Bolton
Safeguarding
Children

SERIOUS CASE REVIEW

In respect of
Child SB

Linda Richardson
Independent Reviewer

Publication Date
31 May 2016

Overview Report Endorsed by:-
Mike Tarver, Independent Chair,
Bolton Safeguarding Children Board

MB Tarver

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As a teenager, SB was described as a calm, quiet and well-mannered child, who could occasionally be stroppy and defiant but not in a way which raised concerns. SB had one particular friend who lived close by and for a couple of months, was 'going out' with another pupil who went to the same school. SB liked sport and had academic potential but this was hampered by poor attendance at school over the years. From late 2014, SB seemed more reluctant to socialise and to leave the house. It seems SB began to stay up late at night and slept more during the day. When teachers or school attendance officers tried to talk with SB, there was a polite but assertive refusal to attend school, or to offer any explanation.

Professionals did not know this family well and it is difficult to imagine what life must have been like for SB living with parents and other family members, given what professionals knew about the family's history.

1 The circumstances which led to a Serious Case Review (SCR)

1.1 SB was an only child who lived with his parents. Children's Services were involved intermittently throughout the early years of SB's life, initially in relation to concerns about neglectful parenting and allegations of violence in the family. As SB grew older, these concerns began to focus on the child's inconsistent attendance at school. Professionals found it difficult to engage with parents and although SB was made subject to child protection and child in need plans, there was never any sustained improvement in school attendance.

1.2 SB was 15 years old and had not attended school for almost two years when, in February 2015, the child was found by father, hanging by a cord on the back of a bedroom door. An ambulance was called and SB was taken to hospital where further attempts at resuscitation were unsuccessful.

1.3 In line with local procedures, Bolton's Learning and Improvement group[1] met to consider whether SB's death met the criteria for a Serious Case Review (SCR). They recommended to the Independent Chair of Bolton LSCB that an SCR should be undertaken. The Chair concurred with this view and commissioned a Serious Case Review in line with statutory guidance.

2 Statutory Guidance[2]

2.1 A Serious Case Review is one where: 'a) abuse or neglect of a child is known or suspected: and b) either – (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the Authority, their Board partners or other relevant persons have worked together to safeguard the child.' Regulation 5 of the Local Safeguarding Children Boards (BSCB) Regulations 2006 require LSCBs to undertake reviews of serious cases in these specified circumstances and to 'advise the Authority and their Board partners on lessons to be learnt'

2.2 Statutory guidance requires SCRs to be conducted in a way that:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings

2.3 The guidance also stipulates that when undertaking reviews, LSCBs should ensure that frontline practitioners are fully involved in the process and are invited to contribute their perspectives without fear of being blamed for

[1] *This is a multi- agency sub group of Bolton's Local Safeguarding Children Board*
[2] *Working Together to Safeguard Children 2015. HMSO*

actions, which they took in good faith. Boards are also expected to consider ways of involving family members and sensitively and appropriately managing their expectations.

2.4 The guidance requires that reports should be written in plain English and in a way that can easily be understood by professionals and the public.

3 The Approach Used

3.1 This serious case review was undertaken in line with statutory guidance.3 The review looked not only at what happened to SB, but also tried to understand some of the factors that influenced why professionals acted as they did or why they did not act at all. Two independent reviewers both of whom had experience of using a systems methodology were commissioned to lead the serious case review process. Neither reviewer was employed in any capacity by the agencies involved in the review process, nor did they know the family prior to the review.

3.2 A Review Team of senior professionals representing the agencies that were or had been involved with the family was established. Their role was to provide a source of high-level strategic information about their own agency and their involvement with SB's family through their contributions to the SCR process and the submission of an Agency Learning Report. Agencies and representatives which formed the Review Team were:

Colleen Murphy	Independent Lead Reviewer (Chair)
Linda Richardson	Independent Lead Reviewer
Business Manager	Bolton Safeguarding Children Board (BSCB)
Business Support	BSCB
Head of Service	Child Protection & Leaving Care, Bolton Children's Services (observing)
Head of Service	Children's Resources, Bolton Children's Services
Detective Inspector	Public Protection Division, Greater Manchester Police (GMP)
Named Nurse	Safeguarding Children, Bolton NHS Foundation Trust
Interim Associate Director	Bolton NHS Clinical Commissioning Group (CCG)
Services Manager	Bolton Integrated Drug & Alcohol Service (BIDAS) Safeguarding
Development Manager	Blackburn with Darwen LSCB
Designated Doctor	NHS Bolton CCG

3.3 Together with the Lead Reviewers, the Review Team collected and analysed data, appraised practice and agreed the content of this report. Members of the Review Team also identified frontline practitioners and first line managers who knew or had worked with SB's family. These practitioners, where they were

still in employment, formed the 'Practitioner Group', which met on three occasions. They offered important details about SB and the work they had undertaken and also provided a rich source of information about local systems and multi-agency procedures and processes. In addition, they helped the Review Team consider the extent to which the findings from this review were typical of practice elsewhere across the authority. The Practitioner's group consisted of:

EIT Manager

EIT Keyworkers x 4, (referred to as EIT 1, EIT 2, EIT 3 and EIT 4)

Case Manager, Arch Initiatives, Bolton Integrated Drug and Alcohol Services Education Welfare Officer, (EWO) Blackburn with Darwen (BwD)

Member of Leadership Team, SCH 2

Senior Pastoral Lead (SPL), SCH 1

Social Worker, Children's Social Care

3.4 Data was collected through the examination of single and multi- agency records and through individual conversations with practitioners and their managers. Both parents were contacted directly and indirectly so their views could be represented in the SCR process, but sadly, they did not respond and their views and perspective is a significant omission in this report.

3.5 The methodology adopted for the review and the opportunity to be an integral part of a multi-agency review process was new to most of the professionals involved. Whilst some reservations may have been apparent at the outset, there was an acceptance about the opportunity it afforded to identify and understand factors that influenced the nature and quality of their work with this and other families.

4 Scope and Terms of Reference

4.1 Using a systems approach requires reviewers to start with an open enquiry rather than a pre- determined set of questions from terms of reference. This means that it is the data collected which helps to identify the key issues to be explored as opposed to the preconceptions of managers or a review panel. Each agency submitted a timeline of interventions at the start of the review process and this information was collated to clarify multi-agency activity so the Review Team were clear about who knew what and when.

4.2 The Serious Case Review looks at the life of SB from February 2012 to February 2015 when SB died. However, information about SB's earlier life has proved particularly illuminating and the Review Team have carefully considered details outside of this timeline.

5 Parallel Proceedings

5.1 The inquest into the death of SB was held in June 2015. The Coroner concluded that SB died by hanging and this was a deliberate act with no one

else involved and no suspicious circumstances. However, the Coroner's report also states it was not possible to state unequivocally that SB intended suicide and recorded a verdict of misadventure.

6 Cross Border Issues

6.1 Between February 2011 and May 2012, the family lived with the paternal grandmother and her husband in Blackburn with Darwen (BwD) it was therefore important that in reviewing professional involvement with this family, there was close collaboration between the two authorities. Both the Review Team and the Practitioners benefitted from the attendance at meetings and the contributions of colleagues from that area. The findings and recommendations from this review are applicable not only to Bolton Safeguarding Children Board but also to the Local Safeguarding Board in Blackburn with Darwen.

7 The Family's Perspective

7.1 Both parents were contacted through formal and informal means on three occasions but did not respond to the invitations to meet with the reviewers. The absence of their perspective is a significant omission in this report and left the Review Team not knowing what might have helped SB and what may have made a difference in work with the parents.

8 The Family as Known to Agencies

8.1 Family Structure (simplified)

Mother	MSB	Mother of SB
Father	FSB	Father of SB
CHILD	**SB**	**Subject**
Maternal Uncle	USB	Uncle of SB (maternal)
Maternal Aunt	MAB	Aunt of SB
Maternal Grandfather	MGF	living in Bolton
Paternal Grandmother	PGM	living in BwD
Step Paternal Grandfather	SPGF	living in BwD

Background Information: 1999 – February 2011

8.2 Although outside the agreed timeframe for this review, the information relating to SB's earlier life was thought to be particularly significant in the light of what happened in later years.

