STOKE-ON-TRENT

SAFEGUARDING CHILDREN BOARD

Serious Case Review SOT14 (1)

Final report

Date 17th August 2015

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1. Introduction

Why this case was chosen to be reviewed

1.1 This case was taken to the serious case review scoping panel on 23rd June, 2014 due to the nature of the Subject Child's death. The Subject Child had been found dead early one morning in May, 2014. During the day of their death it became clear that the previous night all of the children had slept downstairs, whilst the mother had spent the night upstairs, with a man she had recently met. The mother was interviewed by the police and then bailed, pending the result of the Home Office post mortem.

1.2 SOTSCB Independent Chair made the decision that the circumstances of the child's death fully met the criteria for a serious case review, as set out in Chapter 4 of Working Together to Safeguard Children, 2013, on 7th July, 2014.

Succinct summary of the case

1.3 Due to the desire to protect the anonymity of the surviving children all of the children are referred to as "they" and "their".

1.4 This case involves a family made up of six siblings and half-siblings, some of whom lived with their mother, some of whom lived with their fathers, some of whom moved between the two, for periods of time. One lived for a number of years with another relative. Apart from Child 1, all of the children saw each other regularly at their mother's home. Child I lived with their father and from a young age had had no contact with their mother or their half-siblings.

1.5 During the period under review the first contact with children's social care was on 19th November, 2013. The mother contacted social care requesting support because she was pregnant and was finding it hard to cope. A referral was made to the locality team for family support. Social care did not become involved.

1.6 The next time the family became known to social care was when another agency contacted social care on 18th March, 2014, with concerns that the children in the family were being cared for by the maternal aunt who had a learning disability. Social care accepted the referral and commenced a single assessment. (As set out in *Working Together to Safeguard Children, 2013*, this is the statutory guidance for interagency working. The single assessment has to be completed within 45 working days).

1.7 The single assessment was not due to be completed by the time the Child died on 8th May, 2014.

1.8 The Subject Child was found dead early in the morning on 8th May, 2014. During that day it became clear that the previous night all of the children had slept downstairs, whilst the mother had spent the night upstairs, with a man she had recently met.

1.9 The mother was interviewed by the police and then bailed, pending the result of the Home Office post mortem. The report was released 2nd October, 2014. On 15th December, 2014 the mother was charged on two counts of child cruelty.

Historical Involvement with Social Care

1.10 Historically a number of referrals had been made to social care over the years because of concerns that the mother was not meeting her children's basic needs. The first time social care had become actively involved was in 2010 following an allegation of physical abuse. Following a child protection investigation and an assessment, the case was closed.

Family Composition

Mother. Age 31. White, British

Child 1. Age 13. White, British

Child 2. Age 9. Dual heritage. White, British/Not known beyond "Black"

Child 3. Age 8. Dual heritage. White, British/ Not known beyond "Black"

Child 4. Age 6. Dual heritage. White, British/West African

Child 5. Age 4. Dual heritage. White, British/West African

Subject Child. Age 4 months at time of death. Dual heritage. White, British/Not known beyond "Black", possibly Jamaican

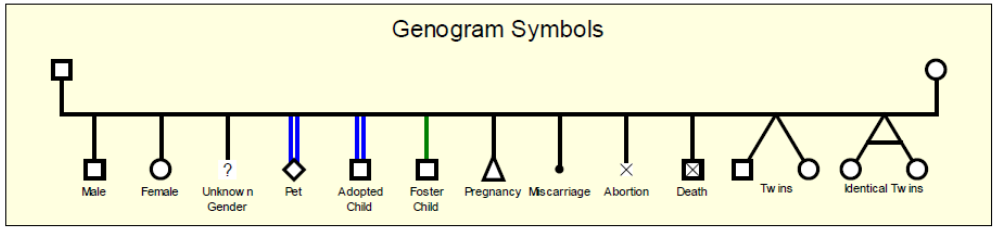
Father of Child 1 is White British

Fathers of Children 2 and 3 not known beyond "Black"

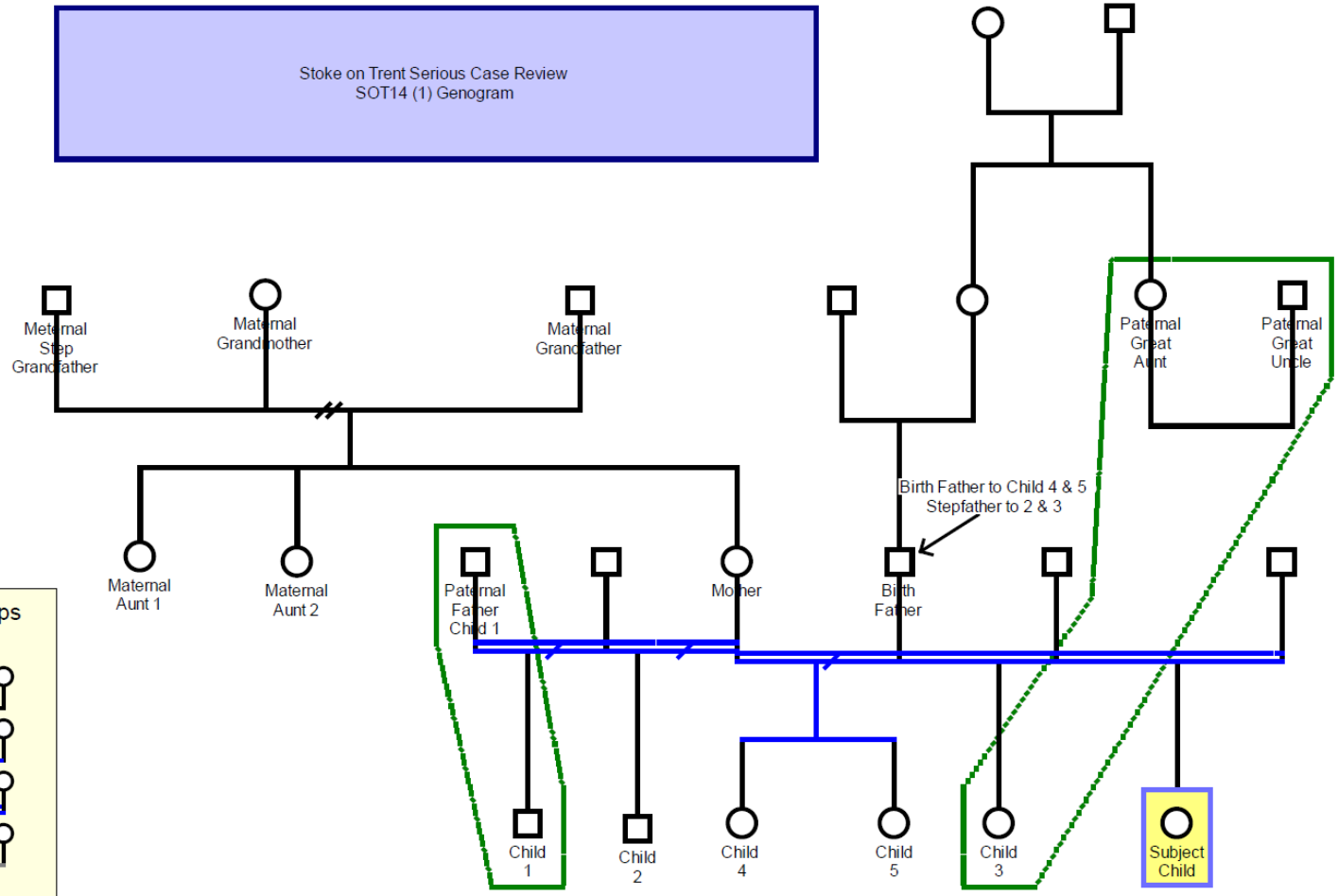
Father of Children 4 and 5 is from a West African country

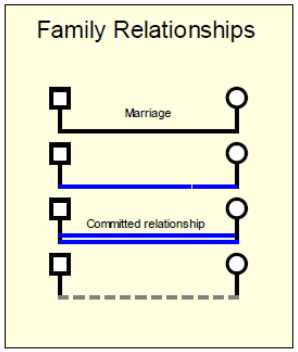
Father of Subject Child not known beyond "Black", possibly Jamaican

All of the children have the same mother.



