological consequences. Living in families where this is a feature of daily family life and is left unresolved can lead to feelings of helplessness and disempowerment and give rise to feelings of anger and mistrust about those in a caring role. This finding has shown that sibling violence is not routinely recognised as a source of significant harm, there is an absence of guidance provided to front line practitioners and the limited recognition of the impact on the development and wellbeing of all family members leaves a vacuum where needs are unrecognised and services ill equipped to provide a response.

How did it feature in this case?

13.43 Throughout late 2013 and 2014 Kate told a number of practitioners about the difficult relationship she had with James and her strong negative feelings towards him. At times she told practitioners that: “they cannot both exist together” and that “one of them must die”. She spoke of James making a sexually inappropriate comment towards her, in the hope that James would be removed from the family home.

13.44 There were a number of practitioners who had been made aware of the difficult relationship that existed between Kate and her brother since their primary school days. This was recorded on the school child protection file and in social care records. Social care had involvement when Kate was 10 and James was said to be using Kate “as a punch bag”. Kate, at this time, said she wanted to kill herself.

13.45 Although during the Review period practitioners referenced this violence to varying degrees, its severity and real impact on Kate was not taken into account when planning interventions. According to the family, James’ previous violence still impacted on Kate significantly during the Review period. Prior to James’ return in June 2014 he had been in a residential school placement returning at weekends. During this time Kate tried to absent herself as much as possible during weekends. Mrs Morris raised

concerns about James' return from residential school and his potential violence towards herself and Kate. However, despite this James still returned home. No services were provided that either appropriately assessed the level of violence perpetrated on Kate by James or targeted intervention to safeguard Kate from her brother's potential violence.

How do we know it is not peculiar in this case?

13.46 The Case Group informed us that across agencies practitioners are beginning to note cases where one sibling is aggressive to another. However, this is not recognised, named or understood as sibling violence and linked to the domestic abuse agenda. Practitioners gave specific case examples of this. They recognised that at times the violence is reframed as 'attention-seeking behaviour' and to some extent sibling violence is 'a taboo subject' and flies in the face of accepted understanding about how families should function.

13.47 The Review Team recognised this and noted that respective agencies do not have protocols or procedures for dealing with sibling violence. Both Case Group and Review Team members stated that it was the opportunity provided by this Serious Case Review that prompted them to reflect on issues around sibling violence for the first time.

How prevalent and widespread is the issue?

13.48 There is little formal research into the area of sibling violence in this country, much of the current research is American. This shows that sibling violence is more widespread than initially thought and can have a significant impact on the victim in the sibling relationship. Button and Gealt in their article 'High Risk Behaviours Amongst Victims of Sibling Violence' bring together a number of pieces of American research[10]. They recognise that sibling violence abuse is under researched and state:

> *"Excluding sibling abuse as a serious form of family violence ignores and trivialises this phenomenon."*

13.49 Later in the article they go on to say that four out of five children aged between 3 and 17 years have hit a brother or sister, however:

> *"More severe forms of abuse such as using objects or weapons to inflict pain are less common. Rates of severe abuse reportedly range from 3% to 6%. Individuals who experience maltreatment by siblings endure both immediate and long term consequences."*

13.50 The article quotes some further research by Wiehe, Ammerman and Hersen who connected psychological sibling violence to habit disorders,

[10] Deanna M. Button and Roberta Gealt, 'High Risk Behaviours Amongst Victims of Sibling Violence', Journal Family Violence (2009)

neurotic traits and suicide attempts.

13.51 Anecdotal information from Adoption Support Services reference several families where sibling violence was an issue and for some children this resulted in adoption breakdowns. Agencies in Dorset do not record data around sibling violence therefore any information is anecdotal. An audit undertaken to review the number of Multi-Agency Risk Assessment Conference (MARAC) cases involving adolescent parental violence noted that out of the 10 cases audited, at least 3 involved violence towards younger siblings. In Dorset paediatric clinics it has also been noted that children who have a diagnosis of Autistic Spectrum Disorder/ Attention Deficit Hyperactivity Disorder / Attachment Disorders paediatricians are reporting concerns at the level of aggression being directed towards other children in the family.

13.52 A small number of Serious Case Reviews refer to issues around sibling violence. This is sometimes within the context of chronic neglect and sexual abuse, but also in respect of the needs of the victims being overlooked, agencies concentrated on the needs of potential perpetrators; those for example with developing mental disorders or psychiatric diagnoses.

15.53 There are a small number of Serious Case Reviews nationally where sibling violence has led to the death of one sibling. One such Serious Case Review is 'Child who was born 17/4/2000 and died on 18/2/2010'[11], published by Bradford Local Safeguarding Children Board, which identified the importance of considering the needs of all siblings and not just the child that is perpetrating the violence.

What are the implications for the reliability of the multi-agency Child Protection system?

13.54 In systems where the impact of sibling violence is understood and recognised, established systems and multi-agency processes such as the child protection system will be sufficiently adapted to ensure the risk of sibling violence is sufficiently assessed. In addition, multi-agency service provision to both the victim and perpetrator will be tailored to meet their needs with robust monitoring in place. Practitioners will understand the seriousness of the issue and the complexities of meeting the needs of both children.

13.55 If the multi-agency safeguarding system does not consider the complexity of sibling violence and the significant needs of both perpetrator and victim, this has the danger of tolerating unacceptable levels of harm to children. When services are provided that focus on the perpetrator of the violence with the aim of changing the presenting behaviour and there is little focus on the needs of the victim beyond immediate physical protection, the emotional and psychological impact of the protracted violence is

[11] Carol Smith, Child who was born 17/4/2000 and died on 18/2/2010, Bradford Local Safeguarding Children Board (August 2010)

overlooked; this can have life-long implications for children in these circumstances.

Finding 4: There is insufficient recognition, knowledge or understanding of the impact of sibling violence on the psychosocial development of children, this means that limited action is taken to protect them or address their needs.

Summary

A safe system recognises and understands the profound impact of sibling violence on the psychosocial development of a child, be they victim or perpetrator. Within current systems and services, the needs of these children are routinely overlooked.

Issues for the Board and member agencies to consider:

- How can the Board be better assisted in understanding the scale of sibling violence in Dorset and the possible ways in which children in these circumstances can be identified and supported?
- The Board should consider the priority given to sibling violence within the emerging domestic abuse and other child protection processes.
- Does innovative practice exist elsewhere that can be built on in Dorset?
- The DSCB should decide where accountability will be held for maintaining detailed monitoring and evaluation of the work around the recognition and implementation of processes designed to protect children from sibling violence.
- The DSCB should consider how they will be best informed of progress and consider how challenge will be provided.
- Finding and planned improvements to be included in respective agency learning and development plans, and in the DSCB learning and development plan.

Finding 5: The knowledge and skills of specialist adoption services are poorly integrated into first response services, this detrimentally impacts on the services provided to adopted children and their families.

