SERIOUS CASE REVIEW

Child J

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CONTENTS

INTRODUCTION AND PROCESS OF THE SERIOUS CASE REVIEW

1.1. This Serious Case Review (SCR) is in respect of a 5 month old baby who died suddenly in March 2017.[1] Child J's siblings were aged under 6 years at the time that he died. The inquest in 2019 recorded a narrative conclusion and the cause of death as 'unascertained'. The local authority has made suitable arrangements to protect the siblings.

1.2. The areas of learning identified include the following;

Assessment, planning and communication:

- Assessments need to take historical information into account; previous assessments, including those regarding parents' own childhood and/or their previous children, need to be summarised in sufficient detail and stored accessibly

- The importance of professionals in contact with children and their families asking themselves "what is life like for this child" "is it good enough"; "what might their presentation and behaviour tell us about their experiences, wellbeing and emotional health"?

Dealing with suspicious, aggressive and avoidant parental behaviour:

- Parents who have previously had difficult experiences of receiving services from children's social care are likely to be suspicious and reluctant to engage. Therefore practitioners need to recognise this and be creative and persistent in; building relationships; looking behind the behaviour; and spotting the moment to offer support and/or escalate concerns.

- Where a pattern of avoidant parental behaviour begins to emerge this should be evaluated as a risk factor in its own right and escalated where appropriate.

- Practitioners benefit from good support to deal effectively with resistant and avoidant parents. Good support should include reflective supervision, and training, supported by appropriate policies and procedures

Substance Misuse:

- Parents who misuse drugs can be very plausible; practitioners should remain sceptical about a parent's statement that their drug use is historical until they are confident they fully understand the likely risks of relapse having taken into account the following factors:
  - the circumstances in which the drug use started,
  - how the person managed to stop, and
  - their individual vulnerabilities for relapse
- Practitioners always need to consider the potential impact on children of actual and potential

[1] Working Together 2015 states a serious case review should be held for every case where abuse or neglect is known or suspected and either a child dies or is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child. The Independent Chair of Milton Keynes Safeguarding Board (MKSB) agreed that the criteria for a Serious Case Review was met in this case.

substance misuse, including when parents are arrested on suspicion of involvement in drugs offences

Domestic Abuse:

- Practitioners need to be more aware how easy it is to underestimate the cumulative impact on both the victim and children when there have been a significant number of "low level incidents" of domestic abuse

1.3. This report will be published on the MKSB website. The MKSB will also ensure that learning is widely disseminated locally. To avoid unnecessary disclosure of sensitive information, details in this report regarding what happened focus only on the facts required to identify the learning. The footnotes should be read alongside the main text. They include the author's comments as well as references to relevant research, legislation and guidance.

1.4. The SCR takes into account multi-agency involvement from the spring of 2015, (when the family arrived in Milton Keynes) until 4 weeks after Child J died in the spring of 2017.

1.5. The MKSB agreed to undertake this review using the Significant Incident Learning Process (SILP)[2], a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted as they did at the time. Family members were also offered the opportunity to speak to the lead reviewer. Only Father agreed to this.

2. DETAILS OF THE FAMILY AND CASE CONTEXT

2.1. Child J has 3 older siblings who will be referred to in this report as Siblings 1, 2 and 3. The parents of the children are referred to as Mother and Father. Other family members will be referred to by their family relationship e.g. Maternal Grandmother.

2.2. Child J was part of a family of mixed heritage. Child J has been described by those who knew him as a placid, contented and alert baby who liked being cuddled, who looked well, and had age appropriate development. Every practitioner who met the family noted that he had a particularly strong bond with his mother.

2.3. The parents had lived in Milton Keynes when they were children. Both had unstable childhoods and a history of substance misuse. Mother's first child was removed from her care as a toddler, due to neglect, and was subsequently adopted.

2.4. Mother and Father met when they first lived in Milton Keynes. During their relationship Father spent a lot of time in Mother's household, but also maintained a separate address. The relationship during the period under review was characterised by instability, including domestic abuse, frequent house moves, and a period abroad. They lived in London prior to Mother being rehoused in Milton Keynes in 2015. Both parents had occasional periods of employment. Siblings 1 and 2 were enrolled in a nursery on arrival in Milton Keynes, to assist with childcare. Both parents presented as bright, articulate and very plausible. The children appeared to be loved, the siblings were engaging and

[2] See appendix 1

boisterous[3], and the family did not stand out in any particular way in the local community where they lived.[4]

3. KEY EPISODES

Key Episode 1: April 2015-March 2016 - arrival of the family in Milton Keynes

3.1. In April 2015 a referral was received from a London borough social worker who had recently completed an assessment. This contained full details of historical concerns but concluded that "no safeguarding concerns were highlighted". The social worker thought the children would benefit from monitoring by a health visitor.

3.2. Milton Keynes Children's Social Care contacted Mother who seemed suspicious and refused support. The London assessment was briefly summarised on Children's Social Care records and no further action taken. In June 2015 a Multi-Agency Referral Form (MARF) was also received from the London health visitor which included concerns about Sibling 2 having behaviour issues and speech delay.

3.3. The family registered with a GP in June. Sometime subsequently alerts were added to two Sibling's records regarding concerns about Father's mental health, possession of a weapon and taking drugs. Two alerts referring to the removal of a child due to neglect and drug use were added to Mother's record. Father's records were not linked to Mother or any of the children.[5]

3.4. Mother attended a new patient health check appointment. She told the practice nurse about her history of crack addiction. She requested some support with anxiety and depression, but failed to attend a follow up appointment a week later. This pattern was repeated when she made a similar request to the GP in August 2015 and at all subsequent times when Mother made a request for help with her mental health.

3.5. Before the health visitor had the opportunity to visit, she received two phone calls from the health representative in the Multi-Agency Safeguarding Hub (MASH). The first was to tell her that a health visitor from the London borough had been in touch, to pass on previous safeguarding concerns. The second was to suggest that the family be visited in pairs due to the suspicious and verbally aggressive reception received from Father when Children's Centre staff made an introductory courtesy visit.[6] The health visitor spoke to the London health visitor who confirmed the past history and recent difficulties with non-engagement with developmental reviews. Speaking with health visitors from previous authorities is routine practice as records sometimes take a long time to arrive, several months in this case.

3.6. Phone contact between health visitor and Mother resulted in a successful home visit when both parents and all 3 siblings were present. The parents were co-operative at this visit, giving details of their history. The health visitor detected, but apparently did not challenge, a strong smell of cannabis in the house. The family were clear that the children had not, and would not, be receiving

[3] Their current behaviour when all together is sufficiently challenging for them to be in a placement with two full time carers.
[4] An area of relative deprivation In Milton Keynes.
[5] Since an audit in March 2017 arrangements have been put in place to ensure families are linked
[6] The health worker in MASH does not recall advising to visit in pairs but this is what is recorded in the health visiting notes

immunisations due to their religious beliefs. These religious beliefs were in line with a broadly Judaeo-Christian viewpoint, with some mysticism type elements which Mother was aware could be "misinterpreted as madness".

