

NORTH YORKSHIRE SAFEGUARDING CHILDREN BOARD

Serious Case Review

'Child D'

Executive Summary

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1. Introduction

- 1.1 This Serious Case Review (SCR) has been undertaken by the North Yorkshire Safeguarding Children Board (the LSCB), a multi-agency partnership which is the key statutory mechanism for agreeing how local organisations will co-operate to safeguard and promote the welfare of local children. The SCR has been undertaken in accordance with the statutory guidance set out in Working Together to Safeguard Children – Chapter 8: Serious Case Reviews (HM Government 2009).
- 1.2 The guidance states that when a child dies, and abuse or neglect is known or suspected to be a factor in the death, the LSCB should always conduct a SCR into the involvement of agencies and professionals in the lives of the child and family, in order to learn lessons about the way in which those professionals and agencies worked (both individually and together) to safeguard and promote the welfare of children.
- 1.3 The purpose of SCRs is to improve working within and between agencies, by establishing what lessons can be learned from the case, and translating lessons into actions which will bring about change.
- 1.4 SCRs are not inquiries into how a child died, or into who may be responsible for the death. These are matters for the Coroners and Criminal Courts respectively. Nor are SCRs part of any disciplinary inquiry or process relating to the practice or conduct of individual professionals.
- 1.5 This Executive Summary is a public document which summarises the key issues arising from the case, and recommendations for action.

2. Summary of Circumstances leading to the SCR

- 2.1 Child D, the oldest of three children, died suddenly and unexpectedly at the age of 12 years. Child D was disabled and had complex health needs as a result of a condition which affects physical and intellectual development in children. It caused Child D to have global developmental delay and to experience a range of health and behavioural problems which necessitated the involvement of a large number of medical and health professionals throughout Child D's life. Children's Social Care was first involved with Child D and the family in 1999, and has had continuous involvement from early 2002. Child D attended a school for children with Special Educational Needs.
- 2.2 The younger siblings of Child D are bright, healthy children who attend local schools where they are making good progress.
- 2.3 Although Child D had very complex health needs, the death was completely unexpected. Child D's father (DF) had found Child D face down on the bedroom floor in an awkward position one morning, and called an ambulance. Attempts at resuscitation were not successful, and very soon after admission to hospital, Child D's death was confirmed.
- 2.4 A post mortem examination was undertaken. This did not establish a cause of death and no concerns about abuse or neglect were identified. In accordance with routine procedures, tissue samples and other specimens were taken for further tests, and the Coroner opened and adjourned an inquest.
- 2.5 A 'rapid response', for the purpose of enquiring into Child D's unexpected death, was made in accordance with LSCB Child Death Review Processes. Key professionals attended an Initial Case Discussion meeting about a week after the death, to consider the circumstances in which Child D had died. A cause of death had not been established at this time, but no suspicions about abuse or neglect were identified. Child D had been seen for a regular health review the day before the death by a Consultant Paediatrician who knew the child well and who had had no concerns.
- 2.6 About 4 weeks after Child D's death, the Police received the results of the toxicology tests which had been ordered at the post mortem examination. The results identified that Child D had ingested a significant quantity of a prescription drug. It was established, that this drug had been prescribed to Child D's mother but never to Child D. In the opinion of the Consultant Paediatrician, Child D was unlikely to have been able to self-administer the drug due to the disability which affected manual dexterity.
- 2.7 Initially, it was not known whether the ingestion of the drug by Child D was the cause of death, but it was later established that it was. The toxicology test results were shared with Children's Social Care and this

triggered consideration of the need for action to protect Child D's siblings within the context of multi-agency child protection procedures. Children's Social Care's involvement with the family in relation to the protection and welfare of the siblings is ongoing at the time of the conclusion of the SCR.

- 2.8 In the light of the findings about the cause of Child D's death, the Police arrested the parents on suspicion of an offence connected to the death and they were subsequently released on unconditional bail. The eventual outcome of a review of the case by the Crown Prosecution Service was that there was insufficient evidence to bring a criminal charge relating to Child D's death against either parent. A significant factor was that it was not possible to establish the circumstances in which Child D had come to ingest the drug. The criminal investigation had concluded by the time the SCR was complete, and no-one has been found to have been responsible for causing Child D's death. At the reconvened inquest, the Coroner returned an "Open Verdict" on the basis that there was insufficient evidence to establish how Child D came to ingest the drug.

3. The Serious Case Review Process

The Decision Making Process

- 3.1 Ten months after Child D's death, the standing SCR Sub Group of the LSCB considered the circumstances of the case and recommended to the Independent Chair of the LSCB that the criteria for undertaking a SCR were met. This recommendation was accepted by the Independent Chair.
- 3.2 The standing SCR Group of the LSCB then considered in greater detail, the information known about Child D and the family and, in the light of this information, agreed the scope of the review (ie what period of time the review should cover), detailed terms of reference, the timescale for starting and completing the review and which agencies should contribute to it. The SCR Sub Group commissioned a SCR Panel to manage the review.
- 3.3 After the SCR began, it became apparent that it would not be possible to complete it within the agreed timescale. This was because, through consultation with the Coroner, it became clear that the inquest was unlikely to be held within the original timescale for the SCR, and as a consequence, information which would be significant to the SCR (i.e. about the outcome and conduct of the post mortem examination) could not be made available to it. Therefore a revised timescale for the completion of the SCR was agreed. The LSCB agreed an interim action plan to address some immediate issues arising from the case.

The Terms of Reference

- 3.4 To maximise the opportunity for learning, it was agreed that events in the child's life should be reviewed from the beginning of 2002 (a year during which there was an incident which could have significance for the SCR) until the end of 2009 (to allow consideration of decisions and actions taken to protect the other children of the family). The SCR Sub Group considered the most important issues for learning from the case and decided that the SCR should address the following questions:

Was the impact (potential or actual) of the parents' mental health issues on the safeguarding of the children fully recognised, assessed and responded to by agencies?

Did the socio-economic background and employment of members of the wider family influence the actions and decision making of agencies?

In the light of the matters referred to in the above questions, was the focus on the child sufficiently strong?

Was appropriate advice given to the family about the safe storage of medication?

Eighteen types of prescribed medication were found in the house – what was the medication and who was it prescribed for?

Were the concerns by the mother with regards to Child D's sleeping pattern recognised and assessed correctly and what (if any) was the effect of that sleep pattern on the parents and the other siblings?

Were there any events, or was there any information given to professionals that should have triggered an assessment and/or safeguarding processes and was the work in this case consistent with each agency's and the LSCB's Procedures for Safeguarding Children?

Did professionals rely too heavily on the family's own reporting of the extent of Child D's disability?

What, if any, impact did the nature and extent of the child's disability have on the recognition of any signs of abuse and on agencies' understanding of the needs of the child, parents' and carers' needs and on service provision/response?