8.3 SB was born early 1999. Both parents lived with mother's father (MGF). At various times mother's brother and sister also lived in the household. Between 1999 and 2005, there was intermittent involvement from Children's Social Care (CSC) following allegations about parental drug dealing and violent behaviour between the adult males in the home and towards MSB. In 2002, MSB contacted the police to report an assault by her brother, USB, on SB. Police took no further action but contacted CSC to advise them of the

incident. The father of SB was at the time serving a prison sentence for drug offences. Records from CSC note that USB had problems with anger management and alcohol and there was no further involvement by CSC although the family was referred to a family centre. SB was 3 years old at the time.

8.4 Between 2002 and 2005, three referrals were made to Bolton CSC, relating to parental substance misuse and lack of parental supervision for SB. The referrals were recorded as being 'for information only' or considered as 'malicious unsubstantiated concerns' and did not lead to any involvement by CSC.

8.5 The parents did not register SB with a primary school and the child only began attending school at the age of 6+, when this was picked up by a school nurse (SN1) and the Local Authority were notified. SB attended three different primary schools, but the Review Team were unable to determine why these moves took place. Ongoing concerns about school attendance led the local authority to obtain an Education Supervision Order[3] in 2007, but this did not lead to any improvement and following growing concerns about the home environment, SB was made subject to a child in need plan[4]. Despite family support intervention, no substantial changes were noted and SB became subject to a child protection plan[5] in summer 2008, under the category of Neglect. Records refer to concerns about SB's poor school attendance, concerns about home conditions, missed health appointments and MSB being on bail, charged with supplying heroin.

8.6 Between 2008 and 2009, professionals could still not find a way to engage with the family; MSB very often refused professionals entry to the home and was recorded as being openly hostile on occasions. Social work records indicate her presentation gave the impression at times that she was using drugs; a suggestion she always denied. The maternal grandfather and maternal uncle who resided in the house were also aggressive towards professionals and evaded contact. FSB at this time was in prison for burglary and drug offences. SB continued to attend school sporadically and MSB frequently gave poor health as the reason for these absences. SB was seen in January 2009 by a school nurse (SN2) who concluded there were no health issues to prevent school attendance.

8.7 Progress in relation to the child protection plan was slow and the family remained evasive and openly hostile to professionals. Early in 2009, police were called to a domestic violence incident and police made a referral to CSC in respect of SB, but CSC took no action. In spring 2009, in line with Public

[3] The Education Act 1996 requires local authorities to make use of an Education Supervision Order (ESO) before prosecuting parents for their child's non-school attendance

[4] Under the Children Act 1989, a child is considered a 'child in need' where they are assessed as being in need of services to help with their wellbeing or development. A Child in Need plan specifies who is involved and what needs to happen to meet the child's needs.

[5] A child protection plan is established where there are concerns that a child is suffering from or at risk of significant harm.

Law Outline[6], a pre-proceedings letter was sent to the family advising them that care proceedings were being considered and inviting them to a meeting so court action could be avoided. The parents did not respond and the meeting did not proceed. CSC was unable to provide any details to the Review Team to explain why these proceedings did not progress.

8.8 According to Police records, officers were called out to the home on several occasions in response to calls about violence within the home and allegations of drug dealing. SB appears to have been present on these occasions and sometimes was noted to be clean and well dressed. On one occasion, police records note SB was 'a little upset' during altercations between adults in the home. SB would have been 10 years old at the time. Records accessed from agency files confirm that on at least two occasions' social workers needing to see SB, required police assistance to gain entry to the home, as MSB would not engage and/or workers had been threatened by an adult in the property.

8.9 Between April 2009 and July 2010, there were regular core group meetings but it appears that MSB rarely attended. According to CSC records, some improvements were noted in July 2010 – housing repairs had been completed and although there was still some concern about SB's attendance at school, it was described as 'the best it had ever been'. At a multi- agency review meeting held later that summer, SB was reported by SN1 to be 'guarded' about family life, but appeared happy and had a good attitude to learning. Neither parent attended this meeting: FSB had recently been released from prison and was on bail to an address in Blackburn. The minutes refer to the parents still being resistant to the CP plan and that they were 'unlikely to change'.

8.10 Despite concerns about the family's hostility and lack of engagement with services, a decision was taken to 'step down' concerns about SB from child protection to child in need status. A social worker, SW1 remained involved to 'ensure progress continued.' There are references in the minutes of that meeting to the fact that 'children's services' were involved in separate proceedings relating to other relatives living at the same address. The Review Team learnt during the review process that these concerns related to the partner and children of USB.

8.11 SB began the autumn term at SCH1[7] in 2010 and in the first month, attendance was recorded as only 60%. The Early Intervention Team[8] (EIT) began their involvement around this time and an EIT worker (EIT1) was allocated to the family to try and improve SB's school attendance. At a 'Child Action Meeting'[9], which MSB did attend two months into the school term; the

[6] When social workers are concerned about the welfare of a child, and are considering asking the court to make orders to protect the child, the Public Law Outline requires that a meeting is set up with parents to see if it is possible to reach agreement about what needs to happen to protect the child from harm, so that court proceedings can be avoided.
[7] SCH1 Secondary school in Bolton
[8] This team worked with school and families to improve school attendance. In some local authorities this would be called the Education Welfare Service.
[9] Child Action Meetings are held following an assessment by any agency and are held to agree the best way of helping and a child and their family

school expressed concerns about absences and SB's emotional presentation. MSB expressed her concerns about SB's headaches and migraines and a growing obsession with cleanliness. Following discussion with the school nurse, (SN2) a short time later, MSB was advised to take SB to see the family GP and she agreed that SN2 could refer SB to the Child and Adolescent Mental Health Services (CAMHS)[10]. This referral was made late in 2010 but in January 2011, CAMHS advised the GP, SW1, and SN2 that the parents had not responded to a letter asking if they wished to 'opt in' for an appointment.

8.12 In the same month, police were called out in response to 'serious concerns' about violence in the home. The Review Team were unable to ascertain the nature and extent of these concerns, but as SB was present when the Police attended the home, a referral was made to CSC but no further action was taken by either agency.

8.13 Records from the EIT service indicate there was 'reasonable engagement' with the family during this time and EIT1 records indicate considerable effort to engage MSB, including working with her on how best to handle meetings in school; MSB subsequently attended two of these 'child action meetings. EIT1 records describe how MSB could appear hostile at first but 'would soften quickly' with the right approach.

8.14 In late February 2011, MSB contacted EIT1 to advise that the family had been 'evicted' and they were now staying in Blackburn with Darwen with PGM and her husband. EIT1 contacted SW1 to pass on this information. At this point SB's attendance at school had improved and was recorded as being 73.3% between September 2010 and February 2011. Having confirmed that the family had moved to BwD, the EIT service closed work with the family on their system. They did not however make any contact with the Education Welfare Service in BwD.

8.15 SW1 made contact with BwD Children's Services and advised that SB was on a child in need plan, and the family had moved into the area and were requesting social work support. SW1 requested that an Initial Assessment was undertaken and later forwarded key documents outlining the family history, including details of CP conference and review minutes to the social worker in BwD.

8.16 In late February, SN2 was informed that the family had moved to BwD. SN2 case notes state the records, were forwarded in early March 2011 to the School Nursing Service in BwD. These transfer of care records included a cover sheet recording details of past child protection concerns and the family history, and information about a Child Action meeting, which had been planned for early March 2011 but was cancelled due to the family and school move. The School Nursing Service in BwD allocated SN3 to work with SB in April 2011. The Review Team were informed that SN2 in Bolton had a

[10] CAMHS is a specialist NHS services. They offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties

telephone conversation with SN3 after the records had been transferred but have not however had sight of the records pertaining to that conversation.

8.17 SB's school records were transferred to SCH2 in March 2011. The Review Team were unable to ascertain exactly what information was transferred from SCH1 to SCH2[11].

8.18 SW1 and a Family Support Worker from Bolton visited the family at the BwD address. SB was seen and appeared well. No concerns were identified. The family case file was subsequently closed to Bolton's system.