Stoke on Trent Serious Case Review
SOT14 (1) Genogram





2. Timeframe under review

2.1 Systems reviews consider how safeguarding systems within a local authority area operate and we test out how safe and effective they are. Therefore when considering where to start the review we do not go back many years because systems will have changed. This does not mean that family history is overlooked but what is relevant is whether the professionals working with the family during the period under review knew about the family history.

2.2 In this case it was agreed that we would start the review from 21st June, 2013, the date of the mother's first antenatal appointment with the Subject Child.

2.3 Usually the review stops from the moment of the child's death but in this case the review team wanted to also test out how effective the rapid response system, the immediate multi-agency response to a child's death, is in Stoke-on-Trent. It was therefore agreed that the period under review would conclude at the end of the working day on 8th May, 2014.

3. Timeline of events

Date	Event/Circumstance
21.06.13	Mother attended first antenatal appointment with Subject Child
19.07.13	Mother told School 1 Child 3 was going to live with their father in another local authority (This was not accurate. Child 3 went to live with their paternal step great uncle and aunt. The uncle of the father of Children 4 and 5).
01.09.13	Child 5 went to live with their father in Stoke-on-Trent. Mother said she was struggling to cope
w/b 02.09.13	Nursery that Child 5 was about to start at did home visit. Father not present, "Auntie" was. Home visit went ahead with "Auntie"
04.09.13	Child 3 did not return to School 1 in Stoke-on-Trent. School 1 established and confirmed Child 3 was now at School 3 in another local authority. Child 3 was living with their paternal step great uncle and aunt
09.09.13	Child 5 started nursery
17.10.13	Child 5 told worker at School 2 that their father puts Child 5 in a cupboard when the child is naughty. Class teacher told Child 5's father that is not "what we do in our culture". Father agreed not to do it anymore. Child 5 also told nursery they live with their mother and with their father
15.11.13	Mother was unclear with health visitor who Child 3 was living with. Mother told health visitor Child 5 was living with their father now but it was a temporary measure. Child 5's notes were not transferred
18.11.13	Health visitor advised mother to inform social care of Child 3's whereabouts because it was private fostering and then Child 3's carers must inform children's social care in the relevant local authority
19.11.13	Mother contacted social care and informed them Child 3 living with paternal uncle and aunt because she was finding it hard to cope, in fact they were paternal step great uncle and aunt. Social care in Stoke-on-Trent informed social care in the relevant local authority and a referral was made to the locality team in Stoke-on-Trent for family support
22.11.13	Mother contacted Child 3's School 1 in Stoke-on-Trent and asked if Child 3 could return after Christmas. Arrangements were made but then School 1 was told Child 3 would return after the new baby was born. This did not happen.

23.11.13	Child 5's health records transferred to health visitor for their father's address
07.01.14	Child 5's health visitor contacted social care to tell them that Child 5 may be staying with their mother some of the time
30.01.14	Subject Child born
04.03.14	Subject Child seen at health clinic. Mother's concern baby was vomiting after feeds and was "chesty". Mother then took Subject Child and Child 5 to the hospital Walk in Clinic (minor injuries unit), as there were no GP appointments left that day. Child 5 had a viral illness. The Subject Child was seen and the Mother advised to take Subject Child to the GP the following day.
06.03.14	Subject Child admitted to hospital, unsettled, crying, drawing their legs up when feeding. Diagnosed with cows' milk protein intolerance and gastro oesophageal reflux. Subject Child was discharged the same day with change of milk formula, prescription for Gaviscon and request for health visitor to review the child's weight in a week
11.03.14	Subject Child seen by health visitor, still vomiting after feeds
18.03.14	Anonymous referral to social care. The mother was allegedly allowing her sister, who has a learning disability to care for the children.
21.03.14	Case allocated to a social worker for a single assessment
27.03.14	Social care visit to the family home. Mother says she does not let her sister care for her children but they do go on the bus with her. She was advised against this and the mother said she would not do it anymore. That day Subject Child was admitted to hospital overnight with bronchiolitis, a wheezy chest.
28.03.14	Social care undertook home visit. Children 4 and 5 and Subject Child present. Children seen alone. No concerns
29.03.14	Child 2 seen by social care. No concerns
01.04.14	Subject Child had brief cyanotic episode (turning blue) at the children's centre. Appointment made by health visitor to see GP. GP referred Subject Child to see a paediatrician at the hospital because of vomiting, choking, rash on face and nappy area and diarrhoea. Medication prescribed. Planned paediatric consultant follow up for 5.6.14
02.04.14	Mother called 999 at midnight. Subject Child breathing problems. Paramedics assessed at scene. Not required to attend hospital
11.04.14	Clinical nurse specialist concluded Subject Child did not need BCG vaccination because their father was from Jamaica
23.04.14	Social care undertook further home visit. No concerns
May, 14	Subject Child died. Initially the death was thought to be a Sudden Infant Death but further information emerged throughout the day. Mother was interviewed by the police and bailed, pending the Home Office post mortem. Children 2 and 4 were taken into police protection. A strategy discussion took place between police and social care. (Cause of death not established until October, 2014 as Sudden Unexplained Death in Infancy).

4. Organisational learning and improvement

4.1 Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including serious case reviews, states that:

4.2 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 2013)

4.3 Stoke-on-Trent Safeguarding Children Board identified that this serious case review held the potential to shed light on particular areas of practice including addressing the following issues:

- The effectiveness of the interface between schools, locality services and social care in Stoke-on-Trent.
- The effectiveness of the single assessment process in Stoke-on-Trent. (The process was first piloted in one area of the city from May, 2013. the pilot was then rolled out across the city in June, 2013. The pilot concluded in April, 2014 and the city now undertakes a child and family assessment, which is currently under review).
- The effectiveness of the different processes when a child moves out of area.

5. Methodology

5.1 Statutory guidance requires serious case reviews 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; and
- makes use of relevant research and case evidence to inform the findings.

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 should 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.

5.2 In order to comply with these requirements Stoke-on-Trent LSCB has used the SCIE Learning Together systems model (Fish, Munro & Bairstow 2010) which allows for proportionality through a sliding scale of options. This SCR used a focused Learning Together review, which does not generally include individual conversations with staff, but engages with them in a one-day workshop.

5.3 Process

- An initial meeting with the first lead reviewer, the review team, the team made up of senior managers from each of the agencies involved during the period under review, followed by a meeting with the review team and the case group, the key frontline professionals involved during the period under review
- A planning day for the first and second lead reviewers
- A workshop with the lead reviewers, review team and case group
- A final meeting with the first lead reviewer and the review team.
- The final report will be endorsed by the Safeguarding Children Board.

5.4 Process limitations

A focused Learning Together Review is exactly that - focused. The opportunities to generate data with the case group and review team are more limited than in a fuller review. This relates both to understanding why practitioners acted as they did in the case, and the extent to which practice issues identified in the case are generalizable issues. We endeavour to reflect this in the way the findings are written up.

5.5 Documents read

Stoke-on-Trent City Council Policy and Guidance on Children Missing Education

Children and Young People single assessment

Strategy discussion minutes. 8th May, 2014

Outcome of s.47 enquiry document. May, 2014

School Nursing Audit. June, 2014

Staffordshire and Stoke-on-Trent Partnership NHS Trust pupil migration report and the standard operating process for notification of children arriving or leaving school in Stoke-on-Trent or North Staffordshire area templates.

5.6 Reviewing expertise and independence

5.7 The serious case review has been led by myself, Joanna Nicolas. I have been an accredited SCIE Learning Together lead reviewer since 2012, having been part of the Government's pilot in the South West in 2011. I have undertaken four full Learning Together reviews since then, as well as a range of other systems reviews. I have been leading serious case reviews, in all forms, since 2008 and have undertaken, or am in the process of undertaking, ten in total. I have been a qualified social worker since 1996 and have worked independently as a child protection consultant, trainer and author since 2008. I have never worked in Stoke-on-Trent and this is the first time they have commissioned me to undertake a serious case review.

5.8 The second lead reviewer in this case has been Kay Bell. Kay has been an accredited SCIE Learning Together lead reviewer since 2011. She led the London-wide pilot consisting of seven LSCBs during 2011-12 and has undertaken two Learning Together reviews. Since then in her role as an LSCB Independent Chair, during 2013-2014 she also commissioned a Learning Together review. She has been a qualified social worker since 1986 and became an independent management and social work consultant in 2012. In a previous role as Children's Services Adviser she worked externally with Stoke-on-Trent as part of overseeing a Government-led Intervention during the period 2007-10, which focused on improving Children's Social Care and Education. She was not commissioned by Stoke-on-Trent during this intervention, or since.