13.56 It is nationally recognised that adopted children and their families face particular challenges. Adopted children may exhibit behavioural issues; attachment disorder; psychological distress and symptoms of loss, bereavement and identity issues. Supporting adopted children and their families for the duration of childhood, is an important national issue and is

the subject of statutory guidance. In recent years, resources have been intentionally focused and services grown up in response. This finding reveals that such services have become isolated from frontline delivery and the importance of providing services to these children for the duration of childhood can be overlooked.

How did it feature in this case?

13.57 James and Kate were fortunate enough to have a consistent Adoption Support Worker throughout their childhood who provided a range of services to the family during the children's early years, and the case remained open to this service to the same Adoption Support Worker under the period under review. The Adoption Support Worker was a key professional with long-term involvement who knew about James' violence and aggression towards Kate, understood the dynamics of the family and knew the history of the family well.

13.58 When the children were re-referred firstly to Early Intervention then through to Children's Services Social Care in 2014, the case was open to the Adoption Support Worker but this information was not accessible to the worker through the Integrated Children's System (ICS) electronic record keeping system.

13.59 Although Kate's adoptive status is referred to by practitioners throughout their work with her, Kate was not truly understood within that context and practitioners across the multi-agency network were unaware of the specialist services that could have been accessed for the family. The lack of integration of the Adoption Support Teams in both the Children's Service and in CAMHS meant that these specialist services were not involved in providing a service to Kate and her family at a critical time in her life.

How do we know it is not peculiar in this case?

13.60 The Review Team learned that Adoption Support Services at the point of adoption and immediately afterwards are well integrated, understood and accessed by agencies and families. However, the availability of Adoption Support some years after is not readily understood by practitioners across the network and the work of these services is not integrated into universal or first response services. Although members of the case group understood that a significant number of these families face problems during adolescent years, frontline practitioners offering support to these children and families were clearly not aware of the specialist resources available either through adoption teams or through Child Adolescent Mental Health Services.

13.61 The Review Team learnt that there is currently no established way for Adoption Support Teams to share knowledge and coordinate responses either on an individual case basis or more broadly through services or resources.

13.62 Adoption and Adoption Support is high on the agenda for the government; they have commissioned significant research[12] and set up an Adoption Support Fund. Research shows that services across agencies do not understand the impact of adoption on children and the families in which they live. Many examples are cited where agencies have failed to offer appropriate support at the right time. This either leads to unhappy and disrupted family life or adoption breakdown. However, there is no current local or national data that relates to this finding.

13.63 A search of the NSPCC Serious Case Review repository shows no relevant Serious Case Reviews around Adoption Support services. Research completed by Adoption UK recognises the impact of chaotic and disruptive early attachment on children, it states:

> *"It is noticeable that the most commonly identified barrier by 27% of respondents was the level of understanding and experience of adoption amongst the professional staff involved."*

13.64 In a safe system specialist services are appropriately resourced to meet the on-going and significant needs of children and families who require adoption support. These services will have the knowledge and capacity to address the profoundly complicated issues. They will be readily accessible to both frontline social workers and other agencies and established protocols will be in place to allow for joint working. A specialist LAC/Adoption Social Worker working within the CAMHS service will be able to prioritise input to adoptive families and offer skilled and tailored interventions to address any attachment or trauma issues. These services will be known about and will be embedded within multi-agency service delivery.

13.65 Systems for information sharing will acknowledge the confidentiality issues attached to adoption, but not inhibit appropriate dialogue and joint assessment. There will be sufficient respect of each services knowledge base, and the limitations and expertise imbued in each role will be recognised. This approach brings benefits for both children and parents.

13.66 When services do not recognise the profound impact of adoption on children and families and where specialist resources are isolated from the work of universal or targeted first response services, services to children and families will be ineffective, poorly targeted and unlikely to promote lasting change. For some children and families, the consequences will be significant.

[12] Selwyn et al, Beyond the Adoption Order: Challenges, Interventions and Adoption Disruption, University of Bristol School for Policy Studies (April 2014)

Finding 5: The knowledge and skills of specialist adoption services are poorly integrated into first response services, this detrimentally impacts on the services provided to adopted children and their families.

Summary

Specialist services, intentionally set up to support the complex emotional needs of adopted children and their families, are ineffective if there has been little attempt to integrate these services into front line service delivery, this leaves children and families without the specialist support they require.

Issues for the Board and member agencies to consider:

- The Board should further consider how Adoption Support Services and specialist CAMHS services are best used in Dorset.
- The Board might like to understand the implications of the new Regional Consortium and consider the impact of its development on the services provided to children in Dorset.
- The Board should satisfy themselves that practitioners across agencies have enough of an understanding of attachment, loss and trauma in respect of adopted children to make appropriate enquiries and referrals in a way that promotes integrated working.
- Does innovative practice exist elsewhere that can be built on in Dorset?
- The DSCB should decide where accountability will be held for maintaining detailed monitoring and evaluation of the learning from this finding.
- The DSCB should consider how they will be best informed of progress and consider how challenge will be provided.
- Finding and planned improvements to be included in respective agency learning and development plans and in the DSCB learning and development plan.

Finding 6: There is a tendency for practitioners across all agencies to be desensitized to teenage crises and their impact, where extreme highs and lows are commonplace, making it difficult to distinguish between 'normal' adolescent development and those requiring specialist input.

13.67 Adolescence is a time when young people begin to separate from their parents and carers and begin to establish their own identity. This combined with the hormone fluctuations of adolescence and the move towards the peer group often means that adolescents exhibit a range of irrational, impulsive and risk-taking behaviours. They exhibit a range of emotional

reactions to situations that they find challenging and this can be difficult for adults to understand and empathise with and manage. Given that this is 'normal' behaviour, practitioners find it a real challenge to recognise when adolescent behaviour is in fact an indicator of significant concern.

13.68 **How did it feature in this case?**

Throughout this case, practitioners stated that Kate was 'no different from her peers' whereas the extent of the extremes of behaviour suggested that her functioning was outside normal expectations. There were many examples of this that manifested throughout the time under review, a small number are referred to.

13.69 The Case Group reported that Kate was easy to engage and would readily share her thoughts, feelings and wishes. At times she would talk positively and would refer to her involvement with amateur dramatics, other activities and her future plans. She would also talk very negatively about her life, her position within the family, her extreme dislike of James, about coming into care, and the fact she did not want to live, using strong and emotive language. Practitioners acknowledged these negative feelings, but did not feel they would overwhelm her as they ultimately did.

13.70 A clear example of this is the Advocacy involvement: The Advocate visited Kate at home and reported that Kate was in a desperate situation, talking of suicide. The Advocate discussed this with her manager and informed CSC when it was explained that at times Kate did appear very desperate and negative, but this was transient. When the Advocate Manager attended the Child in Need meeting and gave an account of Kate's wishes and feelings, all professionals took the information seriously, but it served to confirm for them that this was an innate part of Kate's personality rather than a disturbance of her personality. Mrs Morris was encouraged to take up the offer of CAMHS, but the depth of Kate's despair was not recognised.

13.71 Following the breakup with Justin, Kate's emotional expression and behaviour became increasingly extreme and unstable; clinging to his leg in school and walking several miles across the fields in November to get to his house.

