

# Torbay Safeguarding Children Board

## Serious Case Review Executive Summary

Child 24

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Working together to ensure every child stays safe in Torbay

### **Family members and significant others referred to in this review:**

Child 24 (C24)	= Subject Child
Child 25 (C25)	= Sibling of Subject Child
MOC	= Mother of Subject Child
FOC	= Father of Subject Child
MGM	= Maternal Grandmother of Subject Child
PGM	= Paternal Grandmother of Subject Child
P1	= Previous Partner of Mother
P2	= Previous Partner of Mother
P3	= Partner of Mother

### **Glossary of Terms**

A&E	= Accident and Emergency
CA	= Core Assessment
CAF	= Common Assessment Framework
CAIU	= Police Child Abuse Investigation Unit
CAMHS	= Child and Adolescent Mental Health Services
CIN	= Child in Need
CNN	= Community Nursery Nurse
DAOs	= Police Domestic Abuse Officers
DNA	= Did Not Attend
DS	= Police Detective Sergeant
EDS	= Emergency Duty Service (Out of Hours Team)
EEG	= Electroencephalography
FSW	= Family Support Worker
GP	= General Practitioner
HV	= Health Visitor
IA	= Initial Assessment
IMR	= Individual Management Review
LSCB	= Local Safeguarding Children Board
MASH	= Multi-agency Safeguarding Hub
NFA	= No Further Action
PCHR	= Personal Child Health Record
PND	= Post Natal Depression
SCR	= Serious Case Review
SIG	= Street Index Gazetteer
SWS	= Social Work Student
TSCB	= Torbay Safeguarding Children Board

## 1. INTRODUCTION

### 1.1 Circumstances leading to the review

Child 24, a white British child, died in hospital in 2010 (aged 2 years 8 months), when her life support was withdrawn after establishment of brain stem death. She had been admitted to the Emergency Department by ambulance with cardiac arrest, having been found unresponsive at home.

1.2 The cause of Child 24's death has not been definitively established. She was known to have had a number of apnoeic incidents in the first year of her life.

1.3 However, throughout her life there were concerns expressed about neglect of the children's needs, and it was considered that neglect may have been a contributory risk factor.

1.4 Torbay Safeguarding Children Board (TSCB) therefore decided to undertake a Serious Case Review into the involvement of organisations and professionals in the lives of the child and family in line with Section 8.9 *Working Together to Safeguard Children 2010*.

1.5 Chapter 8 of 'Working Together 2010' sets out the circumstances in which a Local Safeguarding Children Board (LSCB) should consider undertaking a Serious Case Review. They include when:

- *a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; or*
- *a child has been seriously harmed as a result of being subjected to sexual abuse; or*
- *a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004; or*
- *a child has been seriously harmed following a violent assault perpetrated by another child or adult;*

***and*** *the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes interagency and/or inter disciplinary working.*

1.6 The purpose of a Serious Case Review is to:

- *establish what lessons are to be learnt from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;*
- *identify what those lessons are both within and between agencies, how and within what time scales they will be acted upon, and what is expected to change as a result; and*
- *improve intra-and inter agency working and better safeguard and promote the welfare of children.*

## **2. THE SERIOUS CASE REVIEW PROCESS**

2.1 The SCR sub-group of the Local Safeguarding Children Board met within a month after the death to consider whether a Serious Case Review should be recommended in respect of this child's death. A recommendation was made to the TSCB Independent Chair, Bob Spencer, and a SCR panel was set up with an independent chair, Mike Craddock. An independent author, Hilary Corrick, was appointed to write the Overview Report.

2.2 The Serious Case Review (SCR) sub-group of the TSCB established the following objectives for this serious case review:

- to examine and critically appraise the awareness of safeguarding concerns, and the appropriateness of responses, by agencies providing care for all members of Child 24's immediate family;
- to appraise the robustness of current arrangements for reviewing historical information and particularly safeguarding concerns within organisations at the point of referral;
- to evaluate the appropriateness of managerial and clinical oversight across service providers regarding interventions to safeguard Child 24, and the effectiveness of quality assurance systems employed to evaluate practice; and
- to generate practical recommendations for improving organisational arrangements, managerial/clinical oversight and professional practises in relation to families with a history of substance misuse and domestic abuse.