5.9 The first lead reviewer has received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

5.10 Statutory guidance requires that serious case review reports be written in plain English and in a way that can be easily understood by professionals and the public alike. Writing for multiple audiences is always challenging. In the Appendix we provide a section on terminology. Our aim is to support readers who are not familiar with the processes and language of safeguarding and child protection work.

5.11 LSCBs and SCIE are both keen to improve the accessibility of serious case review reports and welcome feedback and suggestions for how this might be improved.

5.12 Participation of professionals

5.13 The review consisted of two groups of professionals, the review team which consisted of a senior manager from each of the agencies involved during the period under review, none of whom had line management of the case and the case group, the key frontline professionals who were involved with the family during the period under review.

5.14 Review Team

Joanna Nicolas	First lead reviewer
Kay Bell	Second lead reviewer, only present for the preparation day and for the workshop
North Locality co-ordinator	People Directorate – Localities
Head of Safeguarding	West Midlands Ambulance Service
Director of Nursing	Royal Stoke University Hospital of the University Hospitals of the North Midlands, (previously known as University Hospital of North Staffordshire NHS Trust)
Designated Nurse for Child Protection	Stoke-on-Trent and North Staffordshire Clinical Commissioning Groups
Strategic Manager Safeguarding and Quality and Assurance	People Directorate - Vulnerable Children and Corporate Parenting
Manager	Stoke-on-Trent Safeguarding Children Board
Strategic Manager Inclusion	People Directorate – Learning Services
Head of Safeguarding Children	Staffordshire and Stoke-on-Trent NHS Partnership Trust
Investigative Services Policy, Review and Development Team Manager	Staffordshire Police

The case group was made up of the key frontline professionals who had been working with the family during the period under review.

5.15 The case group

GP	GP Surgery
Associate practitioner	GP Surgery
Named midwife	Royal Stoke University Hospital
Midwife	Royal Stoke University Hospital
Consultant paediatrician	Royal Stoke University Hospital
Principal manager	People Directorate – Vulnerable Children and Corporate Parenting
Social worker	People Directorate – Vulnerable Children and Corporate Parenting
Social worker	People Directorate – Vulnerable Children and Corporate Parenting
Social work assistant	People Directorate – Vulnerable Children and Corporate Parenting
Detective Inspector	Staffordshire Police
Health visitor	Staffordshire and Stoke-on-Trent NHS Partnership Trust
School Health Team Leader	Staffordshire and Stoke-on-Trent NHS Partnership Trust
School nurse	Staffordshire and Stoke-on-Trent NHS Partnership Trust

Integrated family intervention worker	People Directorate – Localities
Senior family intervention worker	People Directorate – Localities
Child death review nurse	Royal Stoke University Hospital
Head teacher	Children 2 and 4's school, School 1
Deputy head teacher	Children 2 and 4's school, School 1
Head teacher	Children 5's school, School 2
Designated Safeguarding Lead	Children 5's school, School 2

5.16 Due to the brevity of this review the case group was used primarily to provide information about this case and to consider the wider perspective and possible themes for the review. There has been less chance for them to check, challenge and amplify the analysis.

5.17 Perspectives of the family

5.18 It is a family's choice whether they contribute to a serious case review. Every effort is made to engage with the family because their contribution is recognised as extremely important and makes for a much richer review.

5.19 In this case the mother was invited to contribute to the serious case review, on a number of occasions, including at the conclusion of criminal proceedings but declined the invitation.

6. The Findings:

Introduction

6.1 Statutory guidance requires that serious case reviews provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of reoccurrence. These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong.

6.2 In every case that is reviewed, even when we are reviewing cases that have ended in the terrible tragedy of a child dying, there will be examples of good practice, as well as areas for improvement. It is just as important to learn from areas of good practice, as well as poor and both are highlighted in this section of the report.

6.3 This section contains five priority findings that have emerged from the serious case review. The findings explore why professionals acted as they did in this case. Each finding also lays out the evidence identified by the review team that indicates that these are not one-off issues but maybe systemic within Stoke-on-Trent. Many of these findings will resonate with other local authorities. Evidence is provided to show how each finding creates risks to other children and families in future cases, because they undermine the reliability with which professionals can do their jobs.

6.4 First, an overview is provided of professional practice in this case. This clarifies the view of the review team about how timely and effective the help that was given to the Subject Child and their family was, including where practice was below expected standards.

6.5 A transition section reiterates the ways in which features of this particular case are common to other work that professionals conduct with other families and therefore provides useful organisational learning to underpin improvement.

6.6 Appraisal of professional practice in this case: a synopsis

The mother's pregnancy

6.7 When the mother presented with her pregnancy with the Subject Child in June, 2013, health professionals did not explore with the mother her history with her previous children and how that may impact on this baby because they did not see this as significant. The mother had been open with professionals that some of her previous children had gone to live with their fathers because she felt she was too young to be a mother, initially, and then because she was struggling to cope. Family history is always significant, particularly with this mother's history and should have been explored with health professionals, with whom the mother had the most contact. This issue is considered in **Finding Three.**

Child 3's move to another local authority

6.8 When the mother told School 1 at the end of the summer term, July, 2013 that Child 3 was moving to live with family in another local authority and would be attending another school and then Child 3 did not return to School 1 after the summer holidays, School 1 checked up on where Child 3 was. They informed the local authority, as well as undertaking their own search for the child. The name of the school the mother had given was incorrect, so School 1 spent some time googling schools in the area and ringing round until they found out which school Child 3 was now attending.

6.9 Social care demonstrated a good awareness of and response to private fostering arrangements when they were informed that Child 3 went to live in another local authority. They have recorded that they contacted children's social care in the relevant local authority to inform them of the arrangement and persisted with this when the local authority Child 3 was now living in allegedly told them they would not get involved because this was a family arrangement. It was good that social care persisted because they were correct in their understanding of the definition of what constitutes private fostering and this was indeed a private fostering arrangement. This is an example of excellent practice.

6.10 When Child 3 moved the health records did not go with the child, either through the school nursing service or the GP, which they should have done. Child 3 was never registered with a GP in the area they moved to when they moved away from

Stoke-on-Trent. It is expected that a child's health records move with the child but because the children's living arrangements were never sufficiently explored and therefore understood by professionals this did not happen. This was because the mother told professionals that Child 3 was only moving away temporarily as well. This issue of organisational processes being premised on children living with one primary carer, as opposed to there being shared care arrangements is explored further in **Findings Two and Four.**

Child 5 moving to live with their father

6.11 Two months later in September 2013, Child 5 moved to live with their father because the mother said she was struggling to cope. There is no evidence that any professional explored with her what that might mean, which again they should have done. She still had two children living with her full time and another baby on the way.

6.12 Child 5's health records did not move for over two months, this was because as with Child 3 the mother was saying the move was only temporary. It is expected that a child's health records move with the child but because the children's living arrangements were never sufficiently explored and therefore understood by professionals this did not happen. This complexity of shared care arrangements is explored further in **Findings Two and Four.**

6.13 When Child 5 started at the nursery within School 2 the home visit was done but the father, with whom Child 5 was now living, was not there. A woman was there who was described as "Auntie". Although the school worker knew her because she had children in the same school it was never ascertained what her relationship to Child 5 was. What was said by School 2 was that it was "cultural" to have other people look after children. It should have been ascertained what her relationship to Child 5 was. The way of thinking about culture that closes down professional curiosity is explored further in **Finding Five**

6.14 Shortly after Child 5 started nursery Child 5 disclosed that their father put Child 5 in a cupboard and shut the door when they were naughty. School 2 brought this up with the father, which is what we would expect and demonstrates good practice. He was told that is "not what we do in our culture". The father said he would not do this anymore. Although School 2 had no reason to believe this response was continuing when Child 5 misbehaved they made the decision that there did not need to be a referral to social care without knowing whether any other agencies had any concerns about the family. As the father had openly admitted to what would be considered to be abusive practice in this country, we would expect the school to contact social care, to find out whether they knew of any other concerns about this family, rather than making decisions in isolation. One agency will only have one piece of the puzzle. Again, this was not explored further because it was seen as a cultural issue by the school and will be considered further in **Finding Five**