Blackburn with Darwen: February 2011- April 2012

8.19 BwD Children's Social Care and SW2 made a home visit in early March 2011 as part of an Initial Assessment following receipt of the information from Bolton CSC. Both parents, PGM and SPGF were seen and the parents confirmed that they wanted help with housing, as they had to leave their previous accommodation after 'misunderstandings' with the MGF. Parents described SB as a gentle and well-mannered child, who presented no behavioural problems, had lots of friends and was to attend SCH2. SB was 12 years old at the time. During the visit, both parents appeared to have talked openly about their past use of drugs. FSB advised that he had not used drugs since being released from prison 9 months previously and MSB said she had also been drug free for several months. The parents stated that moving to Blackburn was a fresh start but declined the offer of support from drug and alcohol services. The parents told SW2 they did not believe their past lifestyle had impacted on their ability to care for SB. SB was seen and observed to be polite, well-mannered and 'chatty'. The parents were advised to ensure SB started his new school at SCH2 as soon as possible.

8.20 SB began attending SCH2 at the end of spring term 2011.

8.21 Although records indicate that SW2 had arranged to visit Bolton to view the family records, the Review Team were unable to establish whether this visit ever took place. In May 2011, SW2 instigated a welfare check and contacted SCH2. She was advised that since March, SB had a 93% attendance. She was advised that there were no safeguarding concerns. Contact was made again with SCH2 and SN3 in school expressed no concerns. SW2 was advised that SB had recently undergone a health assessment and although MSB had been advised that SB needed dental treatment, there were no other health issues.

8.22 SW2 had supervision with her line manager later that month and a decision was taken that there was no role for Blackburn with Darwen CSC and SB's needs could be well met by universal services. SW2 had not had any contact with the parents since early March and neither had SB been seen by SW2 since that time. The Initial Assessment was concluded and did not refer to or identify any concerns relating to the parents drug misuse. There are no

[11] SCH2 School in Blackburn with Darwen

references to mental health issues or the family's failure to engage with CAMHS earlier in the year.

8.23 SN3 received an A&E notification following an injury to SB's hand a few days later. SB's explanation was that an accident had happened at school and the hand was further injured by accidentally 'banging' it on a metal bed frame when at home. SB was seen two days later by the family GP in Blackburn with Darwen, but was not taken back to hospital for two follow up appointments and was subsequently discharged and the GP notified.

8.24 SB's school attendance began to drop significantly towards the latter part of the summer term and again in the autumn term of 2011. SB's last recorded attendance in SCH2 was November 2011. A school report indicated that SB was not reaching target grades, although effort and behaviour were described as mainly positive. SCH2 referred SB to the BwD Education Welfare Service just before the end of the autumn term in December 2011.

8.25 The Education Welfare Officer (EWO) made a home visit in early January 2012 and was advised by mum that SB was unhappy in BwD but she wanted to stay, as she was now 'drug free'. Although an offer was made for a support package to help reintegrate SB back into school, MSB said she was unsure if SB would agree or comply. PSGF told the EWO that SB should be sanctioned for refusing to attend school. Whilst MSB agreed to liaise with SCH2 and the EWO, it was the view of the EWO that MSB seemed to have lost all parental authority in relation to SB. SB was not seen alone by the EWO and offered no explanation as to why school attendance was poor.

8.26 At the end of January 2012, the EWO made another home visit and spoke again with MSB. SB had still not returned to school and MSB said she had applied for a school place back at SCH1 in Bolton and told the EWO that SB would live with MGF. Three weeks later, the EWO made an unsuccessful home visit and left a calling card. MSB telephoned the EWO and said she had not yet completed the paperwork for SB to return to SCH1 but would progress this. In early March, the EWO met with MSB and was informed that SB had returned to Bolton and she was thinking of doing the same.

8.27 In March 2012, SCH2 forwarded a 'Missing from Education' form to the EWO as SB had not attended school since November 2011 and they had not received any notification that SB was attending any other school. The EWO alerted the 'Child Missing from Education' officer in Bolton and forwarded a 'Movement of Children' enquiry form.

Bolton: April 2012 – December 2013

8.28 On the 14 April 2012, police were called to the house of MGF in Bolton at 4.20 pm in response to an incident in which MSB alleged that SB had been restrained and assaulted by USB. When police arrived, SB told police there had been no assault and the scratches and grazes on SB's arms were as a result of falling over when USB was using restraint to stop SB 'throwing a

mug'. This was not recorded as a child protection incident and no referral was made to CSC.

8.29 A formal warning notice was sent by SCH2 in May 2012 to MSB indicating that a Penalty Notice would be issued unless there was immediate and sustained improvement in SB's attendance at school. MSB contacted the EWO a few days later to advise that she and SB were now back in Bolton. She refused to give the address where she and SB were living but confirmed that SB would be soon be starting back at SCH1. The EWO contacted SCH1 and was advised that SB had been given a start date. The EWO case file was subsequently closed.

8.30 SB started at SCH1 midway through the summer term in 2012. Soon after this, SB presented at Bolton A&E with another closed fracture to the right hand and gave an explanation to hospital staff that the injury had occurred after a fight with a pupil at school, although there are no references in school records of this incident. A letter was forwarded by the hospital to the GP practice in Blackburn with Darwen, with whom the family were still registered. Medical records confirm that SB was not taken for any follow up appointments.

8.31 A meeting with parents was planned by SCH1 for the end of May but neither parent attended. SB continued to attend school irregularly with MSB often phoning school to say that the child was ill with stomach upsets or other ailments. SB did not attend school at the beginning of the autumn term 2012, despite efforts and several home visits by school staff to engage with SB and parents. The family were re-referred to the Early Intervention Team and EIT 2 was allocated to work with the family, supported by EIT1 who had recently returned from a leave of absence. There were 6 no-access visits made by EIT workers before the end of October as the family refused to engage or answer calls. SCH1 continued to make efforts to see SB and encourage the child into school but they failed to engage on any level with the child. MSB continued to contact school to report that SB was unwell so could not attend.

8.32 MSB referred herself to Greater Manchester West Substance Misuse Services, the local drug and alcohol service in Bolton in September and October 2012, but did not attend for any appointments.[12]

8.33 In November 2012, SB rang 999 to report that that FSB had punched SB in the face. Police attended and were told by MSB that SB had been aggressive and angry because MSB had taken some money from SB. FSB had needed to calm the child by using restraint and holding SB down on the bed. SB was spoken to in the presence of parents and told officers that no assault had happened and appears to have confirmed the account given by MSB. According to police records, SB was not seen or spoken to alone. Police made a referral to CSC but this led to no action by CSC and neither did police escalate their concerns. Both SCH1 and EIT2 were unaware of this incident.

[12] This service was later provided by BIDAS with effect from January 2013

8.34 In November 2012, the Senior Pastoral Lead (SPL) from SCH1 made another home visit, and discussed with MSB about whether she had taken SB to see his GP, given his apparent poor health. He was informed that the family did not have a GP in Bolton. SCH1 did not make contact with the School Nursing Service in Bolton to clarify or pursue this information.

8.35 Between November 2012 and January 2013, SB continued to attend school irregularly and there were several more visits by staff from SCH1 during this period, some of which were undertaken jointly with EIT2. In January 2013, SCH1 issued a notice intending prosecution. A family meeting was planned for late January but the parents did not attend. EIT1 continued to have difficulties speaking with parents and in early 2013, left a note for the family stressing the importance of contact and indicating if they failed to respond, contact would be made with CSC.

8.36 EIT1 made a home visit the following day and was told by MGF that MSB and SB were living with a maternal aunt in another area. According to EIT records, EIT1 then contacted the Referral and Assessment Team to notify them that she believed that SB was staying in the West area. The duty officer in the team gave the name of the allocated social worker for EIT1 to make contact and determine if SB and MSB were living at that address. It is unclear if this contact was made as MSB was seen the following day by EIT1, back at the home of PGF.

8.37 According to SCH1 registration records, SB attended school for the last time in February 2013.

8.38 FSB self-referred to Bolton Drug and Alcohol Service (BIDAS) several weeks later. At assessment, FSB confirmed that his child lived with him and his partner and they were residing at the home of MGF. The case manager concluded there were no identified risks to any children in the family.

8.39 The SPL from SCH1 persuaded SB to come into school to be given a new blazer in February 2013 and this would appear to be the last day SB was on school premises. A Penalty Notice [13] for poor school attendance was issued later that month, which MSB paid within 28 days. In March 2013, another joint visit was undertaken with EIT2 and SPL. They met with MSB and SB and agreed to have school work sent home. SB refused to engage with either adult or offer any explanation about absences from school.