13.72 The meaning of her deep distress at the loss of Justin was not fully understood by practitioners. It was not seen in the context of the losses she had experienced over her lifetime. This caused confusion in the professional system as simply dealing with her as a teenage girl getting over her first boyfriend.

How do we know it is not peculiar to this case?

13.73 This subject was hotly debated by the Review Team and the Case Group and many were able to give examples of other young people with whom they were working who exhibited similar behaviours to Kate. They reported that they did not think they had the knowledge, tools or expertise to

differentiate between those young people with fundamental psychosocial problems and those with normal teenage behaviour.

13.74 In Dorset there have been two previous Serious Case Reviews where teenagers have died. Both exhibited confusing presentation with fluctuating moods but the depths of their despair was not recognised. One further Serious Case Review and a Domestic Homicide Review have also involved teenagers where agencies did not recognise or address their needs, or provide adequate intervention. In total 6 children have killed themselves in Dorset between 2011 and 2014.

How widespread and prevalent is the issue?

13.75 A concurrent Serious Case Review in Dorset identified similar issues to this Serious Case Review. The author of Serious Case Review S17[13] states:

> *"A difficulty for all professionals working with Mark was that on many occasions what he was saying and what he was doing did not match. This meant that there was a need for professionals to go beyond listening, to try to understand and respond to the child's perspective."*

13.76 This is the second Serious Case Review in Dorset where the adolescent shows behaviour that confuses professionals. This is a quote from the Serious Case Review S18[14]:

> *"…. immediately before her death had expressed an interest in becoming a school prefect. She showed both a feisty and determined side to her character and was described as stubborn with strong views which she freely shared. She also, at times, presented a very vulnerable, sad and confused picture."*
>
> *"Discussion in the Learning Event during this SCR explored what staff described as a current culture of self-harming, dark thoughts and depression among young people which makes it very difficult to differentiate those at most risk."*

13.77 A Serious Case Review published in Cumbria also noted:

> *"A lack of appreciation of the 'inner world of teenagers' and their perceptions of themselves leaves professionals drawing naïve/over-simplistic conclusions about what they know from their communication with teenagers and what it means."*[15]

[13] Serious Case Review S17, Dorset Safeguarding Children Board (as yet unpublished)
[14] Karen Tudor, Serious Case Review S18, Dorset Safeguarding Children's Board in conjunction with Hampshire Safeguarding Children's Board (as yet unpublished)
[15] Child J, Cumbria Safeguarding Children Board (2014)

13.78 Research such as that conducted by the BELLA group in Germany in 2008 confirms that in respect to adolescent mental health, professionals over emphasise the importance of 'so called' Protective Factors such as positive family and peer relationships.[16]

What are the implications for the reliability of the multi-agency Child Protection system?

13.79 In a safe system practitioners have a good understanding of adolescent development and are able to communicate and work effectively with young people and their families. They will have access to appropriate tools to deliver intervention that match the young person's needs and will recognise when it is necessary to refer the child to more specialist services.

13.80 Adolescence is a period of rapid physical and emotional change. Variation in mood is a common feature, but recognising when a child's mental health is leading to extreme displays of behaviour will lead practitioners to consider further action or a safeguarding response. When practitioners recognise the significance of loss and trauma on young people, who are already experiencing attachment issues and emotional instability, the services provided are appropriately tailored to meet these significant needs.

13.81 Where systems are not in place that enable practitioners to understand the emotional world of teenagers and to know when a teenager may need specialist help through a referral to appropriate specialist services, this can leave those teenagers in need of such help vulnerable and conversely can lead to specialist services becoming inundated with inappropriate referrals which compromises their ability to provide services to those teenagers most in need.

Finding 6: There is a tendency for practitioners across all agencies to be desensitized to teenage crises and their impact where extreme highs and lows are commonplace making it difficult to distinguish between 'normal' adolescent development and those requiring specialist input.

Summary

Adolescent behaviour is characterized by emotional highs and lows and risk taking behaviour. It is therefore difficult for practitioners to differentiate between those young people who will respond to universal or non-specialist services and those young people whose deep-rooted problems require psychological input and an in-depth risk assessment, this has the potential of leaving children at greatest risk without the help they need.

[16] Nora Wille et al, 'Risk and Protective Factors for Children's and Adolescents' Mental Health', BELLA study (2008)

Issues for the Board and member agencies to consider:

- How can the Board be confident that practitioners working with adolescents are supported to recognise the complexities of working with children at this particular stage of development, have not become desensitized to their distress and are able to differentiate e between normal adolescent difficulties and those that require more significant input?
- The Board should ask partners whether they are aware how practitioners can access specialist consultancy, tools, resources and services to support them when working in this challenging field.
- How can the Board be confident that services for adolescents are responsive and timely and take account of the fast-moving pace of the adolescent world?
- The Board may wish to seek to understand whether the training in adolescent neglect has made a difference in respect to practitioner and service responsiveness to children
- Does innovative practice exist elsewhere that can be built on in Dorset?
- The DSCB should decide where accountability will be held for maintaining detailed monitoring and evaluation of the learning and development resulting from this finding.
- The DSCB should consider how they will be best informed of progress and consider how challenge will be provided.
- Finding and planned improvements to be included in respective agency learning and development plans and in the DSCB learning and development plan.

Finding 7: As the system is set up access to specialist adolescent mental health services requires parental permission before they can engage with the child. This means that some children are denied access to services they desperately need if a parent will not consent to opt in.

13.82 There are many providers of adolescent mental health services. This Review refers to both Child and Adolescent Mental Health Services (CAMHS-Tier 3) and the Educational Psychological Services. Both of these are specialist intervention and assessment services in respect of the psychological needs of children. Both of these services use what is referred to as an "Opt-in" process. Following professional referral, these services contact the parent to seek permission before they can engage with the child. Without this permission the child cannot access services.

How did it feature in this case?

13.83 Mrs Morris believed that together with friends and family, she would be able to help Kate through any emotional difficulties she was experiencing. She believed Kate to be a 'child of nature' who would ultimately overcome any difficulties and did not feel that her daughter needed, or would benefit from, professional intervention. On two occasions, with Kate's agreement, professionals referred Kate to CAMHS (Tier 3) and on both occasions the referral was screened with an "Opt-in" letter sent to Mrs Morris who did not respond. On the first occasion CAMHS therefore closed the case and on the second occasion, after receiving no response, the service went through the procedure to close Kate's case. Just prior to closure, the team manager who was signing off the decision to close the case, recognised Kate's name and recalled previous involvement she had had with the family and so made contact with Mrs Morris with the view to persuading Mrs Morris to take up the service on Kate's behalf. An appointment was offered; but it is not known whether this appointment would have been kept as it was a week after Kate's death.

13.84 Kate was referred to the Educational Psychologist through the Children of Concern meeting in the school. The Educational Psychologist agreed to see Kate, but with the absence of parental consent the case was subsequently closed.

How do we know it is not peculiar to this case?