6.15 School 2 has only found out through the review that Child 5 only went to live with their father the week before they started school. They were also under the impression that Child 5 saw his mother for a while but then that stopped, which is not the case. Child 5 has always had regular contact with their mother. None of the professionals knew what Child 5's living arrangements were. We would expect all professionals working in close contact with children, such as schools and health visitors, to understand the child's living arrangement. In April, 2014 the mother told social care that Child 5 lived with her and only spent weekends with their father yet the school never saw, or spoke to, the mother and were of the firm opinion Child 5 lived full time with their father and it had come to the point that Child 5 had no contact with their mother. This is a theme of this review that none of the professionals had a clear understanding of the children's living arrangements, which they should have done. This was because the set up was so unusual that the normal processes and questions did not readily fit for working with this family. These challenges for professionals are explored further in **Finding Four.**

The birth of the Subject Child

6.16 Shortly after the Subject Child's birth a decision was made that the Subject Child did not need a BCG, which is the inoculation against tuberculosis because the mother told some health professionals that the father was from Jamaica, not Africa. However the mother told other professionals that she did not know who the father was. This should have been tested out with other professionals, particularly as the child was clearly dual heritage and the mother had other children with unknown fathers. Both the lack of awareness of the ethnicity of the children and a lack of professional curiosity more broadly are common themes in this serious case review and are explored further in **Findings Three and Five** respectively**.**

6.17 Four of the previous half-siblings had suffered from gastro oesophageal reflux, which is vomiting and regurgitation of feed, most commonly seen in babies. It was the same with the Subject Child. Health professionals responded appropriately to the mother's concerns and treated the baby appropriately.

Social care's involvement

6.18 Social care became involved in March, 2014, two months after the birth of the Subject Child. A referral had been made to them because the mother was allegedly allowing her sister, who has a learning disability, to care for the children

6.19 The living arrangements for the children in this family were out of the ordinary and professionals were not inquisitive enough to be clear about what the arrangements actually were to be confident that there was no risk related to the adults with whom the children were living, nor did professionals sufficiently explore with the mother why she kept having children if she found them hard to cope with. This is explored further in **Findings Three and Four.**

6.20 When the referral was made to social care because the mother was allegedly letting her children go on the bus with their aunt who had a learning disability, she said she would not do it anymore and this was accepted at face value. We would expect this to be tested out further and not just accepted, although social care did accept the referral and agree to undertake an assessment, which is what would be expected in those circumstances, with the known family history. All of the professionals said they felt they had no reason to disbelieve the mother when she said she would/would not do something. She worked well with all the professionals, she was seen to be doing what was asked of her, she was known to ask for advice and was then seen to be taking that advice on board and this was the only concern about her parenting, at that time. This is a common theme of this review, that sometimes some of the professionals accepted what the parents told them, without testing it out, and is explored further in **Finding Three.**

6.21 Although it was good that as part of the single assessment the social work assistant started a family tree, the initial information was given by Child 2 and would have required checking with other family members because the information was not in fact accurate. It named the father of Children 4 and 5 as the father of Child 3, which he is not. We would expect professionals to verify information given by children. This may have happened before the conclusion of the single assessment. There is confusion to this date as to who is the father of each of the children, partly because the mother has been unclear at times and has given different professionals different information. This is explored further in **Finding Four**

6.22 Each of the children living with their mother was seen alone, as part of social care's single assessment, which is what would be expected. There were no risks identified as to the living arrangements of any of the children and the children all spoke warmly of their mother.

6.23 There was no mention of family history in the single assessment, which there should have been. As stated previously family history should form a significant part in any assessment. For example, it has come out of this review that Children 3 and 4 were taken to the West African country Child 4's father is from some years previously, for some time, by the paternal great uncle and aunt of Child 4. At the time professionals were told by the family, and accepted, that this is not uncommon within the family's culture and this was accepted by professionals without question. This is explored further in **Finding Five.** The case group say they would be much more questioning of this now, particularly in relation to female genital mutilation because of increased awareness. (This has subsequently been explored and there is no evidence that any female children in this family have been victims of female genital mutilation but as our awareness of this criminal act has increased, it should have been considered by the professionals). This should have come out in the single assessment.

6.24 The single assessment has been piloted in Stoke-on-Trent since June, 2013. It was being piloted during the period under review. A single assessment has to be completed within 45 working days and although the single assessment had commenced seven weeks prior to the Subject Child's death and visits had been done to the family, there is very little information recorded in it. Social workers in Stoke-on-Trent work in teams known as pods. Cases are allocated to all pod members (two social workers and a social work assistant and pod coordinator) and supervised by a practice manager but there is a named primary worker. In this case the assessment was completed by a social worker with support from a social work assistant.

6.25 The single assessment was the ideal tool to link up such a complex family and yet it did not consider the siblings outside the home, it was only in respect of Children 2 and 4 and the Subject Child, and therefore there was no cross-over of professionals working with all the siblings and therefore no complete picture of what life was like for all of these children. There was also no mention in it of the fathers of the children, nor their ethnicity or religion or their half-siblings, all of which are important factors and should be included in the assessment. All of these factors should have been addressed by the single assessment. Social care only saw "the family" in the context of those children living with their mother. This is explored further in **Finding Four.**

The death of the Subject Child

6.26 When the Subject Child died a police family liaison officer was appointed which, according to national guidelines[1] is not a requirement if a death falls outside of the clear criteria, as this did. The decision is at the discretion of the senior investigating officer. The family liaison officer was also a trained child protection officer, which was the ideal combination and demonstrated excellent practice. (Not all family liaison officers are trained child protection officers and for most sudden unexpected infant deaths there is no requirement for a family liaison officer).

6.27 When the Subject Child died it was not made clear to the professionals working with the children and with the mother what they could talk about and what they should not talk about, this led to confusion which could have been avoided if there had been closer liaison between those involved in the rapid response process and those working with the family. This is explored further in **Finding One.**

General comments

6.28 What has come to light, as a result of the serious case review is that the GPs had only noted the Subject Child and children 2,3,4 and 5 as "Mixed British". School I had one child registered as "Any other mixed background" and one as "White and

[1] http://www.acpo.police.uk/documents/crime/2008/200809-cba-family-liaison-officer.pdf

Black African". Any professional working with a child should know their ethnicity, if the information is available. This is explored further in **Finding Five**

6.29 During the period under review the only concern any professional had was about the mother allowing her sister to care for her children. No professional had any concern about the mother's care of the children, or the home environment, which was always clean and tidy. There were beds in the home for all of the children; apart from Child I and all of the children seemed happy. The relationship between the mother and her children was seen to be a loving one.

6.30 It will probably never be known whether the mother regularly brought strangers home and left the children alone. Although professionals should have been more probing about many areas of the mother's life it may be that she had only done it a few times and nothing more would have come from probing, but the probing should always be done.

Findings

In what ways does this case provide a useful window on our systems?

When considering this question we consider 6 typologies as lines of enquires. These are:-

1. **Tools** - what have we learnt about the tools and their use by professionals?
2. **Responses to incidents/Crises** - are there particular patterns we have identified about how professionals respond to incidents?
3. **Longer term work** – are there particular patterns we have identified about ways of working over a longer period with children and families?
4. **Management Systems** - are any elements of management systems a routine cause for concern in any particular ways?
5. **Family-professional interaction** - what patterns of ways that professionals are interacting with different family members are discernible, and do they introduce risk into our systems?
6. **Innate Human biases** - are there common errors of human reasoning and judgement evident that are not being picked up through current set ups?

Our findings in this case fit into four of the categories of the typology.

As stated above, due to the brevity of this review, the review team have given input that supports these findings as being indicative of what is happening in Stoke-on-Trent. However, the limitations of time mean we have not been able to gather any other available relevant data. There remains therefore, further testing out for the LSCB to do.

7. Summary of findings

The review team has prioritised five findings for SOT SCB to consider. They are:-

Finding One (Response to incidents) A lack of clarity about the secondary functions of the rapid response to a child's death in Stoke-on-Trent and Staffordshire increases the chances that parents are unsupported and siblings left at risk (Staffordshire and Stoke-on-Trent share a Child Death Overview Panel).
Finding Two (Longer term work) If processes for responding to a child's change of school are not always known and therefore implemented then there is no guarantee the child's information will move with them and there is a greater risk of children disappearing**.**
Finding Three (Longer term work) Is there a tendency in Stoke-on-Trent when working with compliant families under s.17, Children Act, 1989 to work superficially, accepting information given by families without testing out the evidence?
Finding Four (Tools) Organisation processes are premised on a family set up in which children live in only one place, usually with their mother, so struggle with arrangements of 'shared care' where children's residence is more fluid between key carers.
Finding Five (Family-professional interaction) Is there a pattern whereby certain family activities are accepted without question if badged as their 'culture', which increases the chances that the actual situation of the children involved remains unknown?