Were sufficient and appropriate efforts made to ascertain Child D's wishes and feelings, and when ascertained, were these acted upon appropriately?

Following the death of Child D, was appropriate action taken to protect the other siblings?

Are there any lessons to be learned about the conduct of the post mortem? In particular, should either a Paediatrician or Paediatric Pathologist have been involved? If the current guidance and procedures do not require this, should they be amended to do so?

Contributors to the SCR

- 3.5 Individual Management Reviews (IMRs) were undertaken and reports provided by the following agencies:

North Yorkshire County Council Children and Young People's Service - Education (School and local authority services relating to Special Educational Needs)

North Yorkshire County Council Children and Young People's Service – Children's Social Care (Disabled Children's Service and Assessment and Safeguarding Team)

NHS North Yorkshire and York Community and Mental Health Trust (Primary Care Trust) (Health Visiting, School Health Service,

Community Mental Health Service, Speech and Language Therapy, Physiotherapy, Occupational Therapy)

South Tees Hospitals NHS Foundation Trust (Hospital Paediatric Service, Acute Mental Health Service, Diabetes Clinic)

General Practitioner

North Yorkshire Police

Barnardo's (Short break service)

NHS North Yorkshire and York PCT (Commissioners' IMR/ Health Overview Report)

Family Involvement in the SCR

- 3.6 Child D's parents were sent information about the SCR in the form of a letter from the LSCB Manager which explained the purpose of the SCR and how they could contribute to it. The Independent Chair of the SCR Panel and the overview report author subsequently met the parents to further clarify the SCR purpose and process, and to provide an opportunity for them to contribute. Their views about the services which they received during Child D's life, and actions taken following the death, have been incorporated into the full report of the SCR (the Overview Report). Parents were also offered the opportunity to make a written contribution to the SCR but chose not to.

LSCB Chair and SCR Panel Membership

- 3.7 The current Independent Chair of the LSCB is Nancy Palmer, who was the chair at the time of the decision to undertake this SCR. The SCR Panel has been independently chaired by Anne Hutson who is an Independent Consultant with wide ranging experience in the field of safeguarding children, as a manager in different organisations, as the author of a number of SCR Overview Reports and as the Independent Chair of SCR Panels. She has never been employed by any of the organisations which are represented on North Yorkshire Safeguarding Child Board.

Membership of the SCR Panel is as follows:

Organisation	Job Title
North Yorkshire County Council Children and Young People's Service	General Manager for Children's Social Care
North Yorkshire County Council Children and Young People's Service	Principal Education Social Worker

NHS North Yorkshire and York	Designated Doctor for Child Protection
NHS North Yorkshire and York	Designated Nurse/Nurse Consultant for Safeguarding Children
North Yorkshire Police	DCI, Protecting Vulnerable Persons Unit
North Yorkshire Safeguarding Children Board	NYSCB Manager

The Overview Report Author

- 3.8 The overview author is Barbara Williams, an Independent Consultant in the field of safeguarding children and children’s social care. She has significant experience in relation to safeguarding children, formerly as a senior manager in local authorities, and as the independent author of a number of SCR overview reports. She currently chairs two LSCBs in another region, and has never been employed by any of the agencies represented on North Yorkshire Safeguarding Children Board.

Related Processes

- 3.9 At the time of the decision to undertake a SCR, a criminal investigation was ongoing. It ended before the conclusion of the SCR, with no charges being brought against any person in connection with Child D’s death. When the SCR process began, it also was known that an inquest had been opened and adjourned, and when the review began, no date had been set for the re-convened inquest. Consultation with the Coroner during the SCR process about the implications of this, led to an extension to the time for the completion of the SCR being agreed so that essential information about the post mortem examination could be included within the information available to the SCR without risk of compromise to the process or outcome of the inquest.

4. Summary of the key facts

- 4.1 Prior to the unexpected death of Child D, professionals who were involved with the children and the family had not had significant concerns about the health or wellbeing of the children, or the care given to them by their parents. Overall, they were seen as happy children who were progressing as expected. There was known to be a supportive extended family living locally, and the family was well integrated into the local community.
- 4.2 However, there were two factors in particular which meant that the family had required the involvement of a very large number of professionals over a significant period of time, from well before the period covered by the SCR. The first factor was Child D's disability and associated complex health needs, and the second was Child D's mother's mental and physical health.

Child D's Complex Health Needs

- 4.3 Child D's disability affected all aspects of physical and intellectual development. It caused problems with mobility, vision, hearing and communication. Child D also had many health problems which led to frequent periods of hospitalisation, and there was also a need for surgery, e.g. to try and improve impaired vision. Child D's health and medical care necessitated the involvement of a large number of professionals from a wide range of specialisms, and was kept under regular review by a Consultant Paediatrician.
- 4.4 A specific health problem caused Child D so much discomfort at times that it was thought to be the cause of self harm through such behaviours as head banging and hair pulling. Child D also had a poor sleep pattern and would often wake several times during the night. This affected the whole family and was a particular source of stress to the parents. Also, during the period under review, Child D was taken to the Accident and Emergency Department on a number of occasions having swallowed or chewed objects or substances which were potentially harmful. There was also a number of minor injuries as a result of knocks and falls. These were mainly seen as being consistent with Child D's mobility difficulties.
- 4.5 Child D had a Statement of Special Educational Need which was regularly reviewed and updated as required. School reported that good progress was made against the individual targets set for Child D, who appeared to be happy in school and had learned to communicate about needs, likes and dislikes.
- 4.6 Despite having such complex health and educational needs, Child D made good progress in relation to reaching individual potential, but required a high level of care and supervision at home. Children's Social Care was involved from 2002 in assessing Child D's and the family's need for support.

Mother's Mental Ill-health

- 4.7 Child D's mother (DM) had experienced mental health problems from some years before the period covered by the SCR. She suffered from periods of anxiety and depression and at times, her symptoms became so acute that she required in-patient hospital treatment. She also had a physical health condition which required regular medication, but there were times, particularly when she was feeling depressed, when she did not take the medication regularly, which was likely to have led to her feeling physically unwell. DM's mental ill-health had an adverse impact at times on her ability to meet the day to day needs of the children, although at such times, their father was supportive and involved with the care of the children. The stress associated with caring for a child with complex needs and associated behavioural difficulties also had an impact at times on DM's emotional health, especially when Child D's sleep disturbance caused her to feel exhausted. Her engagement with mental health services was characterised by seeking help at times of acute need, then withdrawing when she felt better, so that treatment programmes were usually not completed. However the full impact of DM's mental health on her parenting, was unknown to many of the professionals who were involved with Child D and the other children, until after Child D's death.
- 4.8 As a consequence of both Child D and DM having numerous different health needs, there was within the household a large range and quantity of prescribed medications as well as those which had been bought 'over the counter' (non-prescription medicines). After Child D's death, it became apparent that these had not been stored safely and securely.