3.7. The health visitor made a number of routine follow up health referrals for the children. Father brought Sibling 2 to outpatients for a Physiotherapy appointment in September 2015 which had been outstanding in London. Advice was given regarding exercise and footwear. Sibling 2 was not brought for 2 follow-up appointments. A letter was sent to the GP and the parents saying Sibling 2 had been removed from the waiting list. This is in line with the Hospital Trust's "Was not brought policy for children and young people" when there are no clinical or wellbeing concerns; the GP would consider re-referral if further concerns were raised. Children not being brought, especially to review appointments was typical for this family.

3.8. During Key Episode 1 the police dealt with 5 incidents reported by or about family members. Information was shared with Children's Social Care about 3 incidents.[7] Two involved arguments between family members/alleged violence by Father toward Mother. The third involved children being found alone in a messy house; Father returned and stated he had been outside the house, in the parking bay.

3.9. Co-incidentally, on the same day as one of the incidents reported to the police, police officers accompanied the mental health street triage team to make a home visit. Mother had reported being in distress about a historical incident after receiving some training at work. The home visit was made, despite Mother not wanting one, because she was unable to be contacted by phone. Mother agreed to a brief discussion on the doorstep and it was suggested that she contact her GP for a referral to Improving Access to Psychological Therapies (IAPT).

Key Episode 2: March 2016- October 2016 Antenatal period until birth of Child J

3.10. Mother attended the GP practice and a booking in appointment with a Midwife when she was 7-8 weeks pregnant. Mother told the midwife about a history of depression; multiple house moves; the adoption of her first child and her use of crack cocaine in 2007-8. She reported she had stopped using cannabis several months ago and, when challenged by the midwife that she smelt strongly of cannabis, said this was due to visiting a friend who still smokes cannabis. She was referred for consultant care due to some potential health risks associated with her pregnancy.

3.11. The midwife gathered further information from Children's Social Care and the health visitor and decided to offer additional support from the Red Team[8] due to the historical concerns and domestic abuse incidents. Mother refused this support. Records show the Red Team midwife contacted

[7] Domestic Abuse Stalking & Harassment (DASH) forms are reviewed by a sergeant before being passed to police risk assessors in the MASH who decide if information should be shared with Children's Social Care. Direct referrals to Children's Social Care can be made in situations judged as high risk by the attending officers, rather than passing their report through the triage. MASH policy is that if incident is graded "standard risk" and the family is known, but not open, then information will not be routinely shared. DASH gradings: **STANDARD -** Current evidence does not indicate likelihood of causing serious harm. **MEDIUM -** There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse. **HIGH** - There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

[8] Vulnerable Families Midwives

Children's Social Care in London who were unwilling to disclose details other than the fact of historical involvement without a written request. When this was sent health records show that further information was refused as the case was closed. The reason for this is unclear; the London borough has no record of any contact by the midwife.

3.12. During her pregnancy Mother reported feeling increased anxiety and accepted a referral by the midwife to IAPT. During a home visit the health visitor challenged Mother about the failure to take Sibling 1 to speech therapy and gained permission to contact the school. She also recorded that she could smell cannabis.

3.13. The first 3 incidents reported to the police in Key Episode 2 were not shared with Children's Social Care. Mother's pregnancy was known but not recorded by police at any incident prior to Child J's birth.[9]

3.14. The first incident involved an altercation between 3 women at the house. The second incident was a call from Mother requesting a "violent man" be removed from her house. She was heard to ask the siblings "what did daddy do to mummy's throat". Mother would not confirm the name of the male when police officers attended. The police risk assessors in MASH did not review the report for 2 weeks due to backlogs of incidents caused by a staff shortage.

3.15. The third report was from school; that Father had reported an altercation with Mother. Officers spoke to Father who disagreed with the version passed onto the police. On the same day a third party reported Mother and Father arguing in the street with Siblings 1 and 2 present. Father told police this was about contact arrangements. The following day Mother phoned the MASH asking for support and raising concerns about Father making more allegations against her. Accordingly phone contact was made by MASH staff to challenge Father about inconsistent accounts and both parents about the need to work together in the interests of their children.

3.16. Between the 2nd and 3rd reports to the police, Father contacted the MASH alleging that Mother was using crack and Grandmother was a drug user who was always asking for money. Father told the author that he was (appropriately) asked what reasons he had to say Mother was using crack, he stated he said there were a lot of lighters in the house. If this exchange happened it is not recorded. The health visitor confirmed MASH concerns that they might not be getting a genuine picture of the family so, in order to decide an appropriate response to the referral, a social worker from the MASH made an unannounced home visit.[10] The social worker thought he smelt cannabis; Mother said she "did not do drugs anymore". The social worker concluded that the family were going through a difficult time due to the separation. He felt Mother would benefit from some support, which she declined. The social worker concluded a Child and Family Assessment would be appropriate if there were any further concerns.

[9] Poor recording of pregnancy on DASH forms is being addressed by the police

[10] The social worker saw all three children and spoke to the school/nursery but not the police. An Ofsted inspection conducted in Sept – Oct of 2016 https://reports.ofsted.gov.uk/local-authorities/milton-keynes criticised what they described as pre-assessment visits in response to concerns referred about a child's welfare because these visits did not always result from a formal multi-agency strategy discussion with partners to determine whether the threshold was met to undertake child protection enquiries. Children's social care managers at the learning event considered that this was not the same practice and described it as a pragmatic response to gather information to identify an appropriate outcome to a referral.

3.17. Soon afterwards Police officers attended the house in response to Mother alleging that a neighbour had threatened her and Father. The police officers were concerned about the disarray in the house and that the children had not had a recent meal. This information was shared with Children's Social Care.

3.18. The final report to the police was from Maternal Grandmother alleging that Mother had phoned her in distress stating that Father had assaulted her. Mother denied this, and the report was not shared with Children's Social Care.

3.19. Towards the end of Mother's pregnancy the GP referred Sibling 2 back to Physiotherapy due to a reported history of falls. Shortly afterwards the health visitor received a telephone call indicating that Disabled Living Allowance (DLA) had been claimed for Sibling 2 by Mother. The health visitor made it clear to Mother that her observations did not support such a claim, but that she would make appointments for podiatry and physiotherapy to obtain a specialist opinion.

3.20. The assessment by the physiotherapist was very thorough due to the inconsistencies between her clinical observations and Mother's reports of falls. Mother was reluctant to provide the routine social history that is protocol for an initial appointment. She was also unwilling to accept the physiotherapists recommended treatment of correct footwear and exercise and made a remark about it not mattering as they were going to move again anyway. Sibling 2 was not brought to a review appointment. The physiotherapist wrote to the GP about the failure to attend and her concerns, so that these could be shared if the family did move.