8.40 MSB contacted EIT2 in March 2013 and said that SB wanted to return to school. Following a discussion with the Head of Year, EIT2 contacted MSB and said SB should return after Easter break. SB did not however return to school. During a follow up visit by EIT2, MSB said she did not know why SB would not return to school, EIT2 suggested a meeting with school and called the following day and advised FSB that the meeting had been set up for the day after. The parents did not attend the meeting. A second Penalty Notice

[13] A Penalty Notice is an alternative to prosecution, which does not require an appearance in court. Payment of a Fixed Penalty Notice enables parents/carers discharge what is potentially the liability for a criminal conviction

was issued to both parents later that month but this remained unpaid and the parents were fined in their absence.

8.41 EIT2 and the SPL made another joint visit in April. SB again refused to talk but MSB said SB's refusal to attend school was linked to an (unspecified) problem with a teacher at school. The SPL went upstairs to SB's bedroom to find out more about this incident but was told by SB that MSB 'was off her head' and 'didn't know what she was f…. talking about'. Despite encouragement, SB said 'I am not coming back to school sir.' When asked why, SB replied 'I can't be arsed' and would not elaborate further. MSB was advised that arrangements would be made so that SB did not have to attend the class of that particular teacher and SB would be welcomed back at school. SCH1 could find no evidence of any incident taking place in school.

8.42 In June 2013, a new keyworker, EIT3, was allocated to work with the family and a home visit was made. MSB and SB were not at home but EIT3 saw FSB who informed him that he did not know why SB stayed at home and would not attend school. FSB said SB had recently burnt his school blazer. EIT3 made an appointment for later in the week.

8.43 EIT3 visited the family as arranged. Having noticed that despite numerous pages of detailed information on file, there 'were no summaries' of the work undertaken, he decided to find out more about the family background. He spoke with MSB who informed him that SB did not have a good relationship with FSB who had been in and out of prison over the last 18 years. She said that SB had witnessed a lot of domestic violence and that SB did not get on with her brother who was in prison but due for release very soon. EIT3 saw SB but was unable to engage the child in a conversation. As he was leaving FSB appeared and EIT3 observed immediate and aggressive conflict between SB and FSB, with FSB threatening SB with physical violence. EIT3 suggested that FSB calmed down. FSB then left the house and EIT3 arranged with MSB to call the following week.

8.44 EIT3 saw FSB outside the home and he remarked that he wanted something better for SB but did not know why he would not attend school. There was a no access visit a few days later. EIT3 made a third visit one week later but was unable to engage with SB. EIT3 advised MSB that he would be leaving the service, but another worker would be allocated to help SB with schooling at the beginning of the term.

8.45 SB did not return to school for the autumn term in September 2013. EIT4, a new keyworker, made several home visits and calls but was unable to engage with the parents until mid- October when MSB said they wanted school work to be delivered for SB. EIT4 could not persuade SB to talk to her and said she would call back two days later. MSB said that SB 'did not trust anyone' and suggested this was linked to an incident at school. Later that month, a third Penalty Notice was issued but the fine remained unpaid and the local authority proceeded to prosecute the parents for a second time.

8.46 EIT4 called to deliver schoolwork the following week but there was no answer at the house. The following week, EIT4 saw MSB, who said she was worried about SB because the child was refusing to leave the house. MSB says she thought SB was fearful because they had seen the man who had attacked her several months previously and he had just been released from prison. She also told EIT4 that SB was becoming obsessive about clothes, washing them every day before putting them on, and taking 3 or 4 showers a day. SB refused to go with her to see the GP. Although, EIT4, saw SB she was unable to find a way to engage with the child.

8.47 EIT4 contacted the Referral and Assessment Team after this visit to 'obtain some recent historical information' and spoke with a colleague who provided some background information. She was advised that SB could have mental health issues and she should think about using the Common Assessment Framework (CAF) process and contact CAMHS. According to EIT4, she was also advised that this was not a safeguarding issue. This communication is not recorded on CSC files.

8.48 EIT4 contacted CAMHS to enquire about a referral for SB. She was urged to try and persuade MSB to take SB to the GP so a referral to CAMHS could be made. EIT3 explained the difficulties and the CAMHS worker suggested that a CAF should be completed and a referral to CAMHS made through that pathway. EIT records indicate that that EIT4 'received a copy of a core assessment[14] from the social worker. It is likely that this related to the assessment, which had been undertaken in 2011.

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8.49 A further six home visits were undertaken by EIT4, along with numerous attempts to contact the parents via phone and texts, in order to discuss the CAF process and a referral to CAMHS. The parents did not engage. EIT4 often saw SB peering from the bedroom window as she left the property. In February 2014, both parents were fined in their absence following their non-appearance in court in October 2013.

8.50 In early spring 2014, FSB, told a professional that he had concerns about SB's non-school attendance but did not know if CSC were involved.

8.51 The professional, on advice from her manager sought information about contact numbers, and contacted Children's Services. She was advised to make contact with the Referral and Assessment Team for more details. This call was made but the duty officer in the Referral and Assessment team suggested that she contact the Pupil Admission team for further information as her query was about non-school attendance. The Team Manager (BIDAS) later made contact with the Case Manager (CM) in CSC who agreed to contact EIT. The content of this conversation is not recorded.

[14] A core assessment is an in-depth assessment, which addresses the central or most important aspects of the needs of a child and the capacity of his or her parents or caregivers to respond appropriately to these needs.

8.52 On 13 May 2014, the EIT service through the legal department issued a First Warning letter advising the parents that if they failed to cooperate and SB did not return to school, the local authority would prosecute under a more serious offence for which they could face a custodial sentence.

8.53 The final visit was made to the family in May 2014 when after receiving no answer EIT4 left a calling card asking MSB to contact her urgently. The Review Team were told that the EIT service continued to send letters to the family and to SB urging them to get in touch to avoid court action.

8.54 On 30.5.14, after more than a dozen unsuccessful attempts by EIT4 and colleagues to engage with the parents, a management decision was taken to issue a Final Warning letter and urging the parents to make contact with the EIT Service. CSC was informed by letter of the decision to move to 'aggravated proceedings' under Section 444 (1a) of the Education Act 1996 in respect of SB. At this point, the EIT workers were advised by management to cease visiting the family because they had been unable to engage the family and there were concerns about worker's safety if they continued to visit a family who were being taken to court and could face imprisonment. EIT4 contacted SCH1 to inform them of the legal proceedings and requesting they arranged an appointment with SB at the Connexions Centre to discuss post 16 options.

8.55 In early June 2014, Bolton School Nursing team, were advised by SCH1 that SB had re- enrolled almost 13 months earlier. SN4 requested information from the School Nursing team in Blackburn with Darwen (BwD), but only received a one-page document outlining immunisation records and transfer movements. There were no health concerns noted and no reference to any of the information previously forwarded by the School Nursing Services in Bolton to BwD in March 2011. SN4 was advised that further records could be shared on request.

8.56 Later that month, SB presented at Bolton A&E and was diagnosed for the third time, with a closed fracture of the right hand. This had allegedly occurred when SB was 'play fighting' with USB. A letter was forwarded from Bolton A&E to the GP in Blackburn, where the family were still registered. SB was not taken for any follow up appointments.

8.57 The parents did not respond to the two warning letters advising them of a pending prosecution and SB did not return to school. In July 2014, the prosecution papers and statements were submitted to legal services. EIT were later informed by legal services to drop the case against FSB, as they had no evidence he was living at the family's address.

8.58 In September 2014, MSB attended the first court hearing and indicated that SB had not attended school because of an incident in school. The Hearing was consequently adjourned for reports. The trial date was set for January 2015. MSB did not turn up for the trial and was found guilty in her absence. A warrant was issued without bail in order that she could be brought before

court for sentencing. MSB was arrested and brought before the court in early February 2015. She received a fine.

8.59 One week later SB died from hanging.

9 Appraisal of Practice

9.1 There was evidence of some good practice in this review including:

- The work by EIT1 to assist MSB cope with meetings at school and the persistence in which the service tried to engage the parents
- The efforts of SCH1 to engage SB and through a variety of ways and means, coax the child back into the school setting
- The joint visits that took place with EIT workers and staff from SCH1
- The visit by the social worker to the family when they moved to a different area

9.2 This section goes on to look back at the actions and decisions of professionals working with SB and explores why these professionals acted as they did. The 'why' questions are important as they helped the Review Team understand what systems were in place at that time to support good practice or make poor practice more likely. It is important to recognise how much hindsight can distort judgement about the predictability of an adverse outcome.[15] It should be appreciated that the prediction of events is not a straightforward matter; nevertheless it is essential that SCRs examine what happened and why actions and decisions may have made sense at the time. This allows the review to consider whether any system vulnerabilities are still present and how and where these can be changed. The aim of using a systems model is to select and review a specific case and to use this to provide 'a window on the system'.[16]

9.3 All of the practitioners involved at different times with SB and family were affected by the death of this child and the manner in which the death occurred. The members of the Practitioner's group found the review process both challenging and enlightening, and almost without exception they found it at times painful and uncomfortable. They are to be commended for their commitment to what has been a difficult process.