Key Events

- 4.9 In 2002, Child D was alleged to have sustained a minor injury having fallen from a first floor bedroom window, although there is no record of any medical treatment having been sought. No enquiries were made into the circumstances of the alleged incident in the context of Child D's mobility difficulties, but advice was given about safety measures by the Social Worker and an Occupational Therapist. Later the same year, Child D was admitted to hospital having ingested two of DM's tablets which the child was said to have found while playing. Child D received appropriate medical treatment, requiring admission to the Intensive Care Unit of the hospital, but opportunities to make further enquiries about the circumstances in which the tablets had been accessed and to give advice about safe storage of medication, were not taken. During the period under review, there was a number of other occasions when Child D swallowed objects which did not prompt the giving of safety advice.
- 4.10 Early in 2003, the Social Worker (Disabled Children's Service) undertook work on a Core Assessment which was then periodically updated. Child D was recognised to have complex needs and it was recommended that overnight short break care be provided to support

the family. Due to the complexity of Child D's needs and some anxieties on the part of parents, it was over a year before this service could be provided through a link to a family registered with a national voluntary organisation.

- 4.11 During 2005, DM had a period of mental illness which required in-patient treatment. Although Child D was noted to be making good progress in school, and to be in generally good health, sleep disturbance, for which no medical cause could be found, was a particular problem and had caused considerable stress to DM.
- 4.12 During 2006, the short break arrangement came to an abrupt end when parents raised concerns about aspects of the carer's conduct. This was fully investigated and appropriately addressed by the voluntary organisation, but there was a gap of about a year before a replacement service could be provided at a local authority residential centre. Once established, this arrangement was effective in helping to meet Child D's and the family's support needs.
- 4.13 Child D died unexpectedly in 2009, aged 12 years. At the time of the death and in the four weeks following it, there were no suspicions that abuse or neglect could have been factors in the death, although its cause had not been established. Following the receipt by the Police of the results of toxicology tests which showed that Child D had ingested a prescribed medication (which was later identified as the cause of death), and in the light of information that the medication in question had never been prescribed to Child D who would have been unlikely to be able to self-administer it because of limited manual dexterity, consideration of the need to protect Child D's siblings was given within the framework of multi-agency Child Protection Procedures.
- 4.14 Professionals from Health, Children's Social Care, Education and the Police shared information and agreed actions to be taken in three strategy meetings which were held in the six months following Child D's death. Initially, the need to take action to protect Child D's siblings was not identified, but this changed when the parents were arrested in connection with the death, about three months after Child D's death. At this point, it was agreed that the parents (who had been released on bail) should have no unsupervised contact with their children pending the outcome of assessment, and they entered into a written agreement with the local authority (Children's Social Care) that their children would be cared for by close extended family members who would also supervise the parents' contact with the children. (This arrangement continued for a further fifteen months before the children returned to the care of their parents.)
- 4.15 An Initial Child Protection Case Conference was held seven months after Child D's death by which time it had been established that Child D's death had been caused by ingestion of a medication which had been prescribed to Child D's mother. Child D's siblings were not made subjects of Child Protection Plans because their parents had co-

operated with the terms of the written agreement and the children were living with extended family members and having no unsupervised contact with their parents. Thus they were not considered to be at risk of significant harm.

- 4.16 The criminal investigation concluded fourteen months after Child D's death. Review of the case by the Crown Prosecution Service had found that there was insufficient evidence to charge either parent with any offence related to the death, and no other person has been found to be responsible. The Coroner returned an 'Open Verdict' at the resumed inquest almost 1½ years after the death. Clear evidence of how Child D came to ingest the medication which was the cause of death had not been found and the Coroner's view was that there was no evidence that either parent had harmed Child D.

5. Key themes arising from the case.

- 5.1 Given that it has never been established how Child D came to ingest the prescription medication which was the cause of death, and that no-one has been identified as having been responsible for the death, it has not been possible to reach a conclusion about whether the outcome might have been different if different actions had been taken. However, detailed consideration of how agencies and professionals assessed and met needs in the period before Child D's death, and of the work undertaken to protect Child D's siblings after the death, has provided the opportunity to learn lessons and identify improvements which can be made.

Assessment, Information Sharing and Co-ordination of services

- 5.2 Good information sharing and assessment of need are important in ensuring the effectiveness of services and support to a family. In this case, the professionals separately held a considerable amount of information about Child D's needs and mother's health. This had been gained from detailed, specialist assessments but there was no single assessment which created a whole picture of needs and family strengths. A multi-agency forum for regularly sharing information, planning and reviewing plans, was not used. As a result, although there are good examples of communication between professionals, practice in this area was not consistently good and some professionals were not aware of some of the difficulties experienced by family members. Co-ordination of services is particularly important when there is a large number of professionals involved, but in this case, there was a tendency for professionals to work in 'silos' ie to view aspects of need narrowly, solely from the perspective of their own discipline.

The Impact of Parental Mental Ill-Health on Parenting

- 5.3 Although reports of the children's care and wellbeing were positive overall, there was evidence that Child D's mother's mental ill-health did at times impact on her parenting ability. However, although it was not felt that mother's mental health placed the children at significant risk of physical harm, the wider nature of the impact was never fully addressed in assessment. Mental Health Professionals and the GP did not recognise the need to share information about the potential impact of mother's mental health with other health professionals or with Children's Social Care, and in undertaking work on Core Assessments, the Social Worker did not seek information from health professionals about it. This was partly the result of mother's unwillingness for information to be sought, but her anxiety about this was not addressed with her.

Child Focus

- 5.4 The review found evidence of a strong focus on Child D's needs with many references in agency records to care, health, development, behaviour, likes and dislikes. However, observations tended to be made from the perspective of each professional's particular specialism and a picture of the 'whole child' does not emerge clearly. In school, work was undertaken to enhance Child D's ability to communicate and exercise choice, but opportunities to use these approaches more broadly to discover more about how he experienced his circumstances were not taken.
- 5.5 The impact of Child D's complex needs and mother's mental ill-health on the other children was not fully assessed.

Safe Storage of Medication

- 5.6 The multiple health needs of different family members resulted in there being in the household a large quantity and range of medications. In such circumstances, it would have been good practice for advice about safe storage of medication to be given to parents in any family with young children. In this family, Child D's tendency to swallow substances and objects which could be harmful, should have alerted professionals to the particular need for such advice, but there is no evidence that any was given until after Child D's death.

Assessment of Child D's sleep pattern

- 5.7 Child D's poor sleep pattern had an impact at times on the whole family and was a major source of stress to the parents. It is a recognised feature of Child D's particular condition, and was viewed and managed as a 'medical problem' through the prescribing and review of medication. Detailed paediatric assessment failed to identify a specific cause, but opportunities to discover whether there may be other contributory factors (eg behavioural or environmental) were not taken even though the Social Worker was aware that Child D had a better sleep pattern when in short break care – information which was not shared with the Paediatrician.