2.3 The serious case review process was managed by a panel that was independently chaired by Mike Craddock, an independent consultant who has previously worked as a senior manager in children's social care and as an Ofsted inspector of children's services. The overview report for the serious case review was written by Hilary Corrick, an independent consultant who has previously worked as a senior manager in children's social care.

2.4 Membership of the panel was as follows:

- Operations Manager, Children's Services
- Detective Chief Inspector, Devon and Cornwall Constabulary
- Head Teacher (LSCB representative for Torbay primary schools)
- Designated Doctor Torbay Care Trust
- Treatment Effectiveness Manager, for Public Health (Drug and Alcohol Action Team)
- Senior Probation Officer Devon and Cornwall Probation Trust
- Manager, Youth Offending Team

2.5 Individual Management Reviews (IMRs) were requested from:

- Local authority: Children's Services, to include Children In Need, Early Intervention Service and Surestart
- Local authority: Housing Needs Services
- Care Trust: Health Visiting /public health nursing
- Medical Practice: General Practice

- Health Care Trust: Paediatrics; Accident and Emergency (child and adults); Midwifery
  - Ambulance Service
  - Police Service
- 2.6 The Children's Services IMR included the Emergency Duty Service, (EDS), although this is in fact commissioned from the Care Trust.
- 2.7 A Health Overview IMR was produced to synthesise the findings of the four IMRs from health agencies and evaluate the practice of all involved health professionals.
- 2.8 The Terms of Reference for the IMRs were as follows:
- 2.9 **Were practitioners aware of and sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child's welfare?**
- 2.10 **When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was the information recorded?**
- 2.11 **Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?**
- 2.12 **What were the key relevant points / opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?**
- 2.13 **Did actions accord with assessments and decisions made? Were appropriate services offered / provided, or relevant enquiries made, in the light of assessments?**
- 2.14 **Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work outside of normal service provision e.g. those providing out of hours services or working during school holidays?**
- 2.15 **Were appropriate plans in place, e.g. CAF, Child in Need, Child Protection, Child Looked After, Pathway Plan, and were reviewing processes complied with?**
- 2.16 **Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?**
- 2.17 **Were more senior managers or other agencies and professionals involved at points in the case where they should have been?**
- 2.18 **Was the work in this case consistent with agency and LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?**

- 2.19 **Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?**
- 2.20 **Was there sufficient management accountability for decision making?**
- 2.21 **Are there any particular features of this case, or issues surrounding the death or injury of the child/children, that you consider require further comment in respect of your Agency's involvement?**
- 2.22 The scope of the review was agreed including timescales.
- 2.23 The authors of the IMRs were appropriately independent as they had not been involved with the family at any time.
- 2.24 This executive summary highlights the key issues identified by the serious case review and areas for further learning across the partnership.

#### **Parallel processes**

- 2.25 The Child Death process is underway as well as a Coroner's Investigation. Police enquiries have been completed and there is no criminal investigation underway.

#### **Family involvement**

- 2.26 The Chair and report author were able to meet with the child's maternal grandmother. Unfortunately, despite efforts, it did not prove possible to meet with either parent or other family members.

### **3. SUMMARY OF AGENCY INVOLVEMENT**

- 3.1 Child 24 was the second child of white British parents, who separated shortly after her birth. Her mother was only 18 years old at the time of her birth.
- 3.2 At the age of 4 months Child 24 had the first of a number of apnoeic episodes when she stopped breathing and was admitted to hospital. The last event of this nature known to have occurred when she was 6 months old, although she may have had subsequent episodes when medical help was not sought. Tests did not reveal epilepsy, although the medical view was that these tests did not rule out epilepsy.
- 3.3 The family was known to the police because there were a number of episodes of domestic dispute throughout Child 24's life, and before, between her parents and her father's family, and her mother and a subsequent partner. There were two occasions when the mother of Child 24 left her children with babysitters, did not return when expected, and could not be located, hence the police were involved. A further police visit occurred in 2010 when the police wished to interview a different partner. On two of their visits the police were very concerned about the conditions of the flat and notified Children's Services of their concern.