13.85 Members of the Review Team and Case Group members recognised that seeking parental permission for services limits children and young people's access to services that they would potentially find beneficial. They were able to give examples where this had occurred. Children can seek out school nursing and pastoral support which is available through schools, through self-referral. However, referral on to specialist services could be blocked by the requirement for parental consent. The reasons why parents do not opt-in to CAMHS services or give consent to Educational Psychological input has not been researched, and is not well understood in Dorset or nationally.

13.86 In some circumstances there may be a legitimate reason why the services are not taken up. However, for a number of children, where parental agreement cannot be gained, they are left without vital assessments and services. Case Group members spoke about how this can be a source of frustration when working with these children and how they can find themselves continuing to work with children without the benefit of specialist back-up or advice, often feeling they are not adequately improving the outcomes for the children.

13.87 The Case Group understood that the requirement for parents to "Opt-in" to services demonstrated a commitment to the service and to the on-going therapeutic work. However, the Review Team and Case Group considered that the requirement to "Opt-in" to services can also be used as a way of managing resources that are under significant demand and felt that not

enough was done to try and gain parental permission. In addition, the Case Group commented that they often make referrals for specialist services and are not consistently informed when the parents do not take up the services on the child's behalf.

How widespread and prevalent is the issue?

13.88 The Review Team learned that National Guidance and Dorset Guidance are clear that children and young people cannot self-refer to Educational Psychologists. Only schools can refer to them with parental consent. Information is not routinely kept about how many parents do not give consent for this service.

13.89 The referral criteria for CAMHS service clearly defines that a service cannot be offered to a young person under 16 years without parental permission and this follows the services protocols based upon National Guidance.[17] The Review Team learned that the numbers of children failing to receive a service from CAMHS because parents do not "Opt-in" is not recorded, and there are no local or national statistics kept in relation to this.

13.90 A group of practitioners from another Dorset Serious Case Review[18] stated that a significant minority of parents do not "Opt-in" to CAMHS Services on behalf of their children.

What are the implications for the reliability of the multi-agency Child Protection system?

13.91 Children who require psychological or specialist mental health intervention and have access to specialist services as early as possible are provided with vital support from suitably trained professionals who are able to successfully assess the child's psychological needs, provide treatment to address these needs, and provide invaluable input to multi-agency services. This supports an understanding of the child's needs with services tailored to all areas of their development.

13.92 In a system that is working well if parental consent is difficult to gain then all professionals will be made aware of this and concerted efforts will be made to understand what may lie beneath this lack of consent and to provide the support that is needed to progress this on behalf of the child.

13.93 In a system where the provision of services to a child is entirely dependent on receiving active consent from a parent (even when a child has asked for such help) and this consent is not forthcoming, children who are in need of specialist provision will be unable to access the services they require and multi-agency intervention will not be informed by specialist advice. In this system, children with complex emotional and psychological needs will be

[17] Reference Guide to Consent for Examinational Treatment, Department of Health (July 2009)
[18] Karen Tudor, Serious Case Review S18, Dorset Safeguarding Children's Board in conjunction with Hampshire Safeguarding Children's Board (as yet unpublished)

left without the help they require.

Finding 7: As the system is set up access to specialist adolescent mental health services requires parental permission before they can engage with the child. This means that some children are denied access to services they desperately need if a parent will not consent to opt in.

Summary

Adolescence is a time of change as children develop into young people and on into adulthood. Young people can access sexual health and other services independently, but cannot access specialist adolescent mental health services without parental permission, this risks leaving young people without the specialist interventions they require at a critical point in their development.

Issues for the Board and member agencies to consider:

- The Board to consider whether the "Opt in" process is an effective response to referrals for young people with potential mental health problems and decide what service redesign is needed to enable teenagers to access specialist services when required.
- Does innovative practice exist elsewhere that can be built on in Dorset?
- The DSCB to decide where accountability will be held for maintaining detailed monitoring and evaluation of the learning from this finding.
- The DSCB to consider how they will be best informed of progress and consider how challenge will be provided.

Finding 8: Practitioners struggle to work with Disguised Compliance when parents have good knowledge of and are confident in dealing with the system. The families appear engaged and use reasoned argument to convince practitioners of their compliance. The result is that children continue to be at risk and potentially become complicit in the deceit.

13.94 Disguised Compliance is a term used by practitioners to describe families who appear engaged in the work of professionals and services, but in reality are not working in partnership. This can often be difficult for workers to recognise or deal with and is a recognised barrier to achieving good outcomes for children. This case demonstrates the real challenges of achieving effective partnerships with both parents and children in circumstances where families appear engaged and co-operative, but in reality little progress is made.

How did it feature in this case?

13.95 Mrs Morris was an adoptive mother who used cogent arguments in her dealings with practitioners, she was well informed about the issues affecting adoptive children, understood professional terminology and shared a language with professionals to which they could relate.

13.96 Mrs Morris had developed a jaded view regarding the help professionals could give her. This view had been formed over a number of years of experiencing professional involvement in the life of her family, especially during periods when James' violence was extreme, when she felt services were of little help.

13.97 Mr and Mrs Morris firmly held the view that they knew what was best for their children and this did not necessarily include the involvement of professionals or comply with recognised social structures and conventions. This perspective was not taken into account when working with the family, or when considering the issue of compliance with professional expectations or plans.

13.98 There were a number of examples of how this featured in this case over the time under review, and in many ways the family were seen to comply. Social work visits to the family were accepted, Mr and Mrs Morris attended meetings and they appeared to support some of the individual work with both children. They engaged with professionals, appeared to understand what was expected of them, and the reasons behind these expectations. However, in reality there were a number occasions when professional advice and guidance was not followed.

13.99 This included breaching the agreement that Mr Morris should not reside in the family home, and breaching the agreement that Kate and James should not be left unsupervised. In addition, Mrs Morris firmly believed that she knew what was best for Kate and, despite professional advice, chose not to "Opt-in" to the services offered by CAMHS and chose not to give parental agreement for Kate to be seen by the educational psychologist. As a result, Kate was unable to access these specialist assessments or services.

13.100 The subtle complexities inherent within the relationship between the family and services were not understood, therefore conceptualising this relationship as 'Disguised Compliance' was not considered. This hindered the relationship between the family and services, and got in the way of Kate receiving appropriate services.

How do we know it is not peculiar to this case?

13.101 The Case Group gave many examples of work they had undertaken where overt lack of cooperation was easily recognised and had been addressed. It was acknowledged that when working with families in circumstances

where there appeared to be overt cooperation and a good dialogue between parents and services, but where a lack of parental action resulted in drift and delay in how plans were implemented, professionals did not routinely consider that Disguised Compliance may be a feature in the case.

13.102 The Review Team learned that Disguised Compliance is a term that is frequently used, but not actively and comprehensively considered and understood by the practitioners working with individual cases. It seemed that 'Disguised Compliance' has become a term along with 'professional curiosity' that is in widespread use by professionals without peeling away the layers of meaning and implication within individual cases.

13.103 Previous Serious Case Reviews in Dorset have identified issues around family compliance with child in need plans. In a recent Serious Case Review[19], it was found that family members attended child protection conferences and told practitioners they were working within the requirements of the plan, but in spite of clear evidence that suggested this was not true, the family were not challenged.