Assessment and Implementation of Safeguarding Procedures

- 5.8 In the period before Child D's death, the author has not found evidence that multi-agency Child Protection Procedures should have been implemented. However there were events which should have prompted further enquiries, and some opportunities for assessment which should have informed decision making, were not taken – although it cannot now be known whether such enquires would have led to different courses of action.
- 5.9 Events which should have prompted further enquiry were Child D's alleged fall from a first floor window and admission to hospital in 2002

following the ingestion of two tablets – a potentially lethal dose for a child of that age. Subsequently, Child D's attendances at A&E (at least 5 more between mid 2002 and 2007), when objects had been swallowed or chewed, should have prompted enquiry about the circumstances, and consideration of the possibility that parents were not providing a safe environment. Although details of each hospital admission and attendance at A&E were sent to the GP and School Nursing Service, an overview was not taken and the possibility that there may be an emerging pattern which could have indicated the need for planned work on safety issues with parents, was not recognised.

Impact of the Child's Disability on Professionals' Recognition of any Signs of Abuse and Understanding of the Child's and Parents' needs.

- 5.10 Factors which can impact on the ability of professionals to recognise risks and wider needs, when a child is disabled and/or has complex health needs, have been well documented in the literature and may help to explain why, in this case, further enquiries (ie in the circumstances described above) were not made.
- 5.11 Professionals were very strongly focused on assessing and meeting the needs which arose from Child D's disability and complex health needs. This may have contributed to a lack of focus on the significance for the child's safety of the ingestion of potentially harmful substances and objects. Information given by parents tended to be accepted at face value without challenge, which is common when professionals have a strong sense of empathy with parents who are felt to be under considerable stress. All of the professionals who were involved with Child D had expertise in childhood disability, but not all had significant experience in recognising possible signs of abuse and neglect. The problem of sleep disturbance was known to be a common feature of Child D's particular condition, and was managed as a 'medical problem'. Thus opportunities to consider other possible causes and to assist parents in developing strategies to manage the problem, were not taken.

Action taken to Protect the Children following the Death of Child D

- 5.12 Following Child D's death there is evidence that in the decision making and actions to assess risk of harm and to safeguard the other children, child protection procedures were not correctly followed. Once the parents had been arrested on suspicion of an offence connected to Child D's death, action was taken to safeguard the other children by securing the parents' agreement for them to stay with close relatives, and for the parents to have no unsupervised contact with the surviving children.
- 5.13 However, decisions were not clearly based on assessment of risk, strategy meetings were incorrectly used and the record of decisions and actions in the minutes of strategy meetings is not sufficiently clear. The criteria for convening an Initial Child Protection Conference (ICPC) were

not applied correctly and the timescale for convening an ICPC was not adhered to. Enquiries by Children's Social Care into the need for action to safeguard the children (s47 enquiries) and the criminal investigation by the Police, were not jointly planned. This contributed to delay in considering the need for action to protect the children once the result of toxicology tests had been received, and to lack of clarity about information sharing. A consequence of using strategy meetings (as opposed to Child Protection Conferences) as the multi-agency forum for agreeing action, was that parents did not have the opportunity to make a direct contribution as it is not LSCB policy or practice to invite parents to attend strategy meetings.

The Post Mortem Examination

- 5.14 The SCR provided an opportunity to consider whether there were lessons to learn about the way in which the post mortem examination was conducted. The Coroner was provided with a case summary prior to the core post mortem examination which was carried out in accordance with national and local guidance within 48 hours of the death by a Consultant Paediatric Pathologist. At the time of the initial post mortem examination, there was nothing to indicate a suspicion of abuse or neglect, and nothing came to light during the examination which raised such suspicion. Thus there was nothing to indicate that the examination should have been carried out jointly with a Forensic Pathologist, which is a requirement if abuse or neglect is suspected. The post mortem examination did not identify a cause of death and samples of tissue and other specimens were taken for further investigation. Hair samples were not taken at the core post mortem examination as these are not specified in guidance among those which should routinely be taken, and this had an impact on the process of the criminal investigation.

Supervision of Staff

- 5.15 The importance of effective supervision to the quality of practice, the skills, knowledge and confidence of practitioners and, ultimately to outcomes for children and families, has long been recognised. However, the analysis of practice in this case does not provide evidence of good quality supervision which could have challenged practitioners to think differently about their work and about their roles in relation to other agencies and professionals.

Organisational Factors

- 5.16 There is no evidence that organisational factors such as organisational change, high staff turnover and vacancies, which are commonly found to have a negative impact on service quality, were present in this case. In fact there is evidence of good continuity of professional involvement. The Consultant Paediatrician who had overall clinical responsibility for Child D's health care was involved throughout the period under review, as was a Social Worker. Child D's health and educational needs were fully met, but there was some delay in providing overnight short break

care to support the parents. This was due in part to the complexity of Child D's needs, and to some anxiety on the part of his parents which contributed to difficulty in identifying carers which were seen as being a suitable match to Child D's needs.

6. Priorities for Learning, and Recommendations

- 6.1 Although it has never been established how Child D came to ingest the prescribed medication which was the cause of death, and no-one has been identified as having been responsible for the death, the SCR has provided the opportunity to learn lessons about the way in which professionals and agencies worked together in this case, and to make recommendations for change.

Multi-agency working when children have complex needs

- 6.2 Effectiveness in meeting the needs of children and families when children have complex needs, requires professionals to work together to ensure that needs are clearly understood, and services are well co-ordinated around the child and family. Arrangements for information sharing and multi-agency assessment must be in place, so that the provision of services is based upon a whole picture of the child's and family's needs and strengths. There should be a plan which identifies the outcomes which are to be achieved, and the services which are to be provided, and this plan should be reviewed regularly and revised as appropriate in response to changing need.

The impact of parental mental ill-health on parenting

- 6.3 It is important that staff who work within adult mental health services, as well as those who provide services for children, understand the impact of parental mental ill-health on the wellbeing of children and also understand the implications for their roles and responsibilities, including when, and with whom, to share information.

The impact of disability on the recognition of wider needs

- 6.4 It is important that the impact of a child's disability and associated complex health needs on the identification of wider needs and issues for the child's care and wellbeing, are fully recognised. The review has highlighted the importance of staff understanding factors which increase the vulnerability of disabled children to abuse and/or neglect and of them knowing when further enquiries should be made.

Compliance with Child Protection Procedures

- 6.5 Multi agency Child Protection Procedures provide a framework for co-ordinating the actions of professionals when there are concerns about a child's safety or welfare. The procedures specify the purpose of different types of multi-agency meetings and help to make clear the relationship between different processes, and the respective roles of different professionals. It is important that the LSCB has in place robust arrangements for monitoring compliance with the procedures and for ensuring that professionals understand the circumstances in which strategy meetings, Child Protection Conferences and meetings to review plans for Children in Need, should take place.