- 3.4 The health visiting service was routinely involved with the family following the births of Child 25 and Child 24. Both children failed to gain weight as they should have, and there was concern that they each moved down 2 centiles on the weight chart. In 2008 a health visitor noted the flat was “very dirty”. She was also concerned about the mother’s lack of engagement in support groups for young mothers.
- 3.5 A community nursery nurse provided support to the mother following this concern, and her role was taken over by a health family support worker for a 6 month period. Although there were some improvements to the state of the property, she remained concerned about the lack of stimulation for the children and there was evidence that the mother was reluctant to get involved with groups and did not always keep appointments with the worker.
- 3.6 Children’s Services received a number of referrals about the family, as well as notifications of incidents involving the police. The first referral, when C24 was four months old, was from an anonymous source, which said that MOC was not coping with her children, that the house was unclean, MOC was in debt, and the children were unstimulated and had not been out of the house for several days. Furthermore, MOC had recently had a dog removed for neglect. The referrer said she needed family support. The mother claimed the referral was malicious, and this was believed.
- 3.7 There were two subsequent referrals that month through the EDS. Although Children’s Services hoped that the health visitor would undertake an assessment using the Common Assessment Framework, there were tensions between the agencies, and eventually a joint visit was done, as a result of which an Initial Assessment (IA) was completed. A volunteer was provided through Children’s Services to support the mother, but in fact she was never able to make contact with the mother. The case was then closed.
- 3.8 Although Children’s Services were aware that the mother had left the children with babysitters and not returned when expected on two occasions, they accepted the police view that the children were safe and well and did not get involved.
- 3.9 At a later date, a social worker called at the flat looking for a friend of the mothers, and was distressed and concerned by what she found: the flat smelt very unpleasant. Both children were covered in faeces, as was Child 24’s bottle. MOC was seen to have bruises on her upper arms. The family now had a dog and the balcony was covered in dog mess. The social worker was very concerned about the children. A strategy discussion was held with the police. A later visit with the police found evidence of some cleaning and the situation was seen as not meeting thresholds for emergency action. A further visit from Children’s Services the following day completed an IA, with a plan to monitor and provide short term services. The case was allocated to a social work student.
- 3.10 There were four further referrals that year, three of them from concerned members of the public, including the children’s father.
- 3.11 Early the following year the police sent an urgent email to Children’s Services following their visit, expressing serious concern about the “appalling state of the home” which was filthy dirty, no food in the cupboards, no bedding. It did not prove possible to make contact or visit the family until two months later.

The mother denied any difficulties and because it proved impossible to maintain contact Children's Services made the decision to close the case.

- 3.12 Three months after this the family were evicted, and eventually rehoused the following month in privately rented accommodation.
- 3.13 There was a further anonymous referral to Children's Services, which was thought to be historic and not actioned.
- 3.14 Later the same month a referral was received from another service user concerned that the children were rarely fed and often hungry, the children stayed indoors all day and were sometimes locked in their room while the adults smoked cannabis, and the mother was regularly beaten up by her partner. A strategy discussion was held with the police and a joint visit took place the following day.
- 3.15 The flat was untidy and not very clean, not ideal but not reaching the level of criminal neglect. The children appeared well, and although the fridge was bare there was evidence of some food available. There was a smell of stale cannabis, but no evidence of drugs. There were some items of concern (2 samurai swords and a baseball bat which looked as if it had been adapted as a weapon) about which the police gave the mother advice. The immediate neglect concerns were not substantiated – no locks on the children's bedroom door, no evident drugs, and the mother had explanations for all concerns, although the police had doubts about her truthfulness. The threshold for child protection was not met. It was agreed to continue investigation with Children's Services as the lead, and an initial assessment was begun, with plans for a joint visit with the health visitor.
- 3.16 Three weeks later Child 24 was admitted to Torbay Hospital by ambulance having been found lifeless in her bedroom at home at 11am. Although she was put on to a life support machine she was believed to have sustained serious brain damage and the life support machine was switched off two days after admission.
- 3.17. Child protection medicals were carried out on Child 25 and the child of MOC's partner, who had been staying in the household. Arrangements were made for Child 25 to be cared for by her maternal grandmother and the partner's child by the child's mother. A strategy meeting was held with the police, children's services, the hospital, and health visiting staff. A full child protection enquiry (section 47) was started.

#### **4. ENVIRONMENTAL AND AGENCY CONTECT**

##### **Locally**

- 4.1 The Joint Strategic Needs Assessment for Torbay in January 2011 shows that Child 24 and her family lived in an area of Torbay characterised by significant deprivation and high levels of child poverty. Health practitioners, the police and Children's Services staff compared levels of neglect and deprivation within the family home with others in the local area without having a standardised mechanism for assessing individual circumstances.