How widespread and prevalent is the issue?

13.104 Numerous Serious Case Reviews and research papers, since the 1990s, have identified the need for Disguised Compliance to be recognised as a potential factor in the relationship between agencies and families.

13.105 In every day practice the term 'Disguised Compliance' has routinely been used to describe: parents deflecting attention; criticising professionals; pre-arranged home visits; failure to engage with services and avoiding contact with professionals[20].

13.106 Although the circumstances of this SCR are very different, many published Serious Case Reviews[21] [22] recognise the importance of addressing this issue, whatever the cause, and identify a failure by practitioners to successfully manage and address the presenting problem and underlying causes resulting in children not being adequately safeguarded.

13.107 In this Review, the specific type of Disguised Compliance which was motivated by a deep rooted belief that professionals cannot help, has not been the subject of research and therefore there is no national or local data available.

[19] Karen Tudor, Serious Case Review Family S15, Dorset Children Safeguarding Board (as yet unpublished)
[20] NSPCC, Preventing Abuse – Disguised Compliance <https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/disguised-compliance/>
[21] Baby Peter, Haringey Children Safeguarding Board (February 2009)
[22] Ron Lock, Daniel Pelka, Coventry Children Safeguarding Board (September 2013)

What are the implications for the reliability of the multi-agency Child Protection system?

13.108 Many children are safely cared for within families supported by a relationship between professionals and carers that features open and transparent debate about what needs to change and how change will be achieved. Furthermore, when the complexities and potential barriers to joint working between services and families are recognised and understood this provides the best possible chance of achieving joint objectives for the benefit of a child.

13.109 If Disguised Compliance is understood only in terms of families who communicate with professionals in an overtly aggressive or hostile manner or who blatantly do not allow professionals access to the family home, then the subtleties of Disguised Compliance in families where there is a passivity or an appearance of compliance will not be recognised. In these circumstances the safety and wellbeing of children will be compromised and children may be drawn into the deceit that surrounds them impacting on their ability to form trusting relationships with professionals.

Finding 8: Practitioners struggle to work with Disguised Compliance when parents have good knowledge of and are confident in dealing with the system. The families appear engaged and use reasoned argument to convince practitioners of their compliance. The result is that children continue to be at risk and potentially become complicit in the deceit.

Summary

When working with families Disguised Compliance can be more complex than is often referred to in procedures and research. Families who apparently engage, and who demonstrate confidence in their dealings with professionals and a good understanding of systems and processes, can also seek to undermine the way in which professionals intervene in family life, this will ultimately confound professionals and prevent children accessing the support and protection they need.

Issues for the Board and member agencies to consider:

- The Board should consider how to raise awareness amongst practitioners of this finding and identify what support is needed in working with families who appear compliant.
- The Board should consider whether the existing 'Hard to Reach Procedures' are suitably titled, are fit for purpose and whether they are a useful tool in supporting the work of multi-agency practitioners.
- The Board should consider how the issue of Disguised Compliance is addressed across partner agencies in Dorset, including how this

is challenged in supervision.

- ❖ Is there any existing innovative practice that can be built on in Dorset?
- ❖ The DSCB should decide where accountability will be held for maintaining detailed monitoring and evaluation of the learning.
- ❖ The DSCB should consider how they will be best informed of progress and consider how challenge will be provided.
- ❖ Finding and planned improvements to be included in respective agency learning and development plans, and in the DSCB learning and development plan.

Finding 9: The routine use of Contracts of Expectations where family compliance is unreliable, with no clear sanction should the contract be broken renders them meaningless for the family, ineffective in protecting children and impossible to successfully monitor.

13.110 Contracts of Expectations are used to detail agreements between parents and Children's Social Care regarding the expectations on both parties in respect to actions required to safeguard children. There was a flurry of interest in Contract of Expectations[23] in the late 1980s/early 1990s when the Children Act 1989 was enacted, it was assumed that they would be a useful tool in working in partnership with parents, but there has been very little follow up, research and evaluation of their use since.

How did it feature in this case?

13.111 The Contract of Expectations was put in place in response to the allegations that had been made against Mr Morris with the intention of safeguarding Kate and James from harm. The contract was detailed, it stipulated that Mr Morris should not reside in the family home and contained detailed requirements in respect to his contact with the children. The contract was put in place without sufficiently considering the perspective of Mr and Mrs Morris in respect to professional involvement in the life of their family and there was no contingency plan in the event the contract being broken. The social worker was responsible for monitoring compliance, but despite the best intentions, it was a contract that could not be effectively monitored. Within three months Mr Morris had moved back into the family home, the Contract of Expectations was ignored and the children became complicit in the deception.

[23] The term Contract of Expectations is used – these are sometimes called Written Agreements and other terms.

How do we know it is not peculiar to this case?

13.112 The Review Team and the Case Group gave a number of examples of when Contracts of Expectations are used in childcare cases in Dorset. It was understood they frequently form part of child protection plans discussed during Child Protection Conferences and are routinely used when working with families. Members of the multi-agency Case Group and Review Team were clearly familiar with their use.

13.113 The Review Team learned that in Dorset, Contracts of Expectations are used within a procedural vacuum. The Review Team understood that there is no statutory or best practice guidance either locally or nationally in respect of the use of Contract of Expectations. The Review Team learned that in a previous Dorset Serious Case Review[24], there was reference to the use of Contracts of Expectations. The SCR found that in these circumstances the family did not comply and the perpetrator remained in the family home.

How widespread and prevalent is the issue?

13.114 There is no available data that might show how frequently Contracts of Expectations are used in Dorset or how pertinent each Contract of Expectations is to the individual circumstances of a family. However, the Review Team confirmed that these are often being used for families where legal proceedings are considered or in process, and in child protection and child in need cases in circumstances where there are robust expectations for families to make significant changes.

13.115 Other Local Authorities, such as East Riding, have been criticised by Ofsted where practitioners have been found to be:

> *"Too reliant on the use of Contracts of Expectations that are used frequently in cases with nonspecific reasons, indeterminate timescales, no review dates, some signed by parents and some not."*[25]

13.116 An extensive search provides little information of the use of the Contract of Expectations although they are a theme in National Serious Case Reviews. For example, 'Child I' published by Surrey Safeguarding Children Board 2010[26] and 'Child I' published by Lambeth Safeguarding Children Board 2015[27]. The latter review remarks on the over-reliance of Contracts of Expectations in working with families where there are contentious issues. There were also two other Serious Case Reviews that looked at Contracts of Expectations: 'Eric' published by Essex Safeguarding Children Board

[24] Serious Case Review S15, Dorset Safeguarding Children Board
[25] East Riding, Children's Social Care Letter of Expectations: Guidance of Practitioners (2012)
[26] Child I, Surrey Safeguarding Children Board (2010)
[27] Bridget Griffin, Child I, Lambeth Safeguarding Children Board (2015)

2007[28] and 'Child I and her Family' by Surrey Safeguarding Board 2006[29].

What are the implications for the reliability of the multi-agency Child Protection system?