The Post Mortem Examination

- 6.6 The SCR has identified an opportunity to consider improvements to aspects of the way in which post mortem examinations are conducted eg by giving consideration to extending the range of samples which are routinely taken, to include hair samples.

Staff supervision

- 6.7 Reflective supervision of staff is an important way in which staff are supported in their work and enabled to understand their role in relation to that of other involved professionals, and to reflect on decisions and actions in a particular case. It is important that the LSCB checks that all partner agencies have in place appropriate arrangements for the support and supervision of staff, with regard for the roles and responsibilities of the organisation.

Serious Case Review Process and Practice

- 6.8 In addition to learning about the way in which professionals worked together in this case, there is learning about the Serious Case Review Process itself and the interface with Child Death Review Processes. Some delay in concluding the SCR could have been avoided if earlier consideration had been given to the question of whether the criteria for undertaking a SCR were met in this case.

Recommendations

- 6.9 The authors of the Individual Management Reviews have made recommendations for action to their agencies (Appendix 1). The overview report author has endorsed these recommendations as providing a sound basis for improving aspects of agency practice and procedure, and has taken them into consideration in making recommendations for multi-agency working. The multi-agency recommendations have been accepted by the LSCB and translated into an action plan (Appendix 2). Its implementation will be monitored on behalf of the LSCB by the standing Serious Case Review Sub Group, and the results of monitoring reported to the LSCB.

Recommendation 1

The Children's Trust should review arrangements for multi-agency working with disabled children and those with complex health needs against the elements of Standard 8 of the National Service Framework for Children Young People and Maternity Services, and use the results of the review in strategic planning of integrated practice and service provision. A principal outcome should be the establishment of the practice of identifying a key worker from the point of diagnosis (subject to consultation with the child's parents/carers) as a means of promoting

integrated multi-agency assessment and support for families. As a minimum the key worker should:

- ensure there is a multi-agency support plan which is based on coordinated assessment,
- arrange for the plan to be regularly reviewed and revised as appropriate,
- act as a single point of contact for parents/carers and other professionals.

Recommendation 2

The LSCB should take action to check that the providers of all services for vulnerable adults have in place arrangements for the identification of factors which could potentially compromise parenting or childcare responsibilities, and for information sharing and referral in all such cases where service users have the care of children.

Recommendation 3

The LSCB should ensure that the multi-agency training strategy and programmes (multi-agency and single agency) meet the need for professionals who work with adults who suffer mental ill-health and those who work with children and families, to understand the impact on parenting skills and capacity and on children's wellbeing of parental mental ill-health.

Recommendation 4

The LSCB should ensure that the multi agency training strategy and programme specifically address issues for the identification of abuse and neglect in children who have disabilities and complex health needs, that professionals who work with such children and their families access the training and that training is refreshed at appropriate intervals.

Recommendation 5

The LSCB should take steps to ensure that the criteria and threshold for convening a multi-agency Initial Child Protection Conference, and the respective roles of strategy meetings and Initial Child Protection Conferences are clearly understood. The application in practice of the criteria for convening different types of meeting should be monitored through routine multi-agency case audit.

Recommendation 6

The LSCB should ensure that there is in place a protocol for the guidance of Children's Social Care and the Police in identifying the circumstances when s47 and linked criminal investigations are appropriate, and for deciding how joint enquiries should be undertaken

in a way that recognises the respective roles and responsibilities of the two agencies.

Recommendation 7

The LSCB should ensure that it has in place a robust framework for monitoring compliance with multi-agency safeguarding procedures. This should include a programme of regular multi-agency case audits and thematic audits to evaluate the effectiveness of specific aspects of multi-agency and multi-disciplinary practice.

Recommendation 8

The LSCB should check that children who are assessed as 'Children in Need' (s17 Children Act 1989) have a plan which is based on assessment of need and makes clear the outcomes to be achieved, the services to be provided and the arrangements for the review of the plan.

Recommendation 9

The Independent Chair of the LSCB should initiate discussions with the Head of Crime, North Yorkshire Police and the Coroner about the learning from this review in relation to aspects of practice in conducting post mortem examinations, with a view to ensuring that guidance is revised as necessary.

Recommendation 10

The LSCB should ensure that partner agencies and those who provide services for vulnerable adults who are parents, have in place appropriate arrangements (with regard for the role and responsibilities of the agency) for the supervision of staff who work directly with children and families and for managerial oversight of decisions and actions taken in relation to safeguarding children and promoting their welfare.

Recommendation 11

The LSCB should undertake a review of process and practice in relation to Serious Case Reviews, within the context of Working Together to Safeguard Children, Chapter 8 (HM Government 2010). The review should include arrangements for the identification of cases where consideration should be given to undertaking a Serious Case Review, and the interface between the SCR process and Child Death Review Processes.

Appendix 1

Recommendations for the Serious Case Review re Child D

Recommendation	Agency
The Service reviews its Carers Preparation Training to ensure professional boundaries and the potential pitfalls of collusive relationships between carers and parents are adequately addressed	Barnardo's
Staff receive appropriate training regarding professional boundaries, assessment and supervision of carers.	Barnardo's
The Service ensures that all staff access appropriate refresher training regarding good practice guidance on safeguarding disabled children.	Barnardo's
The Service ensures all staff receive appropriate training on the impact of parental mental illness in order to enhance their capacity to provide appropriate support to carers.	Barnardo's
The Service reviews its recording protocol and establishes and implements agreed formats for the recording of contacts with carers, to ensure a robust and analytical assessment of the progress and suitability of placements.	Barnardo's
The Service reviews its referral process in order to ensure all relevant information regarding family circumstances is included in the matching process.	Barnardo's
The Service reviews its minimum standards regarding supervision of carers to include at least one unannounced visit per year, in order to ensure a sufficiently robust mechanism is in place for monitoring the suitability of carers.	Barnardo's
The Service initiates discussions with the local authority to consider establishing a process for conducting joint visits to parents following the disruption of placements.	Barnardo's
Put in place mandatory training for staff that chair strategy meetings or conferences so they have the right skills to deliver appropriate challenge and scrutiny of child protection practice.	Children's Social Care
Ensure all staff who undertake child protection enquiries do so in accordance with the LSCB Child Protection procedures.	Children's Social Care