## **The Parents**

- 4.2 The mother had grown up locally and was not assessed as having additional needs. She said that she had suffered post-natal depression after the birth of Child 25, and was prescribed medication when Child 24 was a baby. She was believed to have some mental health issues and was barely 18 when she was a single mother with 2 children under 2 years, one of whom had episodes which needed urgent medical care, circumstances which might identify her as a person needing additional support.
- 4.3 The father was also thought to be white British. He did not grow up locally so less is known about his upbringing. It was identified that his mother had very serious mental health problems which had caused him distress and family problems.

## **Agencies**

- 4.4 Both Children's Services and the health visiting services are described within the relevant IMRs as agencies under significant pressure from staff shortages, high staff turnover, stress and sickness, and the use of agency staff. A new Director of Children's Services took up her post in 2009 and commissioned an independent review of safeguarding practice which was critical of standards of professional practice and operational management. This was also the time of a national surge in referrals to Children's Services following the publicity surrounding the death of Baby P in Haringey, reflected in Torbay by a more than doubling of children subject to child protection planning, and a "drastic increase in the number of referrals to the Children in Need Service" (Children's Services' IMR).
- 4.5 The authority was the subject of an Integrated Assessment of Safeguarding and Looked After Children's Services in September 2010, and the safeguarding services were found to be inadequate with inadequate capacity for improvement, with performance management at all levels a particular weakness.
- 4.6 The author of the Children's Services' IMR, and SCR Panel members, describe a service in crisis for most of the period under review. Front-line staff and first line managers were overwhelmed by referrals and reactive, top-down senior management which focused on data and measurable indicators, while failing to recognise the pressure on front line services. In 2008 resources were shifted from children in need services into early intervention services, with the intention of reducing demand on the children in need services. However, not only was there no reduction in demand for the children in need services at that time, there was a "drastic" rise in referrals. This resulted in a service where some vulnerable children may have been at risk.
- 4.7 There have been a number of SCRs in recent years locally, many of which have made the same points about inadequate assessment, poor communication and knowledge not shared. These are very much in line with the findings of SCRs nationally. A recent local SCR was completed in July 2010 and highlighted the organisational and capacity issues detailed above and in the Children's Services IMR. It stated: "If the team continues to work under this pressure, they will continue to fail to change outcomes and this could be dangerous." The resulting action plan was barely implemented by the time of Child 24's death, and the Children's Services IMR author, and others, suggest that the situation has not changed since then.

- 4.8 By December 2010 additional resources had been made available to Children's Services, and a Performance Management framework was in place. Nevertheless, staff feedback to the IMR author continues to suggest an organisation where staff feel overwhelmed and insufficiently supported.

## 5. ANALYSIS

### **Awareness of safeguarding concerns and the appropriateness of responses**

- 5.1 The agencies primarily involved with Child 24 and her family - the health visiting service and Children's Services – appear to have considered the situation as one of low-level concern, with occasionally the situation worsening to child protection thresholds.
- 5.2 Since neither agency ever made a comprehensive assessment of the children's situation or needs, nor communicated in a thoughtful way with each other, neither agency was ever fully aware of the level of sustained and chronic neglect the children were suffering.
- 5.3 Indeed, no agency had a clear understanding of the features of neglect and there was no focussed assessment tool to judge the circumstances in which these children were living.

### **Arrangements for reviewing historical information at the point of referral**

- 5.4 The health visiting service maintains records and holds cases corporately, using a graduated level of response depending on need. Unfortunately Child 24 was born before there was a robust system of assessment as to the appropriate level of response.
- 5.5 Because health visiting is a universal service there is no "point of referral" and no obvious moment to review all the knowledge held by the service about a family.
- 5.6 The police are a universal emergency service, and as such they attend cases with little knowledge of the antecedents of the case. The disadvantage of a response based, 24-hour service such as the police is that individual incidents are dealt with on a "one-off" basis, which means that there can be a failure to consider historical and cumulative evidence. The IMR author proposes that an address based "**child concern**" **flagging system** be introduced so that officers can attend an address particularly alert for issues of child neglect and safety. This would be dependent on an assessment/decision-making mechanism for clarifying thresholds for flagging.
- 5.7 In Children's Services it would seem that checking historical information is done by referral coordinators at the point of referral. A recent management audit of decision-making at the point of referral showed that in all cases historical information is being taken account of by the referral manager, but that was not necessarily the case during the period of this review. In the case of Child 24 there were a significant number of "referrals" from police reports to calls from members of the public.