9.4 This section outlines the Review Team's views about how well professionals carried out their roles and responsibilities in working with SB's family, and also provides a link to the analysis of why certain actions may have made sense at the time. The examination of single and multi-agency working leading up to the death of SB has identified several aspects of single and multi-agency learning alongside some reflections about how judgments were applied at key points of interventions. The analysis is structured around specific areas of

[15] Munro (2011: 1.14)
[16] http://www.scie.org.uk/children/learningtogether

significant practice (ASP), which led to 9 findings and highlighted issues for Bolton Safeguarding Children Board to consider. The ASPs are:

ASP 1: The focus of work with SB and his family

ASP 2: The extent to which agencies communicated and collaborated within a multi- agency context

ASP 3: The responses of professionals to the parents who were evasive and hostile to professional involvement.

ASP 4: Supervision and managerial oversight

ASP 5: How transitions and changes were managed

9.5 The Review Team was aware of a previous learning review held in Bolton where a child died in similar circumstances. The Review Team carefully considered the learning from this and national reviews undertaken following similar tragic outcomes, to establish if there were any lessons or common themes, which could inform these findings from this review. Where there are any common themes, these are referred to in the text below.

Areas of Significant Practice

9.6 ASP 1: The focus of work with SB and his family

Why this was considered significant: *Despite initial concerns about neglectful parenting and the home environment, school attendance, rather than the safety and welfare of SB, remained the prime concern for professionals. SB had not attended school for almost two years before dying and in the 10 months prior to the death, there was no agency working or attempting to work with SB or the family. He appeared to the Review Team to be a 'lost' child'.*

9.6.1 Despite the involvement of services over a period of years, there was very little known by professionals about SB; what the child did all day when not at school; what were the child's sources of worry and anxiety, what thoughts the child had about the future and why there was a need to be so 'guarded' when asked about family life. Professionals assumed a level of resilience in SB, which was not tested, and they failed to recognise the full extent of the child's vulnerability and take protective action. Whilst at first, this is difficult to understand in the face of what is known about the co-morbidity of violence in the home, substance misuse and the impact on children, this needs to be explored in the wider context of family history and previous interventions.

9.6.2 There were several occasions when SB was younger, when strategy meetings should have taken place, when for example SB was present during reports of violence between adults in the home. Later, at the age of around 6 or 7, when referrals were made to CSC about poor supervision of SB, CSC concluded that these were 'malicious unsubstantiated concerns' which did not require statutory intervention or further exploration.

9.6.3 As SB grew older, agencies became more focused on school attendance and it was this that became the trigger for CSC intervention when SB was 9 years

old. SB was first placed on a child in need plan, but when this led to no improvements, an initial child protection conference was convened in summer of 2008, and SB was made subject to a child protection plan under the category of Neglect. A decision to pursue Care Proceedings when the parents failed to engage and there was no improvement for SB simply faded away inexplicably when parents did not attend an initial meeting. The Review Team were unable to find any rationale or explanation for this. Two years later, despite no evidence of sustained progress, the decision was taken to remove SB from child protection status as 'progress had been made in terms of school attendance'. SB was 'stepped down' to a 'child in need plan.' Later that year, SB was referred to the Early Intervention Team when school attendance continued to be an issue after SB had started secondary school in autumn 2010.

9.6.4 Although this information is documented in the narrative earlier in this report, and occurs well before the period under review, it is replicated here to highlight the view steadily maintained by professionals over the years that the 'problem' in this family was SB's non- school attendance, rather it being seen as a symptom of what was happening in SB's life. As SB grew older, the impact of SB's early life experiences and the continuing resistance and hostility of the parents towards professionals was not assessed or well understood.

9.6.5 School non-attendance is a complex phenomenon which, to understand completely, requires an awareness of multiple influencing factors within the realms of sociology, psychology, education, social policy, legislation and many other areas. Research[17] studies indicate that the causes of absence are multi-dimensional, but are typically caused by factors within the pupils' school environment, home environment, or psychological difficulties.

9.6.6 SB was referred to CAMHS on two occasions. In response to the first referral, the parents were contacted by CAMHS to ask if they wished to opt in for an appointment. They did not respond to this communication and there was no follow up by the referring professional and any mental health or psychological difficulties SB may have been experiencing remained unassessed. One professional acknowledged 'I didn't really know what to do, the family had never really engaged and SB wouldn't talk to me'. The Review Team were informed by SCH1 that they were unaware of any difficulties SB had when in school, and although they commented that SB ' didn't really have a particular group of friends', this was not of any particular concern. What emerged during the practitioner meetings was a sense that SB was viewed by school staff as a generally polite, untroubled adolescent who did not like school and so no other explanations for the poor school attendance were sought.

9.6.7 The Review Team were of the view that the focus on school attendance left professionals addressing just one dimension of SB's life, and important

[17] Reid, K. (2014a). Managing School Attendance: Successful intervention strategies for reducing truancy Oxon: Routledge.

though that may have been, SB's psychological, emotional and mental health needs were of greater concern. The family's social history and known parental substance misuse should have alerted professionals to his vulnerability and the risks to which SB, as a child, was exposed on a daily basis.

9.6.8 Brandon et al (2010) suggests that the co-existence of mental health issues, domestic violence, and substance misuse create cumulative problems and adversities, which present significant risks factors for children. This review has been presented with information, which suggests that, certainly two of these three factors, and possibly all three were present in SB's life. Parental drug and alcohol misuse are known to create considerable problems for children and young people as they grow and develop. Research[18] suggests that while the effects of drug and alcohol abuse are similar, the former brings with it more anxiety and social stigma for children. Uncertainty about the reactions of others, concerns about stigma and types of interventions that might ensue from services, limits a child/young person's ability to be open about the difficulties they might be experiencing. Research evidence also shows factors associated with experience of co- morbidity for this age group include poor school performance, emotional disturbance, conduct disorder, fears of exposing family life to outside scrutiny and risk of suicidal behaviour.

9.6.9 There was poor theoretical understanding amongst professionals of the inter-linkage of the above factors and the impact they would have on SB growing up. Whilst their presence was of sufficient concern to place SB on a child protection plan at 9 years old, they were clearly considered less of a risk to SB as an adolescent. The impact on SB having lived in a situation where actual or threats of violence and substance misuse were present for so long was not well understood, even within the context of SB being 'guarded' about sharing any information about family life. The extent to which domestic violence was a feature in this family is unknown, but MSB stated clearly to EIT3 that SB had witnessed domestic violence in the family over the years. Although there were several occasions when police were called to the family in response to violent incidents, these seemed to occur in relation to fighting between male adults in the family, and sometimes involved SB. Both police and CSC records indicate that substance misuse and alcohol were contributory factors to these episodes.

9.6.10 Despite the referrals by professionals to CAMHS, SB's general demeanour and the absence of any behavioural difficulties appears to have led professionals into assuming SB was coping with the adversities experienced by the home environment and the parent's lifestyle. They did not view the persistent failure to attend school as a safeguarding issue despite the social history of the family. This highlights the importance of professionals not accepting at face value what they 'see' but using professional knowledge and wisdom to question their assumptions about the underlying causes of specific behaviours in children and in relation to SB, to fully assess the level of assumed resilience. Munro, 2011 describes this process as double –loop

[18] Centre for Research on Families and Relationships, University of Edinburgh 2004 Parental drug and alcohol misuse. Joseph Rowntree Foundation

learning but the process does require a level of reflective practice usually cited within a framework of good supervision and/or professional guidance and this was not evident in this review, an issue explored later in this report.

9.6.11 It is important to recognise the effects of the experience of multiple adversities in childhood for two reasons; first because such experiences have been shown to have profound effects upon individuals, realised in different ways, across the life-course, and second because there can be a preoccupation amongst professionals with singular events or episodes such as non- school attendance and this can serve to obscure or hide the effects of cumulative adversity.