3.21. The nursery submitted a MARF to MASH about Sibling 2's failure to return to school after the summer holidays; the parents had threatened to change schools to somewhere "less intrusive".[11] Concerns described included Sibling 2's unkempt appearance, his aggressive behaviours at school to both peers and staff and Father's concerns about Mother's mental health. MASH spoke to Mother and Sibling 1's school (to which Sibling 2 moved). A letter was sent to Mother providing information about Child and Family Practices (CFP).

3.22. Attendance at consultant appointments during the pregnancy was sufficiently poor for the midwife to escalate to a supervisor. The midwife had a discussion with Mother just prior to Child J's birth. This resulted in Mother giving consent to the submission of a MARF so that she could have all the "accusations" cleared up. This resulted in the commencement of a Child and Family Assessment by a social worker which was concluded in December; the SW had a high workload and progress was hampered by difficulty making appointments with the parents.

Key Episode 3: October 2016-March 2017, postnatal period until Child J's death

3.23. When Child J was born, as the midwives on the ward knew a MARF had been done, and why, they contacted Children's Social Care who confirmed that Mother and child could be discharged home. The midwifery service completed the usual postnatal visits. Mother initially refused a new birth contact from the health visiting team and made a complaint against the named health visitor.[12] Both

[11] The nursery where M had attended was the 3rd pre-school setting that the children had attended, reasons for previous changes are unknown, although the nursery at the school where Sibling 1 attended provided more hours

[12] The complaint was ostensibly about information legitimately shared with the midwife about father being potentially aggressive, however the complaint was equally likely to be due to the health visitor's refusal to support the application for DLA for Sibling 2

midwife and heath visitor gave her the standard advice about preventing Sudden Unexpected Death of Infants (SUDI) in relation to positioning of babies, not co-sleeping and avoiding babies overheating.

3.24. The parents were co-operative with the home visits made by the social worker, although Father made it clear he did not feel an assessment was necessary. The social worker observed nothing of concern in the home and the couple told her they were intending to move away from Milton Keynes soon.

3.25. As she felt "everyone is keeping an eye on her", Mother was reluctant to come to the 6 week check until she was reminded that this is a service offered to all new mothers. Child J was never brought to baby clinic, despite a request from the health visitor for attendance on 2 specific dates.

3.26. At the beginning of December there was a serious fire at the house; Mother was advised to take Child J to the hospital as a precaution. Mother's initial behaviour within the Accident & Emergency Department appeared appropriate. However, as time passed, her behaviour became increasingly bizarre and erratic, alternating between pacing and agitation to periods of calm and with no attempts to address her dishevelled appearance, as attendees in her circumstances would usually do. Accident & Accident staff thought her behaviour and bizarre comments, (eg. ghosts starting the fire and her phone typing on its own), could be indicative of a post-natal psychotic episode and made a referral to the Mental Health Services. Child J was admitted to the paediatric ward for further assessment and review; both parents were unhappy about this. Due to all the circumstances the consultant paediatrician made particularly thorough checks and notes.

3.27. A mental health practitioner attended promptly. Mother was calm and presented rationally during a thorough assessment, which included asking about drug use. Mother denied or down played her comments in hospital. She said relationship with Father was improving. She admitted using cannabis 7 weeks previously. There was no evidence of an acute mental health problem.

3.28. A number of agencies contacted MASH as a result of the fire. The social worker had recently finished her assessment which concluded that while she felt that parents had not been fully honest about their strained relationship and she was concerned about the number of referrals about the family, lateness to school could be due to the demands of having 4 children under 5 years old and that the school were managing the concerns about Sibling 1's behaviour. The social worker used the Signs of Safety model[13] to review her recommendation to cease involvement. She assisted the family to get temporarily re-housed and offered Child and Family Practice (CFP) for practical help. The parents declined this.

3.29. In January 2017 Mother told school she had contacted the police about Father threatening to report her to children's services for being a "crackhead". School completed a MARF; Mother alleged that Father was emotionally abusive, he had smacked Sibling 3, and that he was still living in the same house because he had no-where else to go. Father had also attended school, claiming Mother was angry and upset. The school correctly identified that this was a time where Mother might be persuaded to accept support from the local CFP. This support was agreed by MASH staff and accepted by Mother.

[13] www.signsofsafety.net

3.30. During the early weeks of 2017 there were 3 reports to the police alleging domestic abuse of Mother by Father which were shared with Children's Social Care.[14]

3.31. During January 2017 Mother was prescribed anti-depressants by the GP. When she did not respond to the GP's attempt to arrange a follow-up appointment after a repeat prescription, the GP made the health visitor aware.

3.32. A Signs of Safety mapping meeting involving both parents was convened promptly by the CFP worker to plan the focus of the work. The subsequent Team Around the Family (TAF) meeting was cancelled by Mother.[15] When professionals who had not got the message about the cancellation arrived at the house, both parents were present and there was a strong smell of cannabis.

3.33. Within a couple of months of involvement by the CFP, it had become clear that, despite attempts at providing a co-ordinated service, Mother was continuing not to accept offers of routine health checks and additional support. In addition, there were concerns about the on off relationship with Father, Mother making and then retracting allegations of domestic abuse, and the lack of understanding by both parents of the impact on the children of all the arguments, the going back and forth between properties and not attending school regularly. Accordingly a further TAF was planned to pull together all the information so that a referral could be made to Children's Social Care; this didn't happen because it was superseded by a child protection investigation due to Child J's death.

Key Episode 4: Child Protection investigation after Child J's death

3.34. Child J was taken to the hospital in the early hours of the morning by Mother, having been found unresponsive by Maternal Grandmother on Mother's bed[16] where Mother and the other siblings were sleeping. A crack pipe was found in the house.

3.35. The appropriate Child Death procedures were followed including contacting the police and the council Emergency Duty Team. Later that day a strategy meeting[17] involving appropriate key people was convened by Children's Social Care. This included a record using the Signs of Safety approach.

3.36. A range of appropriate actions were agreed, which included the police finding the children, and considering using their Powers of Protection,[18] interviewing parents and Maternal Grandmother, and taking forensic samples from the baby. Mother's urine proved positive for both cannabis and cocaine. Maternal Grandmother refused to be interviewed by the police. A subsequent hair test for Father, used as evidence during the care proceedings, proved positive for cannabis.

3.37. The police exercised their Powers of Protection and the siblings were placed together in foster care. Due to concerns that Mother was of low mood and expressing suicidal thoughts while in custody, the police and mental health services ensured that Mother had an immediate mental health assessment. This concluded that, despite suffering from reactive depression, Mother was at low risk of suicide and low risk of harm to both herself and her children.