Improve liaison, communication and the formal sharing of assessments between Adult Mental Health professionals and Children's Social workers.	Children's Social Care
Refresh and reinforce key standards for Core assessments through a robust plan of training, monitoring and support for staff.	Children's Social Care
Deliver training and supervision focussed on observing and listening to children in assessment and decision making.	Children's Social Care
Provide an effective mechanism to ensure IROs are challenging standards in assessment and adherence to Child Protection procedures.	Children's Social Care
Education services to raise awareness of CIN process and procedures within schools. Within that emphasise the need for schools to be proactive in challenging and chasing Children's Social Care or other agencies where plans/processes are not followed through or where schools receive no communication from Children's Social Care or other agencies.	Education
Where the outcome of a post mortem is that cause of death is unascertained, hair samples must be taken.	North Yorkshire Police
NHS2 produces a clear, single document containing all aspirations of Primary Care Teams in respect of safeguarding, in discussion with the County 1 Local Medical Committee having regard to LSCB expectations and RCGP recommendations.	General Practitioners
The above document would be re-evaluated, and possibly revised, on an annual basis in the light of changing LSCB/RCGP recommendations and expectations.	General Practitioners
NHS2 considers, in discussions with County 1 LMC, developing a Local Enhanced Service (LES) in respect of its safeguarding aspirations and reports back to the LSCB the level of priority it places on achieving excellence in safeguarding amongst primary care teams, and whether or not it intends to pursue development of a LES.	General Practitioners
Safeguarding LES to be available to primary care for the start of the financial year in April 2011.	General Practitioners
The PCT and LSCB should, together, in any case clearly specify which source document is being	General Practitioners

used to describe training requirements (levels and timescales).	
HOP3 will review the guidance in place in their Accident & Emergency departments in respect of parental self harm to ensure it specifically addresses the issue of children with additional vulnerabilities.	South Tees Hospital NHS Trust
HOP3 will ensure qualified staff in A&E and Children's Services Directorate are aware of the need to make a full assessment of the circumstances of ingestions and for a documented discussion with parents to take place in respect of safe storage of medication and adequate supervision of children. Additionally, qualified staff will be reminded of the Safeguarding Children's Board procedure in relation to referrals to Children's Social Care when a child requires hospital treatment for ingestion of illegal or prescribed substance.	South Tees Hospital NHS Trust
HOP3 will ensure that where a child receiving services as an inpatient or on an outpatient basis is identified as having social worker relevant information will be shared with the social worker, and will be requested from the social worker, with parental consent. Where a child has sufficient understanding to give consent themselves this should also be sought.	South Tees Hospital NHS Trust
HOP3 will reiterate to all staff the importance of ensuring that all handwritten documentation including signatures and designations are legible in line with the Trust Health Care Records Standards Policy (G80).	South Tees Hospital NHS Trust
The NHS1 Child Protection Policy for Mental Health Services must include that when an adult who is a parent or carer of children under 18 and has a mental illness, a decision must be made as to whether it would be appropriate to manage the care of the service user under the Care Programme Approach process. Risk assessments must be undertaken at appropriate intervals by the Care Programme Approach manager or an appropriate Mental Health practitioner using the Safety Assessment and Management Plan (SAMP) risk assessment process and in accordance with the	North Yorkshire and York Community and Mental Health Services

<p>guidance in use for the SAMP risk assessment process. Where any risk to children is identified, further assessment must take place to include analysis of the ability of the parent/carer to meet the child's/children's needs.</p>	
<p>An opportunity must be provided for all clinical staff to update their knowledge and skills in undertaking holistic assessment, including the impact of parental ill health or the impact of a child with special needs on the family functioning.</p>	<p>North Yorkshire and York Community and Mental Health Services</p>
<p>The NHS1 Children's Services Clinical Development Group (CDG) must develop guidance for Health Visitors and School Nurses following the receipt of notifications of a child's attendance at A&E or other Unscheduled Care Services or admission to Secondary Care Services. The Guidance must consider the purpose of receiving the information, analysis of the information and actions required following receipt of a notification including whether it is appropriate to discuss the safe storage of medicines with the parent or carer.</p>	<p>North Yorkshire and York Community and Mental Health Services</p>
<p>The Child Protection Policy and the Medicines Management Policy should be reviewed and updated to include guidance for all practitioners who prescribe medication to discuss the safe storage of medicines when prescribing. Both Policies must be cross-referenced with each other.</p>	<p>North Yorkshire and York Community and Mental Health Services</p>
<p>The Safeguarding Children Team Leader must discuss the findings of this IMR with the Safeguarding Children Team, raising awareness of the need to challenge Children's Social Care regarding delays or inappropriate use of strategy meetings or Initial Child Protection Conferences. This must be complete by 30/07/2010.</p>	<p>North Yorkshire and York Community and Mental Health Services</p>
<p>The County 1 SGB must recommend to Children's Social Care that consent is obtained from parents at the start of a Core assessment that a written summary of the outcome and planned actions resulting from a Core Assessment or CAF be circulated to all the professional contributors to the Assessment.</p>	<p>North Yorkshire and York Community and Mental Health Services</p>
<p>The NHS1 Safeguarding Children Guidance must include a recommendation that when a Core Assessment is completed, the professionals who</p>	<p>North Yorkshire and York Community and Mental Health Services</p>

have contributed to the Core Assessment request written feedback of the outcome and actions agreed.	
The NHS1 Level 2 and Level 3 in house Child Protection Training must be reviewed and updated to include further information regarding: <ul style="list-style-type: none"> • Barriers to protecting children • Engaging difficult to engage families • Recognition of neglect, including inappropriate supervision of children with disabilities. • Anonymous information from this IMR to raise awareness of the vulnerability of disabled children to abuse, including neglect. 	North Yorkshire and York Community and Mental Health Services
The Child Protection Supervision Policy must be reviewed and updated to include a process to review an action plan that did not have the intended outcome. The review process must assess if the outcome has increased the risk to the child and if so, develop a further plan using innovative practice to address the risks.	North Yorkshire and York Community and Mental Health Services
The authors endorse all of the recommendations made within the Individual Management Reviews undertaken by HOP3, NHS1 and the General Practice.	North Yorkshire and York Primary Care Trust
However, the authors believe that the following recommendations are also necessary to improve practice and address the issues highlighted in this case:	North Yorkshire and York Primary Care Trust
The NHS1 Director with lead responsibility for safeguarding children must ensure that all Child Protection/Safeguarding Children Training undertaken by commissioned services addresses a) the importance of holistic assessment, b) inter disciplinary & inter-agency information sharing (both with & without consent), c) the increased vulnerability of disabled children & their siblings, d) importance of assessing attachment, e) the impact of parental mental health issues on the welfare of children and quality.	North Yorkshire and York Primary Care Trust
The NHS1 Director with lead responsibility for safeguarding children, together with the medical director and designated professionals, should consider the appropriateness and effectiveness of current training and ways of improving the relevance of safeguarding training for specific groups e.g. addressing issues of disguised	North Yorkshire and York Primary Care Trust