13.117 In a safe system, contracts of expectations are a helpful way of setting out carefully negotiated agreements between multi-agency services and families detailing the expectations of both parties about how a child/ren can be safeguarded, and their needs met. When these contracts are open and honest about expectations, when expectations are realistic and achievable, and when both parties take responsibility for fulfilling their terms, they can be an open and honest way of working in true partnership to enable the safeguarding of a child, and the meeting of their needs.

If contracts are not equally negotiated, where the power imbalance between services and families is not recognised, or where they are simply used to provide multi-agency services with assurances that the child is safe, there is no value in this tool and the safeguarding of a child will be compromised.

Finding 9: The routine use of Contracts of Expectations where family compliance is unreliable, with no clear sanction should the contract be broken renders them meaningless for the family, ineffective in protecting children and impossible to successfully monitor.

Summary

Contracts of Expectations can be a useful tool but should not be used by agencies unless they are informed by a thorough assessment of family compliance, are genuinely negotiated with families, are clear about the support that will be provided and honest about the consequences of non-compliance. In the absence of these components, contracts of expectations have no value in how children are safeguarded.

Issues for the Board and member agencies to consider:

- The Board should consider seeking information regarding the extent and effectiveness in delivering good outcomes for children in Dorset where Contracts of Expectations are used. Any learning from this process should be used to inform current practice.
- The Board should consider in what circumstances Contracts of Expectations may be helpfully used and how multi-agency practitioners can be best guided to use them appropriately and effectively.
- Does innovative practice exist elsewhere that can be built on in Dorset?

[28] Eric, Essex Safeguarding Children Board (2007)
[29] Child I and her Family, Surrey Safeguarding Children Board (2006)

- The DSCB should decide where accountability will be held for maintaining detailed monitoring and evaluation of the learning and development in the use of Contract of Expectations.
- The DSCB to consider how they will be best informed of progress and consider how challenge will be provided.
- Finding and planned improvements to be included in respective agency learning and development plans and in the DSCB learning and development plans.

14. Appendices

Appendix 1: Statutory Requirements and Methodology for Systemic Serious Case Reviews

14.1 Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including Serious Case Reviews states that:

> "Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children". (Working Together to Safeguard Children WT 2015, 4:7)

Statutory guidance requires SCRs to be conducted in such in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children.
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
- is transparent about the way data is collected and analysed.
- makes use of relevant research and case evidence to inform the findings". (WT 2015, 4:11)

It is also required that the following principles should be applied by LSCBs and their partner organisations to all reviews:

- "there should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice.
- the approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined.
- reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed.
- professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- families, including surviving children, should be invited to contribute

to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process. (WT 2015, 4:10)

Appendix 2: The Review Process for this Serious Case Review

Introduction to SCIE Review

14.2 The case review used the systems methodology developed by the Social Care Institute of Excellence (SCIE) called *Learning Together*. The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the 'deeper', underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case and changing them will contribute to improving practice more widely.

The methodological heart of the Learning Together model has three main components:

- Reconstructing what happened – unearthing the 'view from the tunnel' and understanding the 'local rationality'.
- Appraising practice and explaining why it happened through the analysis of Key Practice Episodes (KPEs).
- Assessing relevance and understanding what the implications are for wider practice – using the particular case as a 'window on the system'.

Using this approach for studying a system in which people and the context interact requires the use of qualitative research methods to achieve transparency and rigour. The key tasks are data collection and analysis. Data comes from structured conversations with involved professions, case files and contextual documentation from organisations.

14.3 **Lead Reviewer**

The Dorset SCR Panel decided to use the opportunity to support two local safeguarding professionals to become accredited SCIE Lead Reviewers. They are Ginny Daniells and Helen Duncan-Jordan. They had been mentored through the Review by an experienced (SCIE accredited) Lead Reviewer, Bridget Griffin. None of the above have any previous involvement with this case.

The Lead Reviewers have received case consultation, supervision and quality assurance from SCIE, this is a standard requirement for all Learning Together case reviews and supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

14.4 **Review Team**

The Review Team was made up of seven senior representatives from the different agencies that had been directly involved with Kate. The role of the Review Team Member is to provide expert knowledge in relation to the practice of their individual agency, to support the agency Case Group

members, to contribute to the analysis of practice and to the development of the findings from the Review. The Review Team were:

Nina Coakley	Business Manager, DSCB SCIE Champion
Liz Balfe	Safeguarding Lead, Dorset HealthCare NHS Trust
Jackie Groves	Senior Manager Early Years & Educational Improvement, Dorset County Council
Alison Ryder	Children's Lead, Dorset County Hospital Foundation Trust
Dr Isi Sosa	Named Safeguarding GP, Dorset Clinical Commissioning Group
Deanna Neilson	Head of Safeguarding, Action for Children
Penny Lodwick	Senior Manager Family Support, Children's Services Dorset County Council

Collectively, the role of the Review Team is to undertake the data collection and analysis and author the final report.

Ownership of the final report lies with the DSCB as a commissioner of this Serious Case Review (SCR).

14.5 Case Group

The Case Group brought together the practitioners who had worked the case at Multiagency events where they were afforded the opportunity to reflect on the case and contribute to learning. Their input is reflected throughout the Review.

14.6 Participation of professionals

This Review would not have been possible without the active support of the Review Team and Case Group.

The Lead Reviewers and the Review Team have been impressed throughout by the professionalism, knowledge and experience the Case Group have contributed to the review. It is commendable how they have had the willingness and capacity to reflect on their work so openly and thoughtfully. Several have remarked that it has been a positive experience to contribute to learning from the tragedy, for others the process has been more difficult. This has given the Review Team a deeper and richer understanding of what happened with this family and within the safeguarding network and has captured the learning that is presented in this report.

14.7 Methodological comment and limitations

During the early stages of the Review process, Lead Reviewers did not have access to an Education chronology. This meant that some relevant information was not known until midway through the Review Process and

although this deficit was rectified, there were some conversations that took place later within the process and some additional conversations that could have taken place that may have contributed to the richness of the data generated

Due to reorganisations within the police force it was not possible for the police to provide a regular Review Team member, a conversation took place with an appropriate officer, but given their limited role in the case they ultimately stood down from the Review Team.

The School Nurse was a key professional in the case and the Lead Reviewers were keen to have a conversation with her and to involve her in the Case Group, unfortunately this was not possible. The Lead Reviewers sought to address this by accessing records and through discussion with her managers.

Two practitioners had left their jobs since the period in question, but they kindly agreed to participate in the SCR. The Lead Reviewers appreciate their commitment to support the learning process.

14.8 **Structure of the Review Process**

The SCIE model uses a process of iterative learning, gathering and making sense of information about a case that is a gradual and cumulative process. Over the course of this Review there have been a series of meetings between the Lead Reviewers, Review Team and Case Group members.

Initially there was a meeting between the Lead Reviewers and the Review Team to explain the SCIE Learning Together model and the role of the Review Team in the process. The Review Team then decided the membership of the Case Group based on their individual involvement in the case.