[14] Two of these were made by Maternal Grandmother
[15] A further TAC meeting involving school, health visitor and CFP worker was held a week later.
[16] At the bottom of the bed. The house was very warm so no need for any covers.
[17] As described in Working Together 2015, a strategy discussion/meeting is convened by children's social care to decide whether or not to initiate enquiries under S47 of the Children Act 1989 –the local authority's duty to investigate whether a child might have suffered or be at risk of significant harm
[18] Section 46 Children Act 1989

3.38. The following day an application for an Emergency Protection Order (EPO)[19] was made. Key new information came to light in court; that Mother had been using crack cocaine approximately 3 times per week for the last 5 months.

3.39. A social worker made a quick and thorough assessment, which ensured the continuance of the Care Proceedings.

4. THEMATIC ANALYSIS

4.1. The learning from this review was identified from information and opinions provided in the agency reports and at the learning event. The themes are:

- Assessment, planning and communication
- Substance misuse
- Dealing with suspicious aggressive and avoidant parental behaviour
- Domestic Abuse

Assessment planning and communication:

4.2. NSPCC research[20] identified 10 common pitfalls in assessment practice when children are living at home. Three of these are particularly helpful in analysing practice in this case.

4.3. The first pitfall is '*Attention is focused on the most visible or pressing problems; case history and less obvious details are insufficiently explored'.* Research repeatedly suggests the need to make time to read the case history. Chronologies and summaries can be helpful, but only if they are of adequate quality.

4.4. MASH staff told this review that electronic case records are reviewed every time a referral is made to MASH and previous contacts are routinely recorded on each new one. However the assessment from the London authority was not stored in the usual place and the summary of the referral from the London borough did not detail all of the relevant history. Most significantly the summary did not include Mother's crack use; that a child had been removed from her care and adopted; and that Sibling 1 had previously been subject to a Child Protection Plan and a Child in Need Plan whilst in a south eastern authority.

4.5. Children's social care participants at the learning event told this review that, because requests for archived records are not always dealt with in a timely manner, and key information can sometimes be time-consuming to extract from old paper files, archived children's social care files on parents are not requested unless there is to be ongoing involvement with a family. This threshold was not reached until after Child J's death. In addition, the existence of an archived record on Mother's first child who was adopted was not obvious as this child was not detailed in family relationships nor visible in the summary.

[19] Section 44 Children Act 1989
[20] Broadhurst et al (2010) 10 common pitfalls in assessment practice and how to avoid them www.nspcc.org.uk/inform

4.6. Children's social care participants attending the learning event told this review that social workers doing duty visits did not always have time to read the history in full. Information from the school and health visitor were taken into account, alongside the duty visit, in response to Father's allegation that Mother was using crack. However the police were not included in the agency checks. This would not have revealed the strangulation allegation as it was still caught up in the backlog, but police may have shared information about the argument between the 3 women, when Mother called one a grass regarding the cannabis "factory".

4.7. The social worker who conducted the Child and Family Assessment did not see the London assessment as it was not stored in the usual place on the electronic case recording system.[21] The assessment done by the CFP worker built on the one done by the social worker. However she did not see the London assessment either, as her manager could not locate it for the same reasons the social worker didn't.[22]

4.8. Information in the London assessment (2014-15) included information from historical records; that Maternal Grandmother had made a number of requests in Mother's teenage years to have her received into care to protect her from drug dealers that were visiting the house; allegations that Mother and Maternal Grandmother smoked crack together and that this was funded by Mother being sexually exploited; and that allegations about domestic abuse had been a feature of parent's relationship since the beginning. The assessment concluded that: whilst there was no evidence of the use of crack since her first child had been removed, Mother had continued to smoke cannabis, including when pregnant with Sibling 2; that she declined drug treatment at this point; that Father had been convicted in 2009 for cultivation of cannabis; and that the nursery that Sibling 1 attended had concerns about child and Father smelling of cannabis.

4.9. It is unlikely that knowledge of the history would have made a substantial difference at any particular point. However, given that it demonstrated that the concerns seen in Milton Keynes were long term and entrenched, it might have accelerated the point at which more intensive intervention occurred.

4.10. The CFP involvement provided co-ordinated activity based on assessment and use of joint visits and Team Around the Family (TAF) arrangements. By early March 2017 the agencies involved were clear that social work involvement was necessary to promote and safeguard the children's welfare. No other agency apart from the school had considered using the Common Assessment Framework (CAF), which might have led sooner to TAF arrangements and/or the involvement of the CFP; some form of assessment is necessary to gain involvement of the CFP. TAF arrangements would have enabled better sharing of all the information known about the family and perhaps brought forward more intense involvement.

4.11. Participants at the learning event expressed a view that use of the CAF was helpful in evidencing what work had been done and any lack of change (especially when they included a chronology). However they also felt that use of the CAF in Milton Keynes had diminished.[23] The barriers relevant to this case that they described included the need to gain consent from parents, (none of the

[21] This has since been addressed
[22] Children's social care records can only be accessed by Managers in the CFPs
[23] This is consistent with the findings of 2 local reports. The recent MKSB Thematic Learning Review (August 2017) which identified the lack of a simple framework to support a "see plan do review" cycle and the Early Help survey findings (2016)

practitioners felt they had a good enough relationship to get consent), and limited opportunities for practitioners working within acute settings to gather information about the whole family.

4.12. In terms of use of alternative tools, although "Signs of Safety" tools are most effective for enabling change when they are used jointly with parents[24], practitioners are increasingly using these as a method of analysis. Participants at the Learning Event told us that use of the local neglect tool was not yet embedded, partly because practitioners found it hard to use.[25]

4.13. What no-one knew in detail[26] before the death of Child J, was that Father had been in care himself as a teenager as the result of criminal behaviour. Father's use of a different name meant a search of old records did not reveal his care history and he told the social worker conducting the C&F assessment that his parents "were always supportive". Whilst this might partly account for the lack of probing about Father's background on this occasion, it remains the case that, in all of the assessments, any history focuses on Mother's childhood and parenting of her first child; there was limited enquiry about Father's childhood or early adulthood. There was also no enquiry about Maternal Grandmother and her role within the family, despite Mother's childhood history and one of the incidents reported by the police involving an argument when Maternal Grandmother was providing childcare.

4.14. The second pitfall is *'Insufficient weight is given to information from family, friends and neighbours'.* There were a number of allegations made to the police and/or Children's Services; about domestic abuse (by Maternal Grandmother and Mother) or Mother's crack use (by Father) respectively. Research[27] suggests that allegations made by family friends and neighbours tend not to be taken as seriously as those reported by a professional, and can be seen as malicious, especially when there is ongoing conflict of some kind. In this case there were a number of significant challenges. The police records show there were many allegations and counter allegations between Father and Maternal Grandmother, and the point at which Father made allegations about Mother's crack use was during one of their separations. In addition, several practitioners reported how difficult it was to know what to believe given that Mother and Father tended to retract allegations and denied domestic abuse, whoever reported it. Mother also consistently denied non historical use of crack.