compliance, risks associated with adult mental health, impact on disability on families re safeguarding children, and safeguarding children training for General Practitioners and their staff.	
The NHS1 Director with lead responsibility for safeguarding children must ensure that all commissioned services have in place Information Sharing Guidance for all staff working with children & adults who are parents, and that this addresses the specific issues relating to safeguarding & promoting the welfare of children including information sharing with & without parental consent.	North Yorkshire and York Primary Care Trust
The NHS1 Director with lead responsibility for safeguarding children must review the service specification for Adult Mental health Services to ensure that any adult who is a parents who presents to Adult Mental health Services results in liaison with their children's Health Visitor or School Nurse, & Paediatrician where involved.	North Yorkshire and York Primary Care Trust
The NHS1 Director with lead responsibility for safeguarding children must ensure that all services commissioned to work directly with children & young people and adults who are parents, including those staff who deliver Child Protection North Yorkshire and York Primary Care Trust Supervision, undertake specific training on recognition & management of disguised compliance.	North Yorkshire and York Primary Care Trust
The NHS1 Director with lead responsibility for safeguarding children must request NYSCB to review their Procedures relating to Disabled Children to ensure that multi-agency Child in Need Planning Meetings are held in relation to these children.	North Yorkshire and York Primary Care Trust
The NHS1 Director with lead responsibility for safeguarding children must review the Services Specification for School Nurses to identify whether increased liaison between School Nurses and General Practitioners, especially where a child is disabled or a parent has mental health issues, would increase their ability to safeguard & promote the welfare of children.	North Yorkshire and York Primary Care Trust
The NHS1 Director with lead responsibility for safeguarding children must review the Service	North Yorkshire and York Primary Care Trust

<p>Specification for School Nurses attached to Special Schools to ensure that their involvement assess the holistic needs of those children rather than merely working to a medical model.</p>	
<p>The NHS1 Director with lead responsibility for safeguarding children must undertake an audit to ascertain whether all patient documentation within Acute Trusts is now retained in one place (e.g. the medical record). Necessary action will be taken following this audit to ensure that all patient documentation is stored together in each Acute Trust.</p>	<p>North Yorkshire and York Primary Care Trust</p>
<p>The NHS1 Director with lead responsibility for safeguarding children should review the Adult Mental Health service specification to ensure that where Police and/or Children's Social Care are involved with a patient's family, any planned home leave is discussed with those agencies, and that where the patient is only allowed supervised contact with their children then a copy of the agreement between Children's Social Care & the parents is retained in the patient's notes, with clearly identified action to be taken by Adult Mental health staff should unsupervised contact be attempted.</p>	<p>North Yorkshire and York Primary Care Trust</p>
<p>The NHS1 Director with lead responsibility for safeguarding children will review with the County 1 SGB General Practitioner Representative and the Local Medical Committee as to guidance for General Practices relating to action to be taken by the practice following the unexpected death of a child.</p>	<p>North Yorkshire and York Primary Care Trust</p>
<p>The NHS1 Director with lead responsibility for safeguarding children will ensure that the Designated Nurse/Nurse Consultant for Safeguarding Children & Designated Doctor for Child Protection will write to all Named Nurses Child Protection & Named Doctor Child Protection within commissioned services to remind them of the importance of ensuring that Strategy Meetings & Child Protection Conferences have full information from all health professionals involved with the relevant family members to enable safe decisions to be made.</p>	<p>North Yorkshire and York Primary Care Trust</p>

<p>The NHS1 Director with lead responsibility for safeguarding children will ensure that discussions are held with Manager 1 regarding the importance of including disguised compliance, assessment of attachment and vulnerability of disabled children in multi-agency training as well as single agency training.</p>	<p>North Yorkshire and York Primary Care Trust</p>
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Appendix 2



Serious Case Review re Child D

LSCB Action Plan

23 August 2010

No	Recommendation	Key Action	Evidence	Outcomes	Lead Officer	Date
1	LSCB to revise the SCR policy and procedure in light of the lessons learnt from the Child D review	Revise LSCB SCR policy and procedure to incorporate the lessons learnt from the Child D review	Revised SCR policy and procedure	Improve understanding by key LSCB stakeholders of the SCR process	LSCB Manager	Aug 2010 Completed
2	LSCB to review the membership of the SCR Sub Group in line with Working Together 2010	Undertake SCR membership review	SCR revised membership	LSCB to comply with Working Together 2010	Chair of the SCR Sub Group	Aug 2010 Completed
3	Practice guidance is made available for IMR report writers	Develop an IMR handbook, incorporating lessons from Child D	IMR Handbook is published	Improve standard of IMRs	LSCB Manager	July 2010 Completed
4	Training regarding roles and responsibilities to be undertaken for SCR Sub Group	Provide a training event regarding roles and responsibilities for SCR Sub Group	Increased awareness of the scope of the SCR process by SCR Sub Group members	Improve understanding of the role and responsibilities by SCR members	LSCB Manager	Nov 2010
5	Only in rare circumstances should an IMR be completed by someone who has not undertaken the IMR training provided by the LSCB	Make LSCB IMR training available for appropriate staff	Incorporated into the annual LSCB Training Programme	Improve standard and understanding of IMRs	LSCB Manager	Nov 2010 and thereafter annually
6	A Child Protection Conference must be convened where a child dies in circumstances that require a criminal investigation and where there are siblings	Add requirement to LSCB Procedures re Child Protection Conferences	Incorporated into LSCB Procedures	Improve inter-agency risk assessment	LSCB Policy Officer	May 2010 Completed

7	In all cases where a child dies in circumstances that require a criminal investigation, an immediate S47 Core Assessment must be started to be completed within 35 working days. Interim report of the assessment should be made to the Initial Child Protection Conference	Add requirement to LSCB Procedures re Child Protection Conferences and S47 Core Assessments	Incorporated into LSCB Procedures	Improve understanding of risk to siblings	LSCB Policy Officer	May 2010 Completed
8	Highlight that the purpose of the Strategy Meeting is to determine the need for and process of a Section 47 enquiry. It is not a mechanism for assessing risk in itself.	Reinforce within the LSCB Procedures Incorporate messages into multi-agency training events	Increased awareness of the role of the Section 47 enquiry	Improve multi-agency understanding of the Child Protection Process	LSCB Policy Officer and LSCB Training Manager	May 2010 Completed
9	Child protection refresher course (Level 3) to be developed for staff in Health, Police and Social Care who regularly attend Strategy Meetings and Child Protection Conferences. Course to become mandatory every three years for these staff. Children's Workforce Development with the aim of making this course mandatory every three years	Course to be developed by the LSCB Manager with Children's Workforce Development, LSCB Training and the Children's Trust Course to become mandatory and incorporated into single agency training strategies	Increase awareness of changes within Child Protection Strengthen safeguarding within Strategy Meetings and Child Protection Conferences	Improve inter-agency understanding of Child Protection for those who have first line management of the system	LSCB Manager	September 2010
10	Ensure that the thresholds for convening a Strategy Meeting and beginning a Section 47 enquiry are clear and understood by agencies	Clear statements in LSCB Procedures re thresholds for intervention at S47	Ensure that thresholds for convening a Strategy Meeting	Improve inter-agency working and understanding of the Child Protection	LSCB Manager	August 2010 Completed,