9.6.12 The role that schools play in promoting the resilience of their pupils is vitally important, particularly so for children, like SB, where their home life is of concern. Where there are concerns about a child, early intervention is important. Recognising that a child may be suffering from emotional abuse or in need of mental health services may not be immediately evident to school staff and education welfare officers, but professionals need to see their role as being broader than responding just to the immediate or current issue. There is clear evidence in this review that professionals continued to deal with the presenting issue, without due consideration of the wider array of adversities that SB had experienced.

Finding 1*: Despite the family's social history, poor school attendance was continually perceived as being the 'problem' within this family, rather than it being considered as a symptom of what was happening in SB's life. The sole focus on school attendance obscured and hid the effects of cumulative adversity, which SB experienced, and this left the child vulnerable.*

9.6.13 SB repeatedly stated that SB was unable to attend school because of ill health; tonsillitis, migraines, vomiting, stomach aches, but despite this SB was never taken to see his GP. SB was also referred to CAMHS because of concerns about the child's emotional presentation and MSB's account of the child's obsession with keeping clean and washing school uniform, every night before school. The failure of MSB to engage with a GP or CAMHS did not heighten concerns of professionals or lead them to consider taking the sort of protective action that they undoubtedly would have taken had SB been a younger child. There is a growing body of evidence that suggests teenagers who are exposed to neglectful parenting are less likely to be referred and less likely to refer themselves to services.[19] This was a key learning point for the practitioners who participated in this review and who acknowledged that they had not considered SB as a 'child' who could be at risk. Consequently they had not considered the need to refer to CSC. This is illustrated by the incident where EIT3 observed threatening and aggressive behaviour of the father to SB in June 2013. EIT3 explained that he did not view this incident as requiring a referral to CSC, as SB was fine when he left, although he had contacted 'someone' in the Referral and Assessment team to seek advice. Similarly the

[19] Brandon et al (2009) Understanding Serious Case reviews and their impact

999 calls made by SB in November 2012 led to a police response but this was not seen as the significant event it was.

9.6.14 It was of concern to the Review Team that neither the school, nor any of the EIT workers considered making a referral to CSC and neither were they advised to do so, by their respective managers or in line with their safeguarding procedures. The practitioners group stressed that in their view non-school attendance would not meet the criteria for a social care referral, and in relation to SB, the group pointed out that any referral would have described SB as a clean and polite adolescent who was refusing services or offers of help. This they suggested would have made it highly unlikely that statutory intervention would have been considered as a priority. They also acknowledged however that had SB been a younger child, they might have found easier to consider that a referral to CSC was appropriate.

Finding 2: *Children who live in families where there is co-morbidity of parental substance misuse and violence within the home are known to be at risk of significant harm. This review has highlighted that when the 'child' is a young adolescent, the impact of these adversities can be overlooked or minimised by professionals who are then less likely to refer their concerns to children's social care.*

9.6.15 During the period under review, CSC was contacted for information by an adult services professional working with FSB and by EIT4, but these contacts were not referrals and the professionals were left working from a single agency perspective. Had there been more multi-agency collaboration and access to good supervision, professionals involved at the time may have been better supported to consider other strategies to safeguard SB than 'just' getting the child back into school. The practitioners only learnt through the SCR process that BIDAS offers support to professionals working with parents where substance misuse is a concern. However, the issue of parental substance misuse was neither addressed nor acknowledged by SCH1 or the EIT service.

9.6.16 There is a need for support staff to see and understand that there are a range of both presenting and underlying factors which may be impacting on a young person's developmental and coping abilities. SB presented as a clean, polite and well-mannered child, who was not offending or going missing, was not known to be misusing substances and was not involved in any anti-social behaviours. The Review Team were of the view, and this was acknowledged by the practitioners, that SB's presentation gave the impression to professionals, including those who met with him in BwD, that SB was resilient and coping with the many adversities imposed by his family circumstances.

9.6.17 Whilst it is recognised that adversity in childhood is not in itself deterministic of poor outcomes in later life, there is substantial evidence that it does increase the probability of compromised outcomes. The practitioners acknowledged that the possibility that SB was at risk of suicide was never discussed or considered and they suggested that had his coping mechanisms been externally directed rather than internally absorbed, they may have found it

easier to identify and respond to his vulnerabilities. This led to a discussion about the difficulties in securing mental health services for adolescents. Whilst it was acknowledged that referrals to CAMHS do lead to better outcomes for some young people, it was clear that given the parent's resistance to professionals, it was always unlikely they would follow up any appointments made for SB. School professionals spoke of the difficulty they encounter in commissioning services for young people who do not reach the threshold for a referral to CAMHS but who still need some form of mental health support. This has led SCH1 to commission their own support for young people in school. Discussions also centred on not only about the lack of mental health provision for young people but also the absence of specialist services to train and support practitioners.

Finding 3*: There is a mismatch between available resources and the needs of young people who need access to mental health services but who do not or cannot meet the criteria for CAMHS support*

9.6.18 Although the majority of SCRs continue to be conducted in relation to younger children, five years and under, with those aged less than one year comprising the largest group, deaths or serious injury of older children regularly make up a quarter of all such reviews[20]. The findings show that adolescents are much less likely to be harmed by physical assault and much more likely to be harmed by their own hand with death or serious injury and this accounts for almost 1 in 10 of cases reviewed.

Finding 4*: A lack of knowledge among professionals about the evidence base related to risk indicators for adolescent suicide can leave them ill equipped to discuss and/ or recognise signs and respond accordingly.*

9.7 ASP 2: The ways in which professionals communicated and worked collaboratively

Why this was considered significant: *This review has highlighted that multi-agency working was not effective and information not shared or used effectively. Whilst appearing to work collaboratively, agencies were in effect working as single agencies and each to their own agenda*.

9.7.1 Clear and open communication between professionals and agencies is well known to be fundamental to effective work to safeguard children and is repeatedly quoted in literature and SCRs, as being the key element in effective multi-agency working.

9.7.2 Although outside the time frame for this review, the child in need and child protection plans produced in 2008 were unfocused and not compliant with expected standards. The Review Team were unconvinced that the decision to remove SB from a child protection plan was based on sound judgement and sustained improvements in the family, but were also of the view that this

[20]http://www.baspcan.org.uk/files/Brandon%20Marian%20S7.4%20Tues%2010.45.pdf Brandon et al (2011)

decision, made prior to the period under review, had a significant impact on how the parents were later viewed by agencies.

9.7.3 At the point at which the family left Bolton in February 2011, SB was subject to child in need status. Details of the family history, including past CP concerns, were forwarded appropriately to BwD Children's Services by the family's social worker and this was followed up by telephone contact between the two agencies where it was agreed that an Initial Assessment would be undertaken. The social worker from Bolton also made a visit to the family and SB at their new address in BwD and noted SB to be well and settled before closing the case file. This was good practice and indicates that learning from a previous SCR in 2009 is integrated into practice.

9.7.4 The school nurse, SN2 in Bolton met SB on several occasions for health assessments and though health records note SB was 'guarded' in response to questions about his family, this information is significant but its implication does not appear to have been identified as such. SN2 was told repeatedly that mum was a trusted adult to whom SB could talk. An exploration of why SB was 'guarded' could have assisted professionals to consider possible hypotheses about what was happening SB's life and also led to different approaches to work with the parents. When SB and family moved to BwD, SN2 forwarded school health records to the School Nursing service in that authority and included a detailed summary of the family history.

9.7.5 The Review Team were informed late in the SCR process that SN2 had a telephone call with SN3 after forwarding these records, but the detail of that conversation was not available. It might be assumed given the knowledge that SN2 had from her attendance at Core group meetings that the challenges of working with the parents and keeping a focus on SB would have been shared. The records passed to SN3 included details of past child protection concerns, child in need meetings, domestic violence and records relating to Child Action meetings. This information, according to SCH2, was not passed to the school by SN3 and neither were any of these details included in the information forwarded by SCH1. The Review Team was unable to determine why this information was not forwarded by SN3 but were advised there was an assumption that the information would have been shared through other channels.