4.15. As well as considering whether information is given in good or bad faith by family members, it is important to consider whether it might be accurate. It is possible both for good faith information to be inaccurate (mistaken for example) or, as in this case, bad faith information to be partially or completely accurate (for example real concerns reported following a falling out).[28] Whilst Father's allegations about Mother's use of crack may have been in bad faith, they may also have been

[24] Social workers use them this way, also hospital paediatric staff use the "3 colomns" with parents when discharging children with complex health conditions; what we are worried about (past harm, future danger, complicating factors); what is working well (existing strengths and existing safety); what needs to happen (family and child protection authority safety goals and next steps for future safety)

[25] They also told the review about some face to face opportunities they use to share information, for example asking relevant professionals to the Multi-disciplinary meetings that are convened by GP practices

[26] Father told some practitioners that he had been adopted but only told the school that he had been in care.

[27] Broadhurst et al, 2009; Buckley, 1999 cited in Broadhurst et al (2010) 10 common pitfalls in assessment practice and how to avoid them www.nspcc.org.uk/inform page 16

[28] Writing Analytical Assessments in Social Work, Chris Dyke. 2016.

accurate. However, in the absence of other tangible evidence of crack use, it was not possible to take any action.

4.16. The third pitfall is *'Insufficient attention is paid to what children say, how they look and how they behave'*. The children were all under 6 years old at the time of Child J's death. The older two had delayed speech and staff who conducted assessments told this review they were reluctant to engage.[29] This would have made it very difficult for practitioners to directly ascertain their wishes and feelings.

4.17. However, during the period covered by this review, the children were mentioned 19 times in police records as having been present at incidents. On most occasions when police officers attended after incidents, the children were seen and generally described as being happy with officers witnessing them playing.[30] However in several of the calls to the police the children could be heard, distressed, in the background. This was not taken into account, as it was not recorded on the forms presented to police risk assessors in the MASH. There was also no mention of Mother's pregnancy; Child J was not mentioned until after he had been born.

4.18. Sibling 1 was regularly aggressive to both peers and staff from admission to nursery aged 4 years, to the extent that Sibling 1 was excluded after biting a member of staff and put on a reduced timetable for transition to reception. Similar concerns began to emerge about Sibling 2. Their behaviour at school may therefore have been indicative of their experience at home and the impact of it. However this would have been difficult to identify for definite at the time as there was also evidence of the parents minimising and not consistently handling the children's poor behaviour.

4.19. When children are less able to directly express their wishes and feelings, these need to be assessed through observation, including putting oneself in the shoes of the child to consider their lived experience. Whilst there was limited tangible evidence of neglect by the time of Child J's death, more scrutiny of the children's lived experience might have heightened concerns at an earlier point to prevent the kind of cumulative harm that would have caused more serious problems for the children as they got older.[31] Managers suggested that emerging evidence of the effectiveness of recent work done locally on fabricated illness might be relevant. In particular, they said this was enabling practitioners to more explicitly consider and articulate the impact of family circumstances and parental behaviour on children when making referrals to the MASH. This appears to be assisting in demonstrating earlier that the threshold for involvement by children's social care is met.

4.20. The health visitor does not appear to have been contacted until the very end of the Child and Family assessment, which was conducted over a 3 month period. Earlier contact could have enabled more observation of the younger children and potential for joint working.

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[29] The parents agreed to requests for the children to be seen alone; this could have been because they were confident that the children would not or could not disclose anything of concern

[30] When they weren't seen this is usually because of Mother's refusal to engage

[31] The terms 'cumulative risk' and 'cumulative harm' were first identified by Bromfield and Higgins in Australia in 2005 who defined cumulative harm as 'the effects of patterns of circumstances and events in a child's life which diminish their sense of safety, stability and wellbeing. Cumulative harm is the existence of compounded experiences of multiple episodes of abuse or layers of neglect.' Bromfield, L., & Higgins, D. (2005). National comparison of child protection systems (Child Abuse Prevention Issues No. 22).

4.21. Communication between agencies was generally effective. Discussion at the learning event between MASH and hospital staff identified scope for raising awareness of how to access social workers in the MASH when hospital staff had serious concerns about children's welfare or safety. This is being addressed.

Summary of learning; assessment planning and communication

4.22. Where there has been significant involvement by children's social care within the same local authority with previous children (eg child protection plan) or the parents in their own childhoods, previous assessments need to be promptly tracked down and taken into account. In addition, the process for storing assessments completed by children's social care in other local authorities needs to be clear and well documented, so any assessment is easily located.

4.23. All summaries of assessments need to be sufficiently comprehensive to give the reader an adequate grasp of salient points.

4.24. There needs to be a relentless focus on the impact on children. Practitioners should ask themselves in every contact: "what is life like for this child"; "is it good enough"; "what might their presentation and behaviour tell us about their experiences, wellbeing and emotional health"? They should also consider which practitioner might be best placed to engage or observe individual children.

4.25. Multi-agency chronologies are undoubtedly helpful in identifying patterns of behaviour and extent of change. Analytical frameworks for example Signs of Safety 3 columns are useful to help practitioners order their thinking. The content of each of these needs to be used effectively to inform assessments and referrals.

See recommendations A, B & C

Dealing with suspicious, aggressive and avoidant parental behaviour:

4.26. The parents were highly suspicious of any agency involvement and very skilled at deflecting attention from matters into which they did not want too close enquiry. To a degree, both behaviours are understandable in the context of their previous involvement with statutory agencies in Milton Keynes in their childhoods[32] and with Mother's first born child. Whilst they were not always entirely happy with the involvement in previous local authorities, their reluctance to co-operate seems to have increased markedly once they returned to Milton Keynes. Their previous experience with agencies probably also enabled them to anticipate what practitioners might need to hear.

4.27. Parents' suspicion most strongly expressed itself whenever they had first contact with agencies that they were not expecting to be aware of them, (for example the children's centre), or when questions about their social history were asked, (for example by hospital paediatric staff). They were sometimes reassured when practitioners explained that this was a universal service or a standard protocol.

[32] Father was abused by a person in a position of trust but not initially believed when he disclosed his abuse

4.28. A previous recommendation that a Child & Family assessment be done if further concerns were raised was not followed. Children's social care practitioners at the learning event felt that this decision would have taken into account that the school had a student social worker about to start placement who Children's Social Care practitioners believed would become involved. However, if this was the reason, the school was not aware of it at the time and the student SW never became involved. This was due to a judgement of school staff that other families had higher priority needs and that introducing a new person to a suspicious family was not appropriate.