- 5.8 Had a chronology been undertaken at any point this would have meant that contacts and referrals were seen within an historical context. An early chronology that was updated as new information emerged would have been provided a context for the procession of Children's Services and EDS staff who had contact with the family.

**Managerial and clinical oversight and the effectiveness of quality assurance mechanisms.**

- 5.9 There is overwhelming evidence of a lack of management and clinical oversight in all settings.
- 5.10 There is no evidence of effective quality assurance mechanisms in any of the agencies which submitted IMRs.
- 5.11 Ofsted inspections have pointed to an endemic lack of supervision within Children's Services, and previous local SCRs have identified the lack of scrutiny relating to children in need cases, such as this one, compared to cases perceived to be within the child protection umbrella.
- 5.12 There is evidence of a worrying difference in perspective between senior managers and front-line practitioners and managers at the time, especially in Children's Services.
- 5.13 However, in all agencies there is limited evidence of some good managerial/clinical oversight.

**Lack of focus on the children**

- 5.14 While it is true that individual professionals were shocked and concerned about the care of the children neither of the agencies who might have been expected to have a detailed professional understanding of the developmental needs of small children (health visiting and Children's Services) undertook a thorough assessment of their development and their needs. At no time did anyone think of what it might be like to be a child living within this household.
- 5.15 The core assessment undertaken with Child 25 subsequent to the death of Child 24 shows that it is possible to work sensitively and thoughtfully with small children and to gain an understanding of their world.
- 5.16 It is too easy to suggest that it is not possible to communicate with very young children. Even if professionals do not consider that they have appropriate skills to undertake such work, it would not have taken a huge leap of imagination and empathy to consider the lives of these children.

**The invisibility of the father and other men in the mother's life.**

- 5.17 The father was the victim of the mother's harassment. On more than one occasion he demonstrated concern for his children. On the last occasion at least, he asked to be kept informed about the well-being of his children but there is no evidence that he was contacted again until after the death of Child 24.
- 5.18 There were a number of other men in the mother's life, and hence in close contact with the children. There is evidence that her relationship with one partner was abusive. He was controlling and threatening. She was seen to

have bruises consistent with being held very tightly, and there was concern about the care he gave to the children. A subsequent partner was known to the police to be violent. At no time was any attempt made to engage with any of these men, including the father, or to include them in assessments.

### **Assessment and planning**

- 5.19 Had there been a thorough, rigorous assessment of the children's development and needs, and the capacity of the adults around them, particularly MOC, to meet those needs then it would have been possible to make a realistic plan for the children and follow it through. The reality was however that neither of the two agencies who might have undertaken such an assessment – the health visiting service or Children's Services – did so, although Children's Services completed a number of IAs. These IAs were superficial and lacked analysis and chronological information.
- 5.20 Both organisations were under high levels of stress as a result of high demand, lack of capacity both on the ground and managerially, reorganisations and external demands. Nevertheless, this is not an adequate excuse for failing to complete work that has been allocated, to a reasonable standard.
- 5.21 Linked with this failure to assess robustly is the failure to think holistically. The state of the property was used by health workers and social work staff as an indication of the children's well being and an improvement in cleanliness and hygiene became an end in itself.

### **Collaborative working**

- 5.22 It is unedifying to note the level of acrimony between the health visiting service and Children's Services early in this child's life, with neither party believing the other is acting in good faith. Later interactions suggest that relationships improved over the period of the review.
- 5.23 Internal communication between health visiting staff and GPs remains difficult; communication between Housing and Children's Services is no longer effective, and the system of police notifications at the time did not always reach the case in a timely way. There is a lack of evidence of dialogue between Children's Services and the police, with a lack of informal discussion following joint visits or when concerns were raised, and no follow up by the police when they believed they had made referrals.
- 5.24 A number of IMRs referred to the extension of the Devon MASH (Multi-Agency Safeguarding Hubs) which will look at ensuring that all safeguarding intelligence is collated, reviewed and shared in an effective manner. This initiative will maximise information sharing opportunities regarding individuals or families and inform assessments and referrals. This will improve service delivery and encourage a holistic overview rather than incidents being dealt with on a 'case by case' basis. Very high expectations are placed on this new approach.