An introductory meeting took place with the Case Group at which the Review Team was also present. At this meeting the SCIE model was explained to the Case Group and their role in the Review process was clarified. Case Group members were informed they would be involved in individual conversations with Review Team members and the Lead Reviewers and given the opportunity to reflect on and explain their involvement with the case.

During the course of the Review, the Review Team met on ten occasions. The Case Group met on four occasions: one for the introductory session and then for two full day follow-on meetings, where the emerging analysis was discussed and challenged. The Review Team were present in these meetings. The Review followed the process, and meeting structures, as outlined by SCIE.

14.9 Timeframe and Mandate

In line with qualitative research principles, reviewers endeavour to start with an open mind in order that the focus is led by what they actually discover through the review process. This replaces the terms of reference (that have a specific focus of analysis before the review process has begun) which are a fundamental feature of traditional Serious Case Reviews.

The timeframe for the Review was set at the initial meeting between the Lead Reviewers and the Review Team on 5 March 2015. The timeframe covered by this SCR is between December 2013 and December 2014.

Within this period under review, ten key practice episodes (KPEs) were identified (covering the period from December 2013 – November 2014). These KPEs were then analysed in detail to provide insight into not only what happened with Kate, but also why things happened as they did. It was from this process of detailed analysis that the learning from the Review (presented as Findings) was generated.

14.10 Sources of Data

The systems approach requires the Review Team to avoid hindsight bias and to learn how people saw things at the time – the 'view from the tunnel'. Identifying and examining KPEs allows the Review Team to understand the way that things happened and explore the contributory factors that were influencing the Case Group's working practice. This is known as the 'local rationality'. It requires those who had direct involvement in the case to play a major part in the Review in analysing how and why practice unfolded the way it did and highlighting the broader organisational context.

14.11 Data from Family Members

The perspectives of Kate's mother and stepfather are reflected within this SCR.

On behalf of the DSCB, the Lead Reviewers wish to express their gratitude to the parents for engaging in this process.

14.12 Data from practitioners

Information was provided by members of the Case Group who were directly involved with the family through a process of individual conversations. They were invited to share their experiences of working with Kate and her family in the context of their knowledge, systems and practice at that time. A total of fifteen conversations were held with individual practitioners. In total, nineteen practitioners formed the Case Group for the Review. A Lead Reviewer and members of the Review Team were involved in each conversation.

The Case Group attended four multi-agency meetings to contribute to the analysis and findings and to share their knowledge of the systems as a

whole to help understand whether practice in this case had a local resonance.

14.13 Data from Documentation

In the course of the Review the Review Team members had access to the following documentation:

- Integrated chronology
- Data from agency records
- Various correspondence across agencies
- Witten agreements with parents
- Children Service Social Care Assessment
- Minutes of meetings
- Own agencies working protocols and policies
- Supervision records
- Childs Wishes and Feelings document
- Job Descriptions
- Referral documents

Appendix 3: Additional Learning

14.14 Intrinsic to a Learning Together Review is that learning by individual professionals, teams, services and agencies is promoted during the course of the Review. The Review Team heard many Case Group members speak about how being part of This Review had given them space to reflect on the services provided to children and supported not only their own professional development but that of the services they represented. The following learning points are a summary of the learning that has already taken place by agencies and services and the action that has followed.

14.15 **Dorset Educational Psychology Service**

Dorset Educational Psychology Service have reviewed their working arrangements to establish closer working with Adoption Support Services. All staff have been reminded to consider the wellbeing of siblings when children and young people are known to be violence in the home. Work is in progress to review practice when parental permission is not forthcoming following a potential referral.

14.16 **Dorset HealthCare NHS Trust**

Dorset HealthCare have reviewed the roles and professional relationships of the Pastoral Support Hub worker and the School Nurse at the school. A new job description has been developed for the Teenage Life Centre worker role and suitable adjustments have been made to the role and responsibilities of this post. The post has been re-graded and this higher grading reflects the degree of expertise and autonomy required for the role, and the working relationships with the School Nurse, CAMHS, the school staff and other professionals have been clarified. The role will report to the School Nurse Manager for the locality and will link directly with the local CAMHS team. Supervision arrangements for the role have also been clarified, with a requirement for regular management, clinical and safeguarding supervision.

14.17 **CAMHS**

Following the notification of Kate's death, CAMHS undertook an internal review. The action taken as a result of the Review were as follows:

1. The daily screening of referrals by two rather than one clinician; thus allowing for the opportunity for discussion and a jointly agreed screening decision.
2. The re-screening of all referrals where families do not "Opt-in".
3. Revision of the LAC/Adoption Protocol.
4. A reminder to clinicians for the need to inform the referrer if "Opt-in" letters are not responded to.
5. All children identified as Adopted, Looked After, Child in Need or Child Protection to be placed on a Looked After Children database.

6. Processes put in place to allow families to self-refer for up to eight weeks following closure of a referral where the family hasn't Opted in.
7. A reminder given to Practitioners and Admin support staff to copy in referrers, GPs and other involved agencies to Opt-in appointments and closure letters.

14.18 **Dorset Advocacy Service**

Action for Children provide the Advocacy service for children in Dorset. Changes have been made as a result of an internal audit of both this case and other cases known to the service. All referrals now include more extensive background and safeguarding information and are triaged according to the circumstances of the child rather than categorisation of the referral.

The Advocacy Manager will assess and decide how much information the Advocate needs to know to prepare to offer a responsive service. No Advocate will be allocated until the manager is satisfied that the young person is in a safe situation.

In addition, when the Advocacy Service is not able to provide an Advocate to visit within four weeks of the referral this is made explicit to the referrer

The Advocacy Service is also providing training to all Advocates on working with young people with complex emotional and mental wellbeing needs and the supervision policy has been reviewed.

Action For Children are strongly inviting Children's Services to consider entering into a discussion about future commissioning of the service potentially reframing and recommissioning the advocacy service to reflect the role of the advocate as advocating for the child within the system, rather than issue based advocacy that has the danger of providing a service to children that minimises a child's voice within the system and can result in an expression of wishes and feelings based on a single issue/moment in time.

14.19 **Children's Social Care**

Following this Review Children's Services are seeking to change the ICS system to ensure that the system reflects when children are open to Adoption Support services and that this information is accessible to all social care staff. In addition, the learning will be actively considered in the scoping and planning for the Regional Adoption Agency with colleagues in Bournemouth, Poole and Families for Children.

Children's Services are taking an active approach to raise awareness and promote collaborative relationships between post Adoption Support and frontline social care teams. This will be extended to agency partners in the near future.

Learning from the Review regarding the provision of Advocacy services to

Children in Need will be consider and reviewed at Contract Review meetings.