4.29. Although Father told the author he did ask for help when the family came to Milton Keynes, there is no record of this. There is however, much evidence that both parents were generally reluctant to accept additional help of any kind. It is striking that one of the reasons given by practitioners for not completing CAFs was the assumption that consent would not be given. It is also significant that the time when Mother agreed to an assessment appears to have been motivated by a desire to avoid involvement rather than gain help. In addition when she did accept (practical) help from the CFP this was at a time of crisis, and with limited engagement; she was reluctant to sign the consent form and frequently cancelled appointments with the CFP worker.

4.30. A number of the letters sent to Mother/parents confirming the outcome of referrals included relevant information about services. Information about CFPs was provided 4 times. Suspicious and avoidant parents are more likely to respond to offers of help if they are made by someone with whom they have a relationship and/or in a crisis. Both circumstances applied when the CFP got involved in early 2017.

4.31. Both parents were also verbally aggressive and intimidating on occasion. Sometimes this appears to have been a deliberate tactic: for example making or threatening to make complaints; Mother's behaviour with the physiotherapist; and Father's at the hospital. When they felt significantly challenged about their parenting by professionals they would seek to escape, for example, by stating they were moving (imminently) to another area or by seeking to change schools. This latter response by parents is not uncommon – but did seem to be part of a pattern in this case.

4.32. Practitioners were able to keep themselves safe by sharing information about concerns[33] and considering strategies to manage risks, for example invitations to clinic, joint visits etc. Emotional support is also important because feeling unsafe undermines the ability to act effectively. Practitioners generally felt they had good access to emotional support and supervision to discuss any concerns about their safety, although reflective supervision is harder to provide on demand. Good supervision is mindful of the difference between effective engagement and collusion.

4.33. Practitioners felt that the steps they took to manage aggressive behaviour in this case were proportional. However it is important to recognise that strategies for managing aggressive behaviour should be kept under review. Tactics like joint visiting can have an escalatory effect, and policies that exclude service users who are aggressive can result in intimidating behaviour being used as a tactic.

[33] The exception was at the hospital where there were flags for the children's welfare but not Father's behaviour

4.34. Some practitioners at the learning event had had training on dealing with aggressive and avoidant parents. Practitioners were clear about the benefits of courses known to have been well received and enthusiastic about making them more widely available.[34]

4.35. Milton Keynes Safeguarding Board has a "hard to engage families" procedure[35] which covers most of the issues above. The procedure specifically includes guidance on professionals' meetings to share information and ownership of concerns. For families where children's social care is not involved these can help identify that the potential risk of significant harm threshold has been met for referral. However convening such a meeting was not considered in this case, perhaps either because of a low awareness of the procedure, or a lack of recognition that such a meeting might have been helpful.

Summary of learning: dealing with suspicious, aggressive and avoidant parental behaviour

4.36. Parents who have previously had difficult experiences of receiving services from children's social care are likely to be suspicious and reluctant to engage. Because withdrawal by parents from services whenever they feel challenged increases the risk for children it is important to: consider the possible reasons behind difficult behaviour; make persistent attempts to build a relationship: use creative ways to engage parents and spot the moment to offer support and/or escalate concerns.

4.37. Where a pattern of avoidant behaviour begins to emerge, including reluctance to agree to assessment, this should be evaluated as a risk factor in its own right and escalated where appropriate.[36] Practitioners could make better use of the MKSB "hard to engage families" procedure. Use of professionals' meetings might assist in identifying whether and when the potential risk of significant harm threshold has been met for referral to children's social care.

4.38. Practitioners benefit from good support and challenge to deal effectively with resistant and avoidant parents.

See recommendation B & D

Substance Misuse:

4.39. The NSPCC summary of those Serious Case Reviews between 2010 and 2013 which involved substance misuse[37] identified learning which resonates for this case. They concluded that too much credence tended to be given to parents' self-reporting of drug use that was not seen as excessive, coupled with reports of happy healthy children. They also suggest that assessment of risk needs to be ongoing. 7 of the 9 new or increasing risks had some relevance for this family. These were new partner (or previous partner coming back); involvement of extended family members in family life; missed appointments with any agency; domestic abuse or mental ill health problems; criminal

[34] The two courses mentioned were a local one for children's social care on dealing with difficult dangerous and evasive people and a nationally available one; http://www.sandstories.co.uk/ which also has a good focus on the child's lived experience

[35] http://mkscb.procedures.org.uk/ykpxz/assessing-need-and-providing-help/additional-practice-guidance/hard-to-engage-families

[36] This was also a learning point from a previous Milton Keynes SCR (Child A published Jan 2016)

[37] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/parents-misuse-substances/

activity or anti-social behaviour incidents; stress (which may impact upon substance misuse habits); moving home.

4.40. A number of practitioners had suspicions about parental use of cannabis, which Mother admitted on occasions. However she was not willing to accept any treatment. Several practitioners looked for signs of drug use, including taking opportunities to look round the house. Some of those who visited the house also looked for evidence of cultivation of cannabis. The focus of attention by practitioners was more on Mother than Father, although it is important to note that Father also has a history of drugs offences and cannabis misuse.

4.41. There are a number of potential risks to children associated with parental cannabis use. These include inhalation of smoke (the school reported their clothing smelt of cannabis so they were likely to have been present on at least some occasions); impact of cost on family finances, possible contact with risky adults when purchased (or sold if cultivated); increased risks of co-sleeping for babies. However the potential impact of cannabis use on the children does not seem to have been explored in detail by any practitioner and the potential relevance missed entirely on occasion. For example when police visited the house to arrest Father for being the tenant of a warehouse where a "cannabis factory" was found, officers did not include this information in the referral they subsequently made to Children's Social Care about the messy house. Nor did they make the connection when they became involved to deal with an argument between women where Mother had accused one of them of being a grass regarding the discovery of the "cannabis factory".

4.42. No tangible evidence of crack use was ever found until after Child J died. After Child J's death Mother admitted that she was using crack cocaine for a minimum of 5 months prior to his death. Previously she had always denied anything other than historical use of crack. Admitting to cannabis use could have been putting into practice "Half a truth is often a great lie"[38] to deflect attention away from more probing enquires about the historical crack use.

4.43. It is accepted that, in the absence of clear evidence, a suspicious parent who is quick thinking, used to dealing with professional involvement, and adept at plausible explanations, will be hard to challenge about their substance misuse until and unless the intensity of involvement permits closer scrutiny, or a more confiding relationship. These conditions began to be in place once the CFP became involved.

4.44. Since Child J's death it has become clear that Mother never received any treatment for use of crack cocaine. Her return to Milton Keynes increased her vulnerability to relapse by putting her back in close contact with Maternal Grandmother, who appears to have been complicit in her drug use as a teenager. The old adage about past behaviour being the best predictor of future behaviour is too simplistic because it does not take into account capacity to change. However there does seem to have been too much weight given to crack use not being likely to be a current or future risk because of the length of time since Mother admitted to last using it.