9.7.6 In May 2011 SCH2 were contacted by SW2 from BwD undertaking welfare check in respect of SB. This query should have been forwarded to the Deputy Head, as he was the Designated Safeguarding Lead (DSL). However a new member of staff responded to the query and after taking advice from other staff in the school reported that SB was doing well, and there were no safeguarding concerns. SCH2 acknowledged that this query in itself should have generated a safeguarding file for SB but the new member of staff responded to the query without advising other colleagues why he was asking about SB. Further enquiries were made by SW2 four weeks later and again it was confirmed there were no concerns and SB had settled in well. SCH2 have now revised their procedures to ensure that any enquiries about the welfare or well-being of pupils by CSC are forwarded to the DSL.

9.7.7 A decision was taken by SW2's manager in June that SB's needs could be met by universal services and there was no role for Children's Social Care.

9.7.8 SB left one authority with child in need status where there were ongoing concerns about the family's lack of engagement and unwillingness to address the issues of SB's poor school attendance and arrived at a second authority where soon after a decision was taken that SB did not require targeted services. The Review Team considered whether in these busy times, with increasing workloads and diminishing resources, it was realistic to expect that SB would have continued to be seen as a child in need, given the family and SB indicating that the move to BwD was a new start and 'all was seen to be well'.

9.7.9 Whilst, an essential element of communication is the exchange of relevant and timely information between professionals, there is however more to communication, than exchanging reports and information. Without any face-to-face meetings or direct contact between key professionals to talk over the history of the family, important information was lost in transition, an issue picked up later in this report. The practitioners' group suggested that in the current climate with mounting pressures at work, sending off a report or an email was often seen as an effective way to communicate.

9.7.10 The family had registered with a GP practice in BwD but they did not attend for a 'new patient' check-up or respond to a telephone call from the surgery. On SB's medical records there was still a pop up which indicated that the child had been subject to a CP Plan in 2008. The Practice Manager noted that there was no additional information received about SB between 2008 and 2011. This raises question about how and when GPs are informed about progress of children on plans so their records can be updated. When the family registered, the practice and the GP assumed that given the date, the plan had been discontinued which in effect it had been but a call could have been made to CSC or to the school nursing service for more information had they been minded to do so. The injuries to SB's hand were not considered significant given the child's age and when the letters arrived from A&E they were simply scanned into records and there were no checks on history. This practice has now introduced a process whereby the need for further discussions is flagged when a child who is, or has been, subject to a CP plan sustains a subsequent injury.

9.7.11 It became known that SB was moving back to Bolton, the EWO contacted SCH1 to confirm that a start date had been agreed, although it is unclear what information was shared at this stage and whether SCH1 was aware that SB had not attended school for over 6 months. Although records were transferred back to SCH1 from SCH2, there is no record of any direct contact between the two schools once SB had moved back to Bolton. Had SCH1 known more about the absences and the conversations between the parents and the EWO in BwD, the need for a more robust and focused response involving other professionals might have become evident.

9.7.12 The role of the Designated Safeguarding Lead (DSL) in both schools was discussed with practitioners. The view was expressed, as this was a 'school attendance issue', there was no requirement to alert the DSL, raising the query again as to when should non-school attendance become a safeguarding concern. The view expressed by practitioners was that 'CSC does not consider that non-school attendance is a safeguarding issue'. However, the Review Team was of the view that neither did the professionals working with the family see SB's non-school attendance as a safeguarding concern.

9.7.13 SB left BwD, the School Nursing files should have promptly been forwarded back to Bolton School Nursing Service, this did not happen, but neither was Bolton School Nursing Service informed by SCH1 that SB had re-enrolled at school. Despite continued absences that MSB explained were due to ill – health, SN3 was not notified until 13 months later that SB was a pupil at SCH1. There was no obvious explanation given for this although it seemed to the Review Team that the focus on school attendance again eclipsed consideration of SB's emotional, physical, and mental health needs.

9.7.14 In September 2012, school contacted the Early Intervention Team to ask for support with SB's non-school attendance and the family were allocated to EIT2. There does not appear to have been any contact with the previous school or the EWO from Blackburn to discuss what may have been happening in the family and clearly this contact would have offered useful insights into family functioning. As the team had known the family previously, there was a view that all the necessary information was contained in local EIT records.

9.7.15 The Review Team noted there was no assessment at the start of work with this family by any of the EIT workers and were informed that at the time, there was no requirement or expectation that an assessment would be undertaken. Having been contacted by the school about non-school attendance, this was clearly seen as the prevailing issue. In itself, this would not be unusual given the remit of the EIT at the time, but without an assessment, the issues around parenting capacity, the home environment and the substance misuse were left unexplored and unassessed. According to EIT practitioners, their understanding was that it was FSB who misused substances and not MSB, although earlier family records referred to MSB's drug use and EIT1 was clearly of the view that MSB's presentation was suggestive of drug use

.

9.7.16 Apart from the brief work undertaken by EIT3, it appears there were no attempts to gather information about the family history. When EIT3 became involved for a short period in the summer of 2013, there was it appears over 24 pages of detailed chronology on file but no summary reports, analysis of work undertaken or evaluation of intervention plans. EIT workers said they used their own judgement to decide how best to work with families and until late 2013; this work did not involve undertaking assessments. In conversations with EIT workers, there was a degree of uncertainty as to whether this was within their remit or whether this would be encroaching on the social worker role. This issue has now been addressed and the EIT role and related responsibilities are now explicit.

9.7.17 This does however highlight an issue around recording practices both within EIT services and at SCH2. The Review Team acknowledge that improvements have been made to these systems since the period under review, but stress the importance of robust reporting and recording systems. Within the EIT service, at the time there was no requirement to periodically produce summaries of the work undertaken or comment on the effectiveness of particular approaches to work with this family. There were no 'front sheet' chronologies in records, which undoubtedly made it difficult for subsequent workers to formulate plans of work. Despite the family history, there was no safeguarding file on SB in SCH2 and without a chronology, it would have been difficult to gauge what interventions had worked with parents and what actions should be progressed but importantly chronologies allow practitioners to gain a sense of past events and how these impact on present concerns.

Finding 5*: Effective recording systems support good practice by the inclusion of succinct and updated chronologies, sound assessments, and regular summaries of the work undertaken with families. This was not evident in this review.*

9.7.18 From spring 2012 to summer 2013, staff from SCH1 and EIT continued to try and engage with SB, MSB and to a lesser extent with FSB. Their efforts produced no change in SB's schooling and led to no improvement in the relationship with the parents. School staff and EIT workers shared with the practitioner's group their frustration that they could not make any inroads with the family and were at a loss to know how what to do next other than resort to legal penalties. Although both agencies were endeavouring to address the symptomatic behaviour of SB, they did not seek to engage the multi-agency network and this was a lost opportunity to harness involvement and know-how from other agencies.

9.7.19 There was a view clearly expressed by practitioners that it was not acceptable for professionals to meet [as a group] unless they had parental consent. Professional's meetings that do not involve family members did not feature in the statutory guidance[21] relevant at the time, and it was, and still is, common to assume that they are not allowed. In fact, Bolton's procedures state that a professional's meetings can take place 'in exceptional circumstances'. It is also perhaps worth noting that meetings between EIT workers and SCH1 appear to have taken place even though the parents did not attend but the Review Team asked about minutes of these meetings and it appears no formal minutes were taken.

9.7.20 A professional's meeting might have included SCH1, SN3, EIT workers, police, a drug and alcohol representative (once it is decided to call a professional's meeting more agencies often come to light) and possibly a worker from CSC. It is possible that through the sharing of information, and joint decision-making, a more effective multi agency and coordinated approach to work with this family would have occurred. Had the Police visited they would have been able to share information when they had seen SB. The

[21] Working Together to Safeguard Children (2010)

issue of SB's 999 call might have brought into sharper focus the home circumstances and the extent of violence in the home.

9.7.21 Although acknowledging the drawbacks of professionals-only meetings, there was a strong message from practitioners that in some circumstances such a course of action can lead to better outcomes for children and improve multi agency working. There was however still uncertainty about how and when such meetings could take place in Bolton. The emphasis of partnership working with parents and the reliance on CAF as a method of engagement clearly inhibited professionals from sharing concerns about families who do not reach the threshold for Child in Need/ Child Protection and who will not agree to, or engage with, the CAF[22] process.