Communication and collaboration in response to incidents

Are there particular good or bad aspects to the patterns of how professionals respond to specific incidents?

7.1 Finding One

A lack of clarity about the secondary functions of the rapid response to a child's death in Stoke-on-Trent and Staffordshire increases the chances that parents are unsupported and siblings left at risk (Staffordshire and Stoke-on-Trent share a Child Death Overview Panel).

7.1.1 Each Local Safeguarding Children Board has a responsibility to review the death of each child that normally resides in their area. This work is undertaken by the Child Death Overview Panel. Each Local Safeguarding Children Board also has to put in place procedures for ensuring there is a coordinated response by the authority, their Board partners and other relevant persons. The statutory requirements are set out in Working Together to Safeguard Children, 2013. Chapter 5.

7.1.2 There is a process to follow with the death of every child but in some circumstances it is deemed to be an unexpected death. An unexpected death is defined as a death that was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death. If this is the case the “rapid response” process to the unexpected death of a child procedure must be followed, which is more detailed than the more general process to be followed for all child deaths.

7.1.3 The prime purpose of the rapid response procedure is to ensure that all relevant information is captured and the aim is that the response is safe, consistent and sensitive to those concerned.

7.1.4 The rapid response process sets out what must be done within the first 2-4 hours, then 4-48 hours, then within 1-6 months. It does not call these functions “primary” and “secondary”. For the purpose of this review the “primary” functions are those around the death of the child and the safety of the siblings and the “secondary” functions are those that consider the ongoing family support, which in the procedures have to be considered also.

How did these issues manifest in this case?

7.1.5 Due to the circumstances of the Subject Child’s death there was an emerging picture as to what had led to the death. The rapid response team, a multi-agency team that is convened as part of the statutory process for child death review, did not work with the other professionals involved with the mother and the children, therefore those professionals were left confused as to how to respond to the family. (There is no suggestion that the children were placed at risk, in this case it was more an issue about the pastoral care of the children and the mother).

7.1.6 Due to the small number of specialists in this area and capacity issues the cause of death was only declared on 2nd October, 2014, five months after the death. The long-term plan for the surviving half-siblings, who had been living with their mother until the death of the Subject Child, could only be considered at this point.

7.1.7 Although the period under review ceases on the day of the Subject Child’s death, this has continued in terms of dealing with the mother, as well. In this case the GP practice did not know what they could/ could not say to the mother and

how/whether to support her. The school and the children's carers were not sure how best to support the children and what they should/should not say.

How do we know it is an underlying issue and not something unique to this case?

7.1.8 When the review team explored what lay behind this situation, we found that the prime purpose and process of the rapid response is very clear and that includes the requirement for professionals to consider the need for a strategy discussion under s.47, Children Act, 1989, which would look at the safety and protection of surviving siblings. What is not clearly set out in policy or procedures is the interface between those involved in the primary function, the death of the child, and those involved in the secondary function, the safety and protection of surviving siblings. Some of the review team and the case group have dealt with similar situations in the past and no one has been very clear about how to proceed, in terms of what they say to siblings and to grieving parents.

How prevalent is the issue?

7.1.9 During the three years from 1st April 2011 to 31st March2014 in Staffordshire and Stoke-on-Trent there have been 67 sudden unexpected deaths of children from a variety of causes. 63 of the 67 deaths (94.02%) were subject to rapid response procedures by a multi- agency team. Of this number 4 cases (5.97%) resulted in the arrest of one or more carers on suspicion of causing serious harm to the child and of those 4 cases 1 case (1.49%) resulted in a successful prosecution in connection with causing the death of the child. This demonstrates that this is not currently a prevalent issue.

How widespread is the issue?

7.1.10 *Working Together to Safeguard Children, 2013* does not set out how this interface between the primary function and the secondary function of the child death process should work; therefore there is no national guidance. It is not possible to know how widespread the issue is. It is something I personally have seen in one other serious case review.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

7.1.11 The issue here is about how siblings are worked with following the death of a child. One of the foundation stones of any effective child protection system should be that the child's welfare is paramount. Once their physical safety has been ascertained a safe system will be one where the child's emotional wellbeing remains the primary focus of the worker and the worker has an ongoing understanding of the legal process and guidance about how to work with the surviving children.

7.1.12 Although working with parents is a separate issue, the same guidance and clarity is needed.

Finding One

A lack of clarity about the secondary functions of the rapid response to a child's death in Stoke-on-Trent and Staffordshire increases the chances that parents are unsupported and siblings left at risk (Staffordshire and Stoke-on-Trent share a Child Death Overview Panel).

Summary

One of the foundation stones of any effective child protection system should be that the child's welfare is paramount. Once their physical safety has been ascertained strength in the system lies with the emotional wellbeing of the child remaining paramount and workers having an ongoing understanding of the legal process and guidance about how to work with the surviving children.

This case has highlighted that there is not this clarity in this area.

Questions for consideration by the Board:-

1. Is this a new issue to the Board?
2. Are statistics available as to how long it is taking to ascertain the cause of unexpected child deaths? And if so, is the time acceptable?
3. How does the way that the secondary functions of the rapid response process works in practice in Stoke-on-Trent compare with other areas? Are there any good practice examples that Stoke-on-Trent could explore and potentially learn from?

Communication and collaboration in longer term work

Were any good or bad patterns identified about ways of working over a longer period with child or adult service users, carer(s) and family members?

7.2 Finding Two

If processes for responding to a child's change of school are not always known and therefore implemented then there is no guarantee the child's information will move with them and there is a greater risk of children disappearing.

How did the issue manifest in this case?

7.2.1 In this case Child 3 moved out of city. At the end of the summer term the mother told School 1 that the child was moving to live with a relation in another local

authority and would be going to school there. When the child did not return to School 1 at the beginning of the autumn term School 1 sought to find out where the child was. The school recalls that they also informed the education welfare service, as is the process but there is no written record of that, either in the school records, or the education records. The name of the school given by the mother was incorrect and it was only through googling and telephoning round did School 1 chance upon where Child 3 was now at school.

7.2.2 School 1 did inform the school health service that the child had left the school. The GP was unaware Child 3 had moved and the child's health records did not go with them. Child 3 was not registered with a GP in the local authority where they were now living. (Since September, 2014 School 1 has introduced a process to their record-keeping which ensures that the school health service is informed when a child leaves their school. This list is completed and sent out every two months).

How do we know it is an underlying issue and not something unique to this case?

7.2.3 Stoke-on-Trent has a "Children Missing Education" policy and the procedure is as follows: - If a pupil stops attending, referral to education welfare service by school after the first 10 days of absence (or earlier if school become aware that pupil has moved address and stopped attending). After 20 days of non-attendance, if the pupil's whereabouts are unknown, the education welfare officer will carry out location checks. If after reasonable enquiries the Local Authority has failed to ascertain the pupil's whereabouts the pupil can be taken off school roll (but not before). The school then uploads the pupil's file to the national lost pupil database. The national database is checked by the education welfare service regularly (at least fortnightly) to see if the pupil has registered with another school.

7.2.4 Although there is evidence of some schools knowing and using this policy, it is not used consistently by all schools in Stoke-on-Trent

7.2.5 In addition to this there is a live transfer of school roll and attendance information from all schools in Stoke-on-Trent to the Local Authority education management system (Capita). Thus, if a pupil is removed from a school roll for whatever reason, this will show immediately on Capita with a leaving date against the pupil's name. (However, the system still relies upon school making the referral to the education welfare service to affect a Local Authority response).

7.2.6 The review team and the case group report that this process does not always work effectively, which may be because some schools are unaware of the policy. (In this case some of the education members of the case group were unclear about this process).

7.2.7 The review team has said that in terms of health records, there is a clear system in place when a child moves school, to ensure their health records move with

them. Because of issues that have arisen previously, it was a recommendation in a previous serious case review in 2012 in Stoke-on-Trent, SOT12(1) that “All Schools to notify the School Nursing Service of new pupils enrolling in schools within one month of the date of enrolment”.

7.2.8 Following this recommendation, a small task and finish group agreed to develop specific templates in order to capture this information. One template was called Pupil Migration Report – Pupils Leaving This School / Academy and a second template was developed entitled: Pupil Migration Report – Pupils Arriving At This School / Academy.