		Multi-agency Child Protection training to be amended to give clear direction Children's Workforce Development to incorporate changes into CSC training materials	and a Section 47 enquiry are understood by those agencies regularly involved in the processes	system		Ongoing
11	The Children's Trust should review arrangements for multi-agency working with disabled children and those with complex health needs against the elements of Standard 8 of the National Service Framework for Children Young People and Maternity Services, and use the results of the review in strategic planning of integrated practice and service provision. The practice of identifying a key worker from the point of diagnosis (subject to consultation with the child's parents/carers) should be adopted as a means of promoting integrated multi-agency assessment and support for families. As a minimum the key worker should: <ul style="list-style-type: none"> • ensure there is a multi-agency support plan which is based on coordinated assessment, • arrange for the plan to be regularly reviewed and revised 	Review of arrangements for multi-agency working with disabled children	Single agency and multi-agency audit Survey of parents/Carers' views	Children's and families' needs are met more effectively through well coordinated services which are based on holistic assessment of need. Parents feel well informed and supported in meeting their children's needs	Director of Children's Services	September 2010

	<p>as appropriate,</p> <ul style="list-style-type: none"> act as a single point of contact for parents/carers and other professionals. 					
12	<p>The LSCB should take action to check that the providers of all services for vulnerable adults have in place arrangements for the identification of factors which could potentially compromise parenting or childcare responsibilities, and for information sharing and referral in all such cases where service users have the care of children</p>	<p>Work with Adult Services to put in place training and information sharing protocols</p>	<p>Audit of Service providers. Case Audits</p>	<p>Professionals who work with vulnerable adults understand the contribution which they must make to safeguarding children. Issues for parenting are assessed and addressed</p>	<p>LSCB Manager</p>	<p>September 2010</p>
13	<p>The LSCB should ensure that the multi-agency training strategy and programmes (multi-agency and single agency) meet the need for professionals who work with adults who suffer mental ill-health and those who work with children and families, to understand the impact on parenting skills and capacity and on children's wellbeing of parental mental ill-health</p>	<p>Training Strategy and Programme to include training for professionals who work with adults who suffer mental ill-health and the impact this has on parenting skills</p>	<p>Audit of take up of training analysis of feedback from training courses, audits of supervision records and individual development plans</p>	<p>The impact of mental ill-health on parenting capacity in its broadest sense is understood and addressed in assessment and intervention</p>	<p>LSCB Training Manager</p>	<p>April 2011</p>
14	<p>The LSCB should ensure that the multi-agency training strategy and programme specifically address issues for the identification of abuse and neglect in children who have</p>	<p>Training Strategy and programme includes work with children with disabilities</p>	<p>Audit of take up of training, analysis of feedback from training sessions, audits of</p>	<p>Professionals have knowledge about factors that increase the vulnerability of disabled children to</p>	<p>LSCB Training Manager</p>	<p>April 2011</p>

	disabilities and complex health needs, that professionals who work with such children and their families access the training, and that training is refreshed at appropriate intervals		supervision records and individual development plans	abuse and/or neglect and are skilled in recognising signs which should lead to further enquiry and assessment		
15	The LSCB should take steps to ensure that the criteria and threshold for convening a multi-agency Initial Child Protection Conference, and the respective roles of strategy meetings and Initial Child Protection Conferences are clearly understood. The application in practice of the criteria for convening different types of meetings should be monitored through routine multi-agency case audit	Training Strategy and Programme. Audit	Monitoring of minutes of strategy meetings and initial child protection conferences, case audit	Enquires are well managed and address the separate but linked tasks of identifying responsibility for causing harm to children, and the need to take action to safeguard and promote the welfare of children	LSCB Manager, Multi-agency audit team	April 2011
16	The LSCB should ensure that there is in place a protocol for the guidance of Children's Social Care and the Police in identifying the circumstances when s47 and linked criminal investigations are appropriate, and for deciding how joint enquiries should be undertaken in a way that recognises the respective roles and	Protocol to be agreed between Children's Social Care and Police. LSCB to monitor Protocol	Protocol agreed by LSCB. Implementation evaluated through monitoring of minutes of strategy meetings and child protection conferences and regular audits of	Enquires are well managed and address the separate but linked tasks of identifying responsibility for causing harm to children and the need to take action to safeguard and	Protocol Head of Safe-guarding DCI, PVU, Police Audits	April 2011

	responsibilities of the two agencies		samples of cases which have involved joint investigation	promote the welfare of children	LSCB Manager	
17	The LSCB should ensure that it has in place a robust framework for monitoring compliance with multi-agency safeguarding procedures. This should include a programme of regular multi-agency case audits and thematic audits to evaluate the effectiveness of specific aspects of multi-agency and multi-disciplinary practice.	Training Strategy and Programme. Audit	Case Audits, monitoring of minutes of multi-agency Child Protection meetings, Initial Child Protection conferences and Review conferences	LSCB has information about the effectiveness of multi-agency safeguarding practice and the contribution made by partner agencies to safeguarding children and can use this information as a basis for action to make improvements as appropriate	LSCB Manager	April 2011
18	The LSCB should check that children who are assessed as 'Children in Need' (s17 Children Act 1989) have a plan which is based on assessment of need and makes clear the outcomes to be achieved, the services to be provided and the arrangements for the review of the plan	LSCB to monitor through audit	Audit of Case Records of a sample of Children in Need	Children in Need receive services appropriate to need and achieve good outcomes	Head of Safe-guarding	April 2011
19	The Independent Chair of the LSCB should initiate discussions with the	Meeting between the Chair of the LSCB and the Head of	Record of discussions and	Potential delay to investigations and	Chair of LSCB	Dec 2010

	Head of Crime, North Yorkshire Police and the Coroner about the learning from this review in relation to aspects of practice in conducting post mortem examinations, with a view to ensuring that guidance is revised as necessary.	Crime	agreed actions	associated distress caused to family members is minimised		
20	The LSCB should ensure that partner agencies and those who provide services for vulnerable adults who are parents have in place appropriate arrangements (with regard for the role and responsibilities of the agency) for the supervision of staff who work directly with children and families and for managerial oversight of decisions and actions taken in relation to safeguarding children and promoting their welfare	Audit of supervision arrangements	Audit of agency arrangements	Staff feel well supported and confident in their role Decisions and actions are challenged appropriately	LSCB Manager	July 2011
21	The LSCB should undertake a review of process and practice in relation to Serious Case Reviews, within the context of Working Together to Safeguard Children, Chapter 8. (HM Government 2010) The review should include arrangements for the identification of cases where consideration	Review SCR policy	Evaluation of SCRs	Timely identification of those cases where the criteria for undertaking a SCR should be considered, clarity about roles and responsibilities for decision making,	LSCB Manager	SCR Process August 2010 CDOP Process and interface January 2011

	should be given to undertaking a Serious Case Review, and the interface between the SCR process and Child Death Review Processes.			clarity about the interface between SCR and other processes, timely learning of lessons for policy and practice		
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