4.45. No-one has ever seen obvious physical signs of Mother's crack use. It is known that she has continued to use crack cocaine since Child J's death. Practitioner's observations of her presentation since then suggest that the erratic and bizarre behaviour she displayed in the hospital are typical of how she has presented around those times. The effects of crack use can mimic psychotic symptoms

[38] Benjamin Franklin 1758

and then cause depression. It is possible therefore that the symptoms of mental illness she complained of were at least partly associated with crack addiction. It is also possible that her long-term use of cannabis was at least partly a way of self-medicating to address feelings and/or depression caused or exacerbated by her abusive childhood.

4.46. Practitioners at the learning event considered that awareness of substance misuse was generally high in Milton Keynes and that the specialist service is very responsive, once people are willing to accept help.

Summary of learning: substance misuse

4.47. Parents who misuse drugs can be very plausible,[39] and agencies had different pieces of the jigsaw relating to suspicions of substance misuse which would have benefited from being analysed as a theme. A clear understanding about current, recent AND previous patterns of use assists practitioners to make better predictions of current and future use.

4.48. Practitioners should remain sceptical about drug use being historical until they are confident they understand:

a) the circumstances in which it started,
b) how the person managed to stop and
c) their vulnerabilities for relapse

4.49. Practitioners need to be aware of the potential risks to children's health and wellbeing associated with parental drug use, including when adults are arrested for drugs offences, and be able to describe and record the potential and actual impact clearly.

See recommendation E

Domestic Abuse:

4.50. During the period, assaults were alleged by Mother, Maternal Grandmother and Father. Mostly Father was the alleged perpetrator.[40] No evidence of actual injuries was ever seen by any agency.[41] The Home Office definition of domestic violence and abuse[42] includes emotional and psychological abuse. Practitioners gave examples of how Father "pressed Mother's buttons" by deliberately saying or doing things to make her angry. Mother was justifiably anxious that Father would make allegations about her.

[39] This was also a learning point from a previous Milton Keynes SCR (Child A published Jan 2016)
[40] Father told the author that he felt he was treated differently (worse) than a woman would be when he made allegations of abusive behaviour as a victim.
[41] Mother has subsequently alleged that injuries were in places not easily visible (eg to her body and scalp)
[42] The cross-government definition of domestic violence and abuse is: any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological; physical; sexual; financial; and emotional abuse. https://www.gov.uk/guidance/domestic-violence-and-abuse

4.51. It was common for Mother to withdraw/deny allegations. Whilst this is not unusual in relationships involving domestic abuse, it makes it more difficult for police to take any action to prevent further incidents unless there is corroborative evidence. This is especially so if difficult circumstances at the time they attend make it hard to identify and/or focus on challenging discrepancies based on what they already know.

4.52. The reasons for Mother not co-operating with the police are not known. However, for example, victims can withdraw allegations because reporting them has ensured their immediate safety, but following through would then increase the risk to themselves or their children. The signs of fear, and the reasons for it, may not always be obvious, and women may act in ways that appear inconsistent and harmful to their best interests.[43]

4.53. Research suggests that the cumulative seriousness and impact of multiple incidents of "low level" domestic abuse tends to be underestimated as each incident is usually seen in isolation.[44] None of the incidents met the definition of anything more serious than the category of 'standard' when the DASH assessments were undertaken. This reduced the opportunity for multi-agency oversight of what was happening as standard categories of domestic abuse are not routinely referred to Children's Social Care. Whilst several incidents were considered sufficiently serious to be referred,[45] some weren't. The sharing of 3 other alleged incidents might have triggered more active curiosity about what was going on in this family; the allegation about potential strangulation of Mother; the conflicting accounts of Father's concerns passed on by the school and the concerns about Father's behaviour at the hospital.

4.54. Midwives routinely ask women at booking whether they are experiencing domestic abuse, however some women will not disclose it. Domestic abuse reports are shared with health visitors and up loaded to GPs records, to which midwives have access. Participants at the learning event indicated that the system for police sharing information with the health visitor and passing it on to the midwives works effectively; as long as police attending incidents record that a woman is pregnant.

4.55. The number of incidents of reported domestic abuse, or neighbour disputes where the children were present, should have prompted some consideration of what it would feel like to live in such an environment. Research suggests[46] that the impact of the stress, fear and anxiety associated with domestic abuse can be significant for unborn children and babies. Mother was not noted as pregnant on DASH forms and, when Child J was a baby, one entry describes him as "fine, not affected as only 3 months old".[47] Practitioners at the learning event expressed the view that awareness of domestic abuse was more consistently good amongst practitioners where exploring

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[43] Sidebotham P et al (2016) Pathways to protection a triennial analysis of Serious Case Review 2011-14 Department for Education para 4.2.5 passim

[44] Stark E (2012) "Re-presenting Battered Women; Coercive Control and the Defence of Liberty" in Violence against women: Complex Realities and New Issues in a Changing World . Les Presses de Universite du Quebec

[45] Since July 2017 practice has been refined so that if any incident is shared ALL previous incidents will be routinely shared, irrespective of previous grading.

[46] National Scientific Council on the Developing Child. (2005/2014). *Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper 3*. Updated Edition. http://www.developingchild.harvard.edu AND National Scientific Council on the Developing Child (2010). *Persistent Fear and Anxiety Can Affect Young Children's Learning and Development: Working Paper No. 9*. http://www.developingchild.net

[47] This has been addressed by the police since

this was a standard part of their practice (for example Midwives) or who worked in localities where domestic abuse was prevalent.

Summary of learning: domestic abuse

4.56. When there are a significant number of "low level incidents" of domestic abuse it is easy to underestimate the impact on both victim and children, and practitioners who deal with a lot of incidents of domestic abuse can become desensitised. In addition signs of fear and the reasons for them may not always be obvious to the onlooker.

4.57. Awareness of the impact of domestic abuse on unborn children and babies needs improving to be consistently good. This is especially so for practitioners where exploring domestic abuse is not a standard part of their practice, or who have limited contact with families where domestic abuse is prevalent.