7.2.9 Earlier in 2014, the SOTSCB Serious Case Review sub- committee revisited two previous serious case review recommendations in order to test out what difference the implementation of the new process / procedure and any training etc. had been made. However when the head of safeguarding for Staffordshire and Stoke-on-Trent NHS Partnership Trust conducted an audit in her service she was of the view that the process was not robust and was not being used as it should have been. (Of the 88 schools audited only 20 school nurses answered yes to the question “Does this school provide you with a timely notification for all children entering or leaving the school”).

7.2.10 Following this audit, there was an agreement that the local authority would produce two reports every four weeks for Health (School Nursing) showing:

- New entrants to all Stoke-on-Trent schools during the previous four weeks (name, DOB, School – which separate out those who are new to the city and those who are moving between Stoke-on-Trent schools)
- All leavers from Stoke-on-Trent schools during the previous four weeks (name and school they left and leaving date)

7.2.11 What has come to light through this serious case review is that the forms are going to the clerical staff at School Health, not to the school nursing service. This issue is now being picked up by Health and Education partners and is being supported by the SOTSCB business manager.

How prevalent is the issue?

7.2.12 The local authority education department works on projected figures. From September, 2014 to July, 2015 it is expected that 1,110 children will move out of the city and therefore out of the city schools. 1,104 children will move into the city and therefore into the city schools and 1,389 children will move schools within the city, of those 1,044 are primary age. (These figures do not include children starting in primary school, or children moving from primary to secondary school). There are 33,000 compulsory school-age children in the city. Stoke-on-Trent has recognised that pupil mobility is a significant issue in Stoke-on-Trent and this issue is being considered at senior manager level. There will be many factors that influence a change of school, including housing and parental choice.

How widespread is the issue?

7.2.13 There is no national database that records each child, where he/she is living, with whom and when he/she moves. GP records are the only records that always move with a child, if they register with a new GP. School records should move. Social care records never move with a child.

7.2.14 Stoke-on-Trent City Council is not aware of any national dataset for the comparison of pupil mobility but undertakes informal benchmarking with other authorities. The observations made are that the levels of mobility have increased in recent years but that this trend has also been noted in similar urban settings.

7.2.15 Since January 2000, schools undergoing inspection by Ofsted have been asked to provide data on pupil mobility. Inspectors and schools should now be able to access national data in order to make comparisons but it is unclear whether that data is available.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

7.2.16 Our best chance of keeping children safe and protected is if we know where each child is living and with whom and for the professionals working with the child to know about their family and their history. If children move about and their information does not move with them, we have an unsafe system.

7.2.17 There is a small field of research and reports in the area of pupil mobility including Strand & Demie (2007)[2], Machin, Telhaj and Wilson (2006)[3] and the National College for School Leadership's report "Managing pupil mobility to maximise learning"[4]

7.2.18 General conclusions appear to be that pupil mobility has a significant negative association with poor performance at GCSE level, even after including statistical controls for prior attainment at age 11 and other pupil background factors.

Finding Two

If processes for responding to a child's change of school are not always known and therefore implemented then there is no guarantee the child's information will move with them and there is a greater risk of children disappearing.

[2] http://wrap.warwick.ac.uk/53/1/WRAP_Strand_0481308-090708-Mobility_Lambeth_Secondary_2006.09.08.pdf
[3] http://cee.lse.ac.uk/ceedps/ceedp67.pdf
[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/339984/managing-pupil-mobility-to-maximise-learning-full-report.pdf

Summary

Our best chance of keeping children safe and protected is if we know where each child is living and with whom and for the professionals working with the child to know about their family and their history. If children move about and their information does not move with them, we have an unsafe system.

This case has highlighted that this is not happening routinely in Stoke-on-Trent.

Questions for Consideration by the Board

1. Does the Board consider the current policies and procedures around children moving schools are sufficient?
2. Does the Board know the extent to which is it known and used across schools?
3. What feedback is there from those who have to implement the policies and procedures about how practical and/or effective they are?
4. Are the multi-agency implications of the forecast numbers of children moving schools in Stoke-on-Trent being adequately considered?
5. How might the Board and member agencies help?

7.3 Finding Three

Is there a tendency in Stoke-on-Trent when working with compliant families under s.17, children Act, 1989 to work superficially, accepting information given by families without testing out the evidence?

How did the issue manifest in this case?

7.3.1 The primary source of information about a child, their family and their circumstances will come from the family itself; usually the mother and it can take time to build up a rapport with the family. Professionals then have to decide whether to accept that information at face value. The challenge for professionals will always be how to ascertain whether the information given is reliable. This should be done by testing the information out. In this case social care's single assessment was not informed by the agencies that knew the children best and there is no evidence that any professional tested out information given by the mother, for example when she said she would stop allowing her sister to care for her children it was accepted at face value.

7.3.2 The mother had six children and over the years three of them had gone to live with their father, other family members, or other people because the mother said she was having trouble coping.

7.3.3 During the mother's pregnancy with her sixth child, the Subject Child, there was no evidence of exploration with the mother about how she might cope with this baby, despite the fact that she had sent two of her children, who were aged eight and four, to live elsewhere because in her words, she was "struggling to cope". It is not common for a woman to keep having babies and then give them to the father to care for, or other relatives, or even other people as happened with Child 3 and yet everything the mother said about why her children were going to live with others was accepted, without her reasons being explored and no thought was given to the new baby in this context.

7.3.4 There is no suggestion in this case that the mother was not answering questions truthfully, or that she was hiding information from professionals. There is no suggestion of disguised compliance. There was also a considerable amount of evidence that the mother did what was asked of her. It was more about the type of questions that were asked. For example you will elicit a different response if you ask "Does each of the children have a bed?" as opposed to "Where does everyone usually sleep?" If questions only skim the surface it is likely the answers will too.

7.3.5 The mother was described as "likeable". She asked for advice and was seen to take the advice given. The home was always clean and tidy and there were no professional concerns about the care of the children. The relationship between the mother and her children was seen to be loving and reciprocal. The children who were known to live with their mother were all seen alone and all spoke very warmly of their mother. All of this meant that the workers did not question what the mother was telling them.

7.3.6 The mother told social care that Child 1 had lived with their father since they were three and this was accepted as fact however there was other information that Child 1 had gone to live with their father when Child 1 was one day old, that Child 1 had spent some time living with their father's ex-wife and that Child 1 had gone to live with their father when Child 1 was four and a half and the single assessment said that the mother had not seen Child 1 since the child was two. The answer is that no one really knows and it was not explored, the information given by the mother was just accepted.

7.3.7 Professionals asked the mother who the father of each child they knew about was. The mother gave different professionals different information. In most cases it is perfectly reasonable to accept what a parent tells us, we would not expect professionals to question, or challenge, every piece of information given by a parent, unless there are child protection concerns, which there were not in this case. What is key here is that if the professionals had talked to each other they would have realised the mother was saying different things to different professionals.

7.3.8 As set out in 5.3.3, what came from this review is that the answer someone gives will depend on the question that is asked, for example "How many children are

living in this home?" may elicit a different answer to "How many children have you got?" "

7.3.9 What has also been learnt following the death of the Subject Child is that the mother had had intimate relations with a few men over a period of time and that she had brought the men home. The day before the Mother and her children had been out with a man she had met recently. This man had wanted to stay with her that night but she had refused because another man she also had met recently was in her home and was staying that night. She had been asked about relationships but she said she did not want a relationship because she wanted to focus on the children but asking about relationships is not the same as asking about meeting sexual needs.

7.3.10 The night before the Subject Child died all of the children had slept downstairs. Workers had noted there were enough beds for each of the children but what this review teaches us is that the number of beds is not necessarily what is relevant, if the culture of the family is that it is normal to sleep downstairs. The case group does not know what the culture in this family was, in terms of the sleeping arrangements. All of the children had identified which was their bed to workers. This is another example of how we can work superficially without getting to the heart of the family and understand what is actually going on within the family.

How do we know it is an underlying issue and not something unique to this case?

7.3.11 Input from the review team and the case group suggests that particularly in cases that are not identified as child protection, information given by families may not be subject to the same level of scrutiny by the professionals. Information is more likely to be taken at face value, which can result in a more superficial response. (There was no view by the review team that this case should have been seen as child protection, in which case a response would be more urgent. There were minimal concerns about the children).