### **Disguised compliance**

- 5.25 A number of the IMRs refer to the mother's willingness to agree to attend groups, clean the flat, attend for the children's immunisations, and her failure

then to do so. Although she could be hostile to workers, generally she appeared cooperative and plausible, even when the story she was telling was clearly implausible.

- 5.26 The number of different social work staff and health visiting staff made it difficult to get beyond this level of defence, and this was made more difficult by what can only be construed as deliberate evasion. This meant that professionals spent considerable time and energy trying to make contact with the mother, time and energy which could have been spent working with her and analysing the impact of the neglect on the children's development.
- 5.27 What is known is that "resistant families" require long term, consistent, work, involving the provision of a dependable professional relationship rather than episodic interventions.

### **Substance misuse**

- 5.28 There were a number of references to the mother's alcohol and drug misuse. At no time was there any assessment of her alcohol and drug use, or the impact even low-level substance misuse can have on parenting capacity.

## **6. GOOD PRACTICE**

- 6.1 The review has sought to highlight areas of good practice where they existed; these were unfortunately limited in number, and when identified by IMR authors were too often only the starting point for good practice. The following areas of good practice were identified within the IMRs and agreed in the overview report:

### **6.2 For the police:**

- Officers shared concern about the mother's mental health with Children's Services on a number of occasions, showing a good understanding of the impact of mental health issues on children;
- Police showed sensitivity to the mental health needs of the father's mother, and awareness of the possible impact of her difficulties on her children.

### **6.3 Health**

- Persistence in trying to locate the family when they had been rehoused.
- Repeated and sustained attempts to get the children immunised.
- Good interagency work after the death of Child 24 so that procedures were followed and Child 25 was appropriately safeguarded.

### **6.4 Children's Services**

- High quality work with the family and Child 25 following the death of Child 24.

## **7. CONCLUSIONS AND LESSONS LEARNED**

- 7.1 It is not known what this child died of, and there is no evidence the death was preventable. But it is known that both of the children were living in bleak conditions for some periods of their lives, and that all involved agencies had intermittent concerns.
- 7.2 There is no evidence either that staff in any agency deliberately failed these children. Nevertheless, despite high levels of contacts and referrals in regard to this family, and known vulnerabilities, there was an authority-wide systemic failure to protect the children.
- 7.3 There was a significant volume of work undertaken to no effect. Although the context was one of high levels of referral and organisational stress, it is hard to see that this was an issue of resources; had the case been recognised as one of abusive levels of neglect on occasion, resources would have been made available.
- 7.4 In terms of Children's Services there was a failure to distinguish referrals which needed a robust and sustained approach from those cases which were less serious; in the health visiting service, despite concerns about the conditions the children were living in, there was no developmental assessment and follow through; the police thought in a blinkered way about criminal thresholds for neglect, rather than the situation these children were living in.
- 7.5 There are a number of occasions when opportunities were missed and there was a general failure to adopt a planned multi-agency approach. In every agency involved there were things that could have been done better. The key areas of failure however are:
- A lack of comprehensive assessment, particularly by Children's Services, but also by the health visiting service;
  - A failure to take adequate account of historic information;
  - A lack of understanding of the seriousness of neglect and its impact on children's development, and how to work with neglectful parents;
  - Agencies working in silos and little evidence of multi-agency working;
  - A failure to start from the day-to-day experience of the children.
- 7.6 These are lessons which have been reiterated in other SCRs and enquiries. Significant learning about each other's agencies and perspectives took place in the SCR panel during the process of this SCR. The agencies involved in this SCR need to reflect on how those lessons can be translated to front-line workers and managers.

## 8. RECOMMENDATIONS

- 8.1 There were a significant number of recommendations made for individual agencies contained within the full overview document. The following recommendations are for **Torbay Safeguarding Children Board to:**

- Examine the structural reasons why previous recommendations and action plans have either not been implemented, or, if implemented, have not achieved the outcomes sought.
- Ensure an agreed cross-agency performance framework, and institute a programme of case audit, which would include children, young people and their families as well as front-line staff.
- Ensure that all agencies have a shared agreed definition of what constitutes neglect, clarity about the impact of neglect on children, and a joint approach to thresholds and strategies.
- Produce a strategy for resistant families, ensuring that agencies are aware of the importance of working together with a clear, shared approach with resistant families and those who use false compliance to avoid involvement with services.