See recommendation F

5. GOOD PRACTICE

5.1 When undertaking a review, it is important to also consider any good practice undertaken on the case. A number of positive interventions were noted above and it is important to highlight them again here. They include:

- Health visitor and social worker working in the London borough shared information proactively when the family moved
- Health representative in MASH identified the family after the referral from London
- TVP & Street Triage, who decided that the seriousness of the information warranted a home visit despite Mother not wanting one
- School staff visited Sibling 1 in his home environment prior to his admission to nursery and identified that this was a family that might need extra support
- The midwife and health visitor shared information with each other during antenatal and postnatal period
- The GP referred key incidents for discussion in the Multi-Disciplinary Team
- That health visitor expressed her disagreement that Sibling 2 met the criteria for DLA but also referred for a specialist opinion
- When Mother complained the health visitor recognised that a change of health visitor might benefit the family; until then the named health visitor had been the same person
- The newly qualified physiotherapist provided a thorough assessment of Sibling 2, was not intimidated by Mother's behaviour, consulted the hospital safeguarding lead and passed on her concerns about the potential for "doctor shopping"
- The Child and Family assessment completed by the social worker provided a balanced analysis which acknowledged past concerns and behaviour and current concerns and potential risks
- The strong partnership between the school and the social worker
- The support provided to the registrar by the sister in the Emergency Duty Department in response to Father's aggressive behaviour
- The escalation of concerns by the Emergency Duty registrar to the hospital safeguarding lead to ensure that Child J was admitted to hospital after the fire

- That the registrar and the nurse acted effectively to encourage Mother to stay for the mental health assessment and stayed hours beyond the end of their shift to ensure an effective response to Mother and Child J after the fire
- The speed and thoroughness of the mental health assessment of Mother in response to a request from the Emergency Department
- The paediatric staff on the ward systematically addressing and recording all the issues raised by their Emergency Duty colleagues
- The school safeguarding lead successfully challenged the view that MKAct was a sufficient response to the family's needs in January 2017
- The school safeguarding lead knew the children well and established a rapport with Mother that enabled a referral to CFP
- The prompt advocacy by social worker and CFP with housing
- The CFP assessment built on the Children and Families assessment conducted by the social worker.
- CFP established a relationship with Mother in particular and provided a swift, intensive and tenacious response which included visiting Father in the town outside Milton Keynes where he and Sibling 3 had been temporarily re-housed
- When the Health Visitor was informed that Mother was moving she went to the house to check
- The application of learning from a previous local SCR involving drugs misuse; the importance of looking out for evidence of drugs use and seeing the bedrooms
- The Team Around the Family worked well together, and recognised relatively quickly when it was necessary to escalate their concerns to Children's Social Care.
- When Mother did not respond to the GP's attempt to arrange a follow-up appointment after a repeat prescription for anti-depressants the GP made the health visitor aware
- The speed of the assessment and joint police and Children's Services action to protect the siblings after Child J's death.
- Following the death of Child J the chaplaincy team provided hospital staff with an opportunity for a professional debrief; a safe space for staff to reflect on the impact that their involvement had on them personally
- When the first foster placement was breaking down, Sibling 2 was allowed into school all day to give sufficient time for Children's Social Care to find a suitable alternative local placement which kept the 3 siblings together and enabled the older two to continue to attend the same school.

6. CONCLUSIONS AND LESSONS LEARNED

6.1 In his 2003 inquiry report into the death of Victoria Climbie[48], Lord Laming used the phrase "respectful uncertainty" to describe the attitude social workers (and indeed other practitioners) need when working in child protection: that they must be much more sceptical and mistrustful about what might be really happening behind closed doors. In this case a number of practitioners used the phrase “respectful disbelief” which is a particularly useful concept for working with people where there are issues of substance misuse, domestic abuse and avoidant behaviour.

6.2 Whilst more scepticism about what practitioners were being told might have been useful on occasion, the parents were skilled at deception and it is difficult to take action when there is limited tangible evidence. Even had more intense involvement commenced earlier, and been successful in finding out more about what life was like for the children, there still would have been no way of predicting Child J’s death.

6.3 Whilst there are a number of learning points from this review which will be useful to improve services for children and families in Milton Keynes, there was also considerable evidence of good practice in this case from all agencies. Examples included: attempts to build relationships with the parents, professional curiosity and tenacity, prompt responses and thorough assessments, information sharing, partnership working, and escalation. Accordingly a learning point from the most recent triennial review of Serious Case Reviews has considerable relevance; that ”the harms children suffered occurred not because of, but in spite of all the work that professionals were doing to support and protect them”.[49]

[48] Lord Laming (2003) The Victoria Climbie Inquiry. The Stationery Office
[49] Sidebotham P et al (2016) Pathways to protection a triennial analysis of Serious Case Review 2011-14 Department for Education page 162

7. RECOMMENDATIONS

The individual agency reports have made single agency recommendations. Milton Keynes Safeguarding Board has accepted these and will ensure their implementation is monitored.

To address the multi-agency learning, this Serious Case Review identified the following recommendations for Milton Keynes Safeguarding Board (MKSB):

A) That MKSB ensures that practitioners are competent in understanding, describing and recording children's lived experience, and that they can effectively convey the impact of this on the child, especially when making referrals to Children's Social Care.

B) That the MKSB's current work on Early Intervention, including the revision and use of the CAF, explicitly takes into account the learning from this review, in particular processes to support appropriate escalation to CFP and to Children's Social Care services.

C) That MKSB seeks assurance from Children's Social Care that:

I. The practice of making duty visits to assist in decision-making about the appropriate outcome of a referral regarding a child's welfare has been reviewed in the light of the 2016 Ofsted inspection report[50] and that any continuation of this practice is explicitly supported in the relevant procedures.[51]

II. Criteria has been agreed for when historical information should be retrieved from archives to inform assessments.

D) That MKSB ensures practitioners consistently use a probing and analytical approach to gathering and sharing information when a parent is suspected of substance misuse: this should include the implications of past, present and potential future misuse, as well as the impact on children.

E) That MKSB ensures practitioners feel confident and well supported in dealing with suspicious, resistant and avoidant parents.

F) That MKSB ensures practitioners are competent in working with families where domestic abuse is a feature: in particular that they are fully aware of the impact of domestic abuse on babies, including before their birth; and consider the cumulative effects of "low level incidents" on both victims and children.

[50] https://reports.ofsted.gov.uk/local-authorities/milton-keynes
[51] "A – Z of Children and Families Policies and Procedures"

Appendix 1: Methodology and structure of report

The MKSB agreed to undertake this review using the Significant Incident Learning Process (SILP)

Principles of SILP: proportionality; learning from good practice; active engagement of practitioners involved at the time; engaging with families; systems methodology; avoidance of hindsight bias
Stages of SILP; multi-agency agency chronology; agency reports which identified the single agency learning; two learning events held in November 2017 for practitioners and managers; comments and challenge to this overview report for practitioners and managers

The Lead reviewer and author is Karen Perry, an experienced ex senior local authority manager of services for children who need protection and/or care. Karen is entirely independent of Milton Keynes SCB and its partner agencies.

A description of what happened during the period within the scope of the review is split into "Key Episodes". Key episodes are periods of intervention that are judged to be significant in terms of identifying learning through understanding the quality of the work undertaken with the children and their family.