7.3.12 As one member of the case group put it "We were looking at what we could see, not what we could not see".

7.3.13 Although the single assessment template document does have a section on family history some members of the case group acknowledged they do not always ask for this.

How prevalent is the issue?

7.3.14 Professionals generally work on the basis of believing what parents tell them, until they have a reason to disbelieve, or unless they have concerns. A common finding from serious case reviews nationally is that professionals have been overoptimistic and we need to guard against that.

How widespread is the issue?

7.3.15 This is an issue that will affect all case work. 'Respectful uncertainty' should be inherent in all our work but we know that the reality is too often that the parents' word is accepted, without being tested out and it is particularly challenging when the mother seems to be doing everything that is asked of her and there are no concerns about the children.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

7.3.16 A safe system requires professionals to develop relationships with family members whilst also maintaining the ability to stand back and consider all the evidence. If professionals do not truly understand what is going on in any given family they will not be able to recognise the true level of risks and/or strengths and therefore put in place the right balance of support and scrutiny which is what results in a reliable multi-agency system.

7.3.17 Risks to children cannot be effectively assessed if the child's world is not fully understood by all professionals working with the family.

7.3.18 If we do not get to the heart of what the issues really are we will respond to the symptoms, not the cause.

Finding Three

Is there a tendency in Stoke-on-Trent when working with compliant families under s.17, Children Act, 1989 to work superficially, accepting information given by families without testing out the evidence?

Summary

We create a safe system if we understand the world from the child's perspective and know the reality of their life. If we do not have this information our understanding of the strengths and risks in the family will be limited and therefore ineffective.

Questions for Consideration by the Board

1. Does the Board know anything about the extent to which professionals across the city exercise professional curiosity about the families they work with?
2. Has the drive to work in partnership with families inadvertently reduced healthy levels of professional curiosity and 'respectful uncertainty'?
3. Are Board members routinely acting as champions for the safeguarding being everyone's business and modelling what being a children's champion means in day to day work and life?
4. Is it realistic to expect professionals in different agencies and professions to ask follow-up questions to parents and triangulate information given about children as a matter of course? If not, in what ways does the Board expect practitioners to be supported in prioritising where this is needed?
5. How would the Board know if the situation in Stoke-on-Trent improved or degraded in this respect?

Tools

What have we learnt about the tools and their use by professionals?

7.4 Finding Four

Organisational processes are premised on a family set up in which children live in only one place, usually with their mother, so struggle with arrangements of 'shared care' where children's residence is more fluid between key carers.

How did these issues manifest in this case?

7.4.1 There were a number of agencies involved, each of which will have required their own paperwork to be completed, yet most of the agencies did not know of all the siblings and none were clear of the living arrangements of all the children because their focus was only on the primary carer of the child, without understanding that the child might be living between both parents and therefore the care is shared and no one parent should take primacy. With the children who seemed to be living with the mother professionals only spoke to the mother, not the father and vice versa.

7.4.2 As a number of the children moved between each parent, the relevant professionals should have known of other agencies' involvement but they did not because their information gathering and assessment tools are premised on a child living with a primary carer. This meant there was confusion between professionals as to who was working with the family. For example, it was only through the serious case review that the children's centre learned of all the other agencies involved. (They had offered the mother an assessment but she had not wanted one and an early help assessment is voluntary). When social care accepted the referral and started working with the family they were unaware the family was receiving support from the children's centre, they only came to realise this through doing the assessment.

7.4.3 None of the professionals knew what Child 5's living arrangements were. The school believed Child 5 lived with their father full time and had no contact with their mother. This was an assumption they made because the only parent who came to the school was the father and when they had visited his home they had not met the mother. They had not thought to find out more about the child's living arrangements. They also did not know that Child 5 had only gone to live with their father a few days before Child 5 started at the school nursery. The mother told social care that the child lived with her and spent weekends with their father. There was no communication between Child 5's school and the professionals working with the mother and the children living with her, including social care.

7.4.4 School 1 only knew of three of the siblings. It was not until the serious case review that they knew of Children 1, 3 and 5.

7.4.5 Throughout the report there are examples of how we miss out on the subtleties of shared care, or more fluid arrangements. Most of our forms will ask very prescriptive questions about who the primary carer of the child is and who has residence of the child.

How do we know it is an underlying issue and not something unique to this case?

7.4.6 The case group and review team reported that it is not uncommon for some professionals to be unaware of which other professionals are working with the family, even when all the children live under one roof. Part of the problem is IT systems that do not "talk to each other".

7.4.7 Many of the families we work with are large and complex and the review team states it is not uncommon not to know about every strand of every family. As previously stated professionals are dependent, to a degree, on information given to them by families and some families will deliberately mislead.

7.4.8 The review team states that it is not uncommon, when siblings and half-siblings are living in different homes, for there to be insufficient liaison between the professionals working with each part of the family. Processes allow for professionals to focus on the children living in the home and to work with one parent. Apart from knowing the bare details of the absent parent there is no expectation that professionals will work across two households. It is not thought there are any forms that ask whether there are shared care arrangements in place.

How prevalent is the issue?

7.4.9 In Stoke-on-Trent there are 14,770 lone parent families. Of those 11% are lone fathers. It is not known how many children move between parents, or parents and other relations.

How widespread is the issue?

7.4.10 In recent years there has been a small but steady increase in shared care. Research suggests that in the UK at least 9% of parents share care - where a child spends the equivalent of at least three days and three nights per week with each parent. There is also growing policy interest across the political spectrum in shared parenting in its widest sense. The coalition government's agreement in 2010 stated: "We will encourage shared parenting from the earliest stages of pregnancy – including the promotion of a system of flexible parental leave".[5]

7.4.11 According to research[6] just over a quarter (26%) of households with dependent children are lone parent families, and there are two million lone parents in Britain today. There are three million children living in a lone parent household (23%

[5] http://www.oneplusone.org.uk/wp-content/uploads/2012/03/firm-foundations-report.pdf
[6] http://www.gingerbread.org.uk/content/365/Statistics

of all dependent children). Around 8% of lone parents in Britain (186,000) are fathers. Blended families are becoming more common and families are becoming more complex. The number of children, nationally, who move between parents, or other family members, is not known.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

7.4.12 If our organisational processes and forms are based on the premise that children live with one parent, usually the mother, we will not understand the complexities of many modern day families. This, in turn, will mean we are not capturing accurate data around families, or understanding the true nature of the family and therefore the child's world.

Finding Four

Organisational processes are premised on a family set up in which children live in only one place, usually with their mother, so struggle with arrangements of 'shared care' where children's residence is more fluid between key carers.

Summary

If we are to work effectively with families we need to understand the dynamics of the family. Families are becoming increasingly complex and our systems need to reflect that, otherwise we will have an ineffective system.

Question for Consideration by the Board

1. To what extent is this seen as a priority issue for Stoke-on-Trent?
2. Is there agreement about the extent to which this should be left to the initiative of individual workers or encouraged by the structure and design of processes and accompanying tools?
3. Does the Board think it would be helpful to review current processes and systems to ascertain the extent to which they work against professionals getting a good picture of children's living arrangements in all but the most standard family set ups?
4. Is the Board aware of the extent to which IT systems that do not "talk to each other" restricts the sharing of information currently across agencies?
5. Does the Board think genograms should be used routinely across agencies and those genograms then cross-referenced between agencies?

7.5 Finding Five

Is there a pattern in Stoke-on-Trent whereby certain family activities are accepted without question if badged as their 'culture', which increases the chance that the actual situation of the children involved remains unknown?

7.5.1 There are many different definitions of race, ethnicity and culture. For the sake of argument in this review I have used traditional definitions of race and ethnicity, which relate to biological and sociological factors respectively. Race refers to a person's physical appearance, such as skin colour. Ethnicity, on the other hand, relates to cultural factors such as nationality, culture, ancestry, language and beliefs.

How did these issues manifest in this case?

7.5.2 When Child 5 was about to start nursery at School 2 the school did a home visit. The record of the visit stated that the father was not there but there was an "Auntie" there. It was not clarified what relation this lady was to Child 5, she was known to School 2 because she had a child there. The home visit went ahead even though it was said to be very hard to communicate with this lady because of her limited English. It seemed to be accepted that it was fine to talk to this woman because they knew her and she was an "Auntie" although she knew nothing about Child 5 and part of the purpose of the visit is to find out more about the child before they start nursery, particularly around things like where they are with their toilet training because in the words of the school "That's what they do". During the review there have been several references by the frontline professionals to "That's what happens in their culture, lots of Aunties".