14.20 **Pressure on Resources and Prioritisation**

The Case Group and the Review Team represented a number of agencies involved in this Review strongly stated that practitioners are required to work in increasingly pressured environments with limited resources being required to deliver services with ever higher expectations. Against this climate, both supervision and information sharing become a particular challenge and this is a matter they wish to bring to the attention of the Board**.**

14.21 Appendix 4: Acronyms used and terminology explained

Statutory guidance requires that SCR reports:

> "be written in plain English and in a way that can be easily understood by professionals and the public alike" (WT 2015, 4:SCR Checklist)

ADHD	Attention Deficient Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
APV	Adolescent Parental Violence
CAF	Common Assessment Framework
CAIT	Child Abuse Investigation Team
CAMHS	Child and Adolescent Mental Health Service
CSC	Children's Social Care
DSCB	Dorset Safeguarding Children Board
EHS	Early Help Service
GP	General Practitioner
KPEs	Key Practice Episodes
LAC	Looked After Children
LSCB	Local Safeguarding Children Board
MARAC	Multi Agency Risk Assessment Conference
OFSTED	Office of Standards
SCIE	Social Care Institute of Excellence
SCR	Serious Case Review
SEN	Special Educational Needs
TAC	Team Around the Child

Dorset Safeguarding Children Board

Response to the findings from Serious Case Review Family S16

9 Findings were identified by the Overview Author for this review. The DSCB has responded to each as below:

Finding 1

There is a perception in the multi-agency system that Children's Services Social Care will only accept referrals where there are immediate Child Protection concerns. This means that children living with significant family difficulties and complex emotional needs are not appropriately referred.

Action

The threshold tool and decision matrix will be reviewed as part of Dorset's Early Help offer to help agencies identify levels of need among children and the appropriate levels of response. This review will be complete by September 2016.

The pan-Dorset Escalation Policy has been reviewed and a process has been put in place to clarify the status of an escalated case.

The pan-Dorset Escalation Policy has been reintegrated into all safeguarding training and recirculated to staff.

Outcome

Professionals working with children in Dorset will have greater confidence in completing common assessments, and convening team around the family arrangements. It will result in more information sharing between professionals and more effectively coordinated early help for children and families. Professionals will also be clearer about when to escalate safeguarding concerns. All of these changes will produce more positive outcomes for children and families.

Finding 2

The limited use of the Common Assessment Framework (CAF) in Dorset is resulting in a lack of awareness about its value by multi-agency professionals. This leaves Early Support Services uncoordinated.

Action

The Dorset Common Assessment Framework (CAF) was relaunched in autumn 2015 and the Children's Trust Board will be leading a multi-agency group looking at how Common Assessment Arrangements will work in the future. This will be completed by December 2016.

Outcome

Professionals working with children in Dorset will have greater confidence in completing common assessments, and convening team around the family arrangements. It will result in more information sharing between professionals and more effectively coordinated early help for children and families. Professionals will also be clearer about when to escalate safeguarding concerns. All of these changes will produce more positive outcomes for children and families.

Finding 3

Professional response to children and families is led by categorisation of the case rather than the needs of the child and family.

Action

The Child In Need notification, assessment and planning provision will be reviewed and further embedded across all partner agencies through a number of different processes. This will lead to professionals making more decisions about families based on their needs and not only on available resources. This review will be completed by September 2016.

Outcome

Children and Families in Dorset will have their needs at the centre of the decision making process. Professionals in Dorset will make decisions about families based on their needs and not only on the available resources. Professionals will be confident that partner agencies will work together to provide supportive and enabling plans for children and families to succeed and develop.

Finding 4

There is insufficient recognition and understanding of the impact of living with real or perceived sibling violence on the psychosocial development of individual children. This means that limited action is taken to protect them or address their therapeutic needs.

Action

The complexities and response expected from professionals will be included into the pan-Dorset Domestic Abuse Procedure, all relevant safeguarding training and a case study will be developed to support professionals with working with families experiencing sibling violence. This will be completed by September 2016.

Outcome

Professionals in Dorset will recognise and respond appropriately to children who are living with the difficulties of sibling violence. Professionals will understand the impact and complexity for families living with a violence child/ren and will provide effective assessment and intervention to meet the needs of the whole family.

Finding 5

The knowledge and skills of specialist adoption services are poorly integrated into first response services. This detrimentally impacts on the services provided to adopted children and their families.

Action

The profile of the Adoption Support Service will be raised through a number of methods:

- through direct links and work with the DSCB
- by awareness raising through newsletters and other communications methods
- through additional training events

All of this will be undertaken according to the new South West Consortium and will compete by September 2016.

Outcome

Adoptive families in Dorset will have access to resources to support them appropriately. Professional in Dorset will be aware of and understand the complex issues faced by adoptive families. They will know how to access support from the specialist Adoption Support service in Dorset to help them support families when needed.

Finding 6

There is a tendency for practitioners across all agencies to be desensitized to teenage crises and their impact where extreme highs and lows are commonplace making it difficult to distinguish between 'normal' adolescent development and those requiring specialist input.

Action

A revision of the pan-Dorset Emotional Health and Wellbeing Strategy is underway and services for children with emotional and mental health difficulties are being redesigned. This will be completed by December 2016.

Outcome

Teenagers in Dorset who suffer from complex emotional and mental health issues will have access to professionals who will understand their presentation, and know who, and how, to access services to support for them appropriately. Professionals working with teenagers will have the appropriate skills to meet the needs of young people and will have access to specialist services to support them in recognising the complex presentation of young people in crisis.

Finding 7

As the system is set up access to specialist adolescent mental health services requires parental permission before they can engage with the child. This means that some children are denied access to services they desperately need if a parent will not consent to opt in.

Action

The redesign of emotional and mental health services will consider how young people under 16 can access services to meet their needs without parental consent. This review is expected to complete by December 2016.

Outcome

Young people in Dorset will have access to help and support services that do not require parental permission. Professionals will have the skills and confidence to work with young people knowing that there are times when managing their safety and welfare requires parental engagement.

Finding 8

Practitioners struggle to work with 'disguised compliance' when parents have good knowledge of and are confident in dealing with the system. The families appear engaged and use reasoned argument to convince practitioners of their compliance. The result is that children continue to be at risk and potentially become complicit in the deceit that compounds the risks to them.

Action

The pan-Dorset Hard to Reach procedure will be reviewed to ensure that the complexities of working with 'disguised compliance' are explored. The DSCB will quality assure supervision arrangements in respect of working with hard to reach families and the messages will be further incorporated into training during summer 2016.

Outcome

Professionals in Dorset will be confident in their assessment of families; fully understand the motivations that impact and influence the families decisions making and engagement with agencies. Professionals will have access to high quality training and supervision to help them understand and reflect on the complex presentation of some families and young people.

Finding 9

The routine use of Contracts of Expectations where family compliance is unreliable, with no clear sanction should the contract be broken renders them meaningless for the family, ineffective in protecting children and impossible to successfully monitor.

Action

A policy for using a contract of expectations with families will be incorporated into the pan-Dorset Safeguarding Children Procedures in June 2016 and training will be delivered on how to use this appropriately.

Outcome
Families in Dorset will be involved in, and fully understand and agree, any form of written agreement undertaken with them, and the consequences if they do not adhere to that agreement. Professionals will ensure all written agreements are based on achievable goals which are fully understood, and agreed with the individuals concerned. Professionals will regularly monitor written agreements with families and have contingency planning in place should a family be unable to adhere to the agreement.