7.5.3 The most known about all the fathers was the father of Children 4 and 5. He was known to be from a West African country. When he was challenged by School 2 for putting Child 5 in a cupboard when the child was naughty, he was told by School 2 "that is not what we do in our culture". The view in the school was that in the African culture parents can be much more liberal with corporal punishment. The professionals did not know about the fathers, or in some cases their contact with their children and therefore the children's situation and strengths and risks in their lives remained unknown.

7.5.4 The mother told social care that Child 3 was living with her ex-partner's aunt and uncle in another local authority in September, 2013. Again, comments were made that this is not uncommon in "their culture". The mother has said she did not know who Child 3's father is and so Child 3, aged seven was going to live with people to whom the child was not related. Professionals had assumed that the father of Children 4 and 5 was also the father of Child 3 but this was not the case. Although social care did inform the local authority where Child 3 was now living of this arrangement, which was the right thing to do, there was no exploration, or consideration given by professionals as to whether this was in the child's best

interests. It seemed to be accepted because “that’s what they do”, even though this child was not actually related to the adults she had gone to live with.

7.5.5 Professionals accepted what the family told them about cultural practices, such as the giving of names and children moving between family members as fact, without testing them out, or challenging them. Accepting practice as “cultural” without querying it meant that the details of the children’s lives were not well understood and if we do not understand the child’s world we cannot assess levels of risk, or strengths.

7.5.6 The GP had only noted the Subject Child and Children 2, 3, 4 and 5 as “Mixed British”. School 1 had one child registered as “Any other mixed background” and one as “White and Black African”.

How do we know it is an underlying issue and not something unique to this case?

7.5.7 During the review frequent comments from members of the case group were “It’s cultural”, “it’s what they do”. There were also considerable assumptions made and the muddling of Black, African, Afro-Caribbean, West African and Jamaican, as if all people from those continents and countries have exactly the same culture because their skin is the same colour. If professionals are making assumptions about race and ethnicity with one family, they will be making them with others.

7.5.8 The review team confirms that there is a lack of understanding across agencies in Stoke-on-Trent about race, ethnicity and religion and the significance of it in a child’s life, which can result in an acceptance of family activities as “cultural”, without considering the impact on the child.

7.5.9 It is through doing this review that I have learnt that in the West African country the father of Children 4 and 5 originates from there are approximately 250 ethnic groups, or tribes. Approximately 40% of the country is nominally Christian, 20% are Muslim and 40% follow indigenous faiths, or are of no religion. Female genital mutilation is carried out in some regions, by some tribes. None of this was known to the case group, or the review team.

7.5.10 At that time social care’s single assessment form did not include a section on religion; therefore staff were not triggered to think about religion, it now does. Abuse does not happen as a result of a religion but as a result of a culture. Talking to families about religion is another way to try to understand the culture within the family. The review team and the case group both said this does not happen routinely in Stoke-on-Trent.

7.5.11 GPs do not have to record the ethnicity of children although it is deemed to be good practice to do so.

7.5.12 The review team has said it is not uncommon for schools not to record the ethnicity of their pupils, although they are supposed to.

How widespread is the issue

7.5.13 The review team is confident that what has been seen with this group of professionals, in terms of a lack of curiosity when working with families from the Black and Minority Ethnic community and accepting practice as "cultural", is not unique to this case and this group of professionals.

7.5.14 What we learn from serious case reviews is that a lack of sensitivity, or over-sensitivity plays a part when a child from the Black and Minority Ethnic community is thought to be being maltreated. We see over-representation of that group when we consider numbers of children who have died and been the subject of a serious case review and under-representation when we consider children on child protection plans. What that tells us is that the White/British majority are less likely to see abuse of a child from the Black and Minority Ethnic community. The first thing that some families from the Black and Minority Ethnic community will do, if they are questioned about abuse of their child, is accuse the worker of being racist. The response to that is often that the case is closed.

How prevalent is the issue?

7.5.15 The last census of England and Wales was in 2011. According to this the population of Stoke-on-Trent is 86% White/British[7]. The rest of the population is made up of a number of minority ethnic groups. This figure will undoubtedly have changed in the last four years. One can assume that as the majority of the population are White/British, the majority of those working with children will also be White/British.

7.5.16 I am not suggesting that the children in this family were being abused; only that White/British workers are too quick to accept "It's cultural".

7.5.17 This is an issue that will affect all case work. 'Respectful uncertainty' should be inherent in all our work but we know that the reality is too often that the parents' word is accepted, without being tested out.

7.5.18 It is a common feature of serious case reviews nationally that some information provided by families is not reliable. It is also a common feature that professionals working with the family have had little understanding of what is really happening within the family.

7.5.19 It is a common feature of serious case reviews nationally that professionals are over-optimistic when working with families.

[7] http://webapps.stoke.gov.uk/JSNA/JSNA.aspx?ID=408

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

7.5.20 If we are to truly understand the child's world and therefore the strengths and the risks within it we need to be making decisions that are based on evidence and not assumptions

7.5.21 If any agency does not have ethnicity and culture at the front of their mind and therefore possible implications, in terms of religion and/or cultural practices, they will not be asking questions about the child's experiences. This, in turn, means we will not truly understand the child's world and the strengths and risks within it.

Finding Five

Is there a pattern in Stoke-on-Trent whereby certain family activities are accepted without question if badged as their 'culture', which increases the chances that the actual situation of the children involved remains unknown?

Summary

In this case decisions were made based on what professionals believed to be "cultural" practice, sometimes because that was what the parents told them. As with all of our work we will create a safer system if decisions are based on evidence, not assumptions, and information tested out, so that we understand the child's world.

Question for Consideration by the Board

1. Have any issues been raised at the Board previously about how professionals respond to activities or behaviour deemed 'cultural'?
2. Does the Board know how often professionals in Stoke-on-Trent are working with families from the Black and Minority Ethnic community?
3. Does it surprise Board members that staff are so acting in this way around the issue of culture?
4. Does any intelligence exist about how common this is or isn't? Does the Board think it would be helpful to test this out more broadly?
5. Do Board members have any insight into what lies behind such responses?
6. Do you think it is currently easy for practitioners to raise questions or concerns they might have about cultural issues and how they should best respond to them, in their own organisations or in a multi-agency setting? What acts as a barrier? How might this be legitimised?
7. What support, if any, is provided to staff to help them be sufficiently knowledgeable about the main ethnic groups locally?
8. Is ethnicity and cultural practices and norms something that supervision and management oversight are routinely provided on, across different agencies?

8. Appendix

Glossary of Terms and Acronyms

LSCB- Local Safeguarding Children Board

SOTSCB – Stoke-on-Trent Safeguarding Children Board

SCIE – Social Care Institute for Excellence

School 1 – the school attended by Child 3 initially and Child 2 and 4 throughout

School 2 – the nursery/school attended by Child 5

School 3 – the school attended by Child 3 in the local authority the child had moved to

Child in Need - Under Section 17 (10) of the Children Act 1989, a child is a Child in Need if:

- He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
- He/she is a Disabled Child.

Child protection – Section 47(1) of the Children Act 1989 states that: Where a local authority have reasonable cause to suspect that a child who lives, or is found, in the area and is suffering, or is likely to suffer, significant harm, the authority shall make such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

Police Protection – under s.46 of the Children Act, 1989 the police have powers to take a child into police protection if he/she believes the child is at risk of significant harm, in a particular situation. This power only lasts for up to 72 hours

Private fostering – Private fostering is when a child under the age of 16 (or under 18 if disabled) is cared for by someone who is not their parent or a 'close relative'. This is a private arrangement made between a parent and a carer, for 28 days or more. Close relatives are defined as step-parents, grandparents, brothers, sisters, uncles or aunts (whether of full blood, half blood or marriage/affinity)

Pupil mobility - Pupil mobility is defined in this document as “the movement in and out of schools by pupils other than at the usual times of joining and leaving” This is the Ofsted definition from 2002.

Rapid response – as set out in Working Together, 2013, each LSCB must have a rapid response protocol when a child dies suddenly or unexpectedly

s.20, Children Act, 1989. Under s.20 a child can be voluntarily accommodated by the local authority, with the permission of those with parental responsibility

Working Together to Safeguard Children, 2013. The statutory guidance for inter-agency working to safeguard and promote the welfare of children.