9.7.22 Neither the school nor the EIT service saw their agency as responsible for either instigating a CAF, as it was then, or calling a professionals meeting, despite the fact that these were the practitioners best placed to identify children at an early stage who have additional needs which would benefit from a multi-agency response. In the practitioner's group, discussions centred on a concern that by calling together a group of professionals, they could be left holding a Lead Professional role and this prevented many agencies including schools from initiating these meetings.

9.7.23 Views were expressed that, in general, professionals felt they did not always have the necessary skills or confidence to initiate CAFs and/or to take on the Lead Professional role. Even when CAFs are initiated, the Review team was told that the CAF process was not always considered as a high priority by agencies so meetings were not well attended. Some practitioners considered that unless the meetings were set up by Children's Social Care and attended by social workers, they were not considered as 'formal' meetings" and so were less effective. One practitioner said he felt that at the time ' CAF didn't really fit, it was disjointed and not viewed as an assessment tool'. Other professionals in the room endorsed this view.

9.7.24 Where work involves parents who are difficult to engage or resistant to engage, multi-agency work is essential and needs to focus on the impact of parental behaviour on the child and the capacity of the parents to achieve change where change is required. Using tested assessment tools on both of these aspects assists practitioners to establish in a timely way where a higher level of intervention is needed to maximise a child's life chances. The danger of persevering with goals that are unachievable is that children, as with SB, continue to live in sub or deteriorating standards of care without any applied assessment to expose risk or their vulnerability.

Finding 6: *The failure to collaborate within a multi-agency context means that key information was not shared or discussed; this leaves professionals*

[22] The Common Assessment Framework (CAF) is an Early Help tool used to identify the best way to help children and their families so their situation does not worsen

working in isolation and highlights vulnerability in multi-agency systems designed to safeguard children. This was evident in this review.

9.8 ASP 3: The responses of professionals to the parents who were evasive and hostile to professionals.

***Why this was considered significant**: It is noted in records that on the occasions when contact was made with the family, parents and other family members were often, but not always, aggressive and hostile towards professionals. The failure to be able to meaningfully engage with the parents who were regarded as 'highly resistant' left professionals frustrated and resorting to legal measures. This left SB in a vulnerable position.*

9.8.1 This review illustrates the complexities of trying to work with parents who are highly resistant and who will not or cannot engage with professionals. The term 'highly resistant' sits however on a continuum. At one end are parents who are reluctant and hesitant about accepting help and at the other end are parents who are very accomplished at misleading child welfare professionals into believing that progress is being made whilst nothing is actually changing.

9.8.2 The parents of SB sit perhaps somewhere in the middle of this continuum. They do not appear to have been too concerned about whether professionals thought there was progress, it would seem they simply wanted professionals to stop bothering them and although assurances were made that they would get SB back to school and they would attend meetings, these promises never materialised. What is significant here is that professionals knew from when SB was a young child that the parents were unwilling to change their behaviours - this was stated explicitly when SB was taken off a CP plan in 2010 – but as SB grew older, the parent's unwillingness to engage, although frustrating, became an accepted aspect of work with this family.

9.8.3 Poor understanding of the significance of co-morbidity and on how to engage resistant families was compounded by a number of general factors. The absence of any assessments, planning, or supervision was significant and the failure for any handovers between EIT workers meant each subsequent practitioner was simply 'starting again'. This, together with a degree of optimism of each worker, led to an unintended consequence of discontinuity, which possibly made it easier for the family to 'resist' any engagement.

9.8.4 Despite the tenacity of EIT workers and the staff from SCH1, the parents of SB refused at all levels to cooperate with professionals, occasionally expressing concern and confusion as to why SB would not attend school. There were a variety of views expressed by the practitioners as to why SB could not maintain regular school attendance, ranging from MSB needing to keep her child close to ideas that SB was fearful of what might happen to MSB if she was left alone. These views or hypotheses were however never tested and this allowed professionals to continue to work on 'carrot and stick' strategies. SB was offered support, inducements, and flexible opportunities to attend school, whilst parents were issued with fines and fixed penalty notices, and the threat of being reported to CSC if they did not engage with EIT

workers. It is entirely probable that the parents believed given their past experiences, that there would be no significant consequences for their non-cooperation with authorities and SB's persistent non- school attendance.

9.8.5 It is significant that the Review Team were unable to access any assessments, which had been undertaken during the period under review. At the time, it was not common practice in the EIT service for assessments to be undertaken when work began with a family; schools referred a child to the service for non-school attendance and workers made a visit to the family to determine what support was needed and how they might assist to improve the child's attendance at school.

9.8.6 The Review Team were told that attempts by EIT 4 to instigate a CAF were futile as parents did not respond and without parental consent the CAF process could not progress. This seemed to have left the school staff and the EIT workers in a position of not knowing how best to move forward and so efforts continued as both agencies tried repeatedly to encourage SB back into school but without the benefit of any assessment. Asked why the situation did not warrant a referral to CSC, the Review Team were advised that neither school staff nor EIT workers considered that SB would meet the threshold for significant harm, and they did not think to contact CSC to discuss other possible interventions.

9.8.7 Visits to the home usually involved standing on the doorstep talking to MSB and very occasionally, school staff or the EIT workers would be invited into the house and even then they were rarely invited into the front room. Conversations were usually focused on SB and school attendance as opposed to what might be happening in the family. One practitioner acknowledged 'I felt I couldn't discuss issues about drugs without being able to establish a rapport'. The Review Team were unable to locate any evidence of robust and sustained challenge by professionals, other than when they resorted to fines and fixed penalty notices. In the professionals meetings, the EIT practitioners confirmed they were at a loss as to how to move forward and legal options were eventually seen as the only way forward.

9.8.8 Research highlighted in a C4EO briefing suggests that families who are 'hard to reach' have characteristics usually associated with mental illness, substance abuse and domestic violence, but that does not necessarily mean they are targeted by child protection services. According to research, many of these families come into contact with tier 1 or tier 2 professionals working in universal and targeted support services and these professionals may not be sufficiently skilled or experienced to detect the degree of families' problems or respond with any of the necessary authority.

9.8.9 Most services to children and families are provided on a voluntary basis through universal or targeted services. Whilst professionals were concerned about the inability or unwillingness of the parents to change their behaviours, the reasons why they refused to engage were never fully explored, their evasiveness and hostility certainly thwarted any attempts by professionals to probe further. The Review Team were unsure of how much was expected of

the workers from the EIT service and whether it was realistic to suggest this was an intrinsic part of their role.

9.8.10 As mentioned previously, the reasons for non-school attendance are multifaceted. So too, are the reasons why parents will not engage with professionals. When parents are involved in illicit drug use, research suggests that secrecy becomes essential to guard against legal interventions; parents can be particularly mistrustful of outsiders and resistant to attempts to help, even when there is evidence that a child in the family is in need of services.

9.8.11 It is clear that the parents of SB, and indeed other family members were distrustful and anxious about contact with professionals but without the benefit of informed assessments, the reasons for these responses remain only guesswork. There are however examples, which perhaps offer some insight into, work with the parents in this family. One is the work undertaken by EIT1 whose records suggest that MSB's hostility 'softened' with the right approach. EIT1 worked with MSB so she could be more confident in attending meetings at school and this appeared to have led to her attendance at certainly two, subsequent meetings. The second example relates to the conversation between MSB and EIT3, where significant information was shared by MSB about family relationships and the view expressed to the same worker by FSB suggesting he 'wanted more for his child'. These interchanges offer a glimpse into possibilities of engagement with these parents but these were not pursued and suggest that work with these particular parents required skills and expertise beyond the scope and skill base of the EIT workers.

9.8.12 A number of lessons are consistently identified in the analyses of SCRs in England: better communication and collaborative work between the range of professionals, the importance of assessments and a greater understanding of the impact of drug and alcohol misuse when working with parents. Given the consistency of these messages, questions are repeatedly asked why they are not firmly embedded into practice. Brandon and colleagues (2008) suggest that where parents are hostile and aggressive towards agencies, agencies are often found to exacerbate the situation by offering a succession of workers each of whom did not always have key information and/or the right skill set and were therefore less likely to instil confidence or trust in resistant parents. There is evidence in this review that the changes of EIT workers were not without impact on the working relationship the service had with parents.

9.8.13 Professionals need to be equipped to deal with difficult and hostile parents and supported by their colleagues and agencies. They also need to know the limits of their own knowledge and expertise and call on the skills of others or specialist services when needed. It is crucial however there is support and systems in place to help them know when and how to do this.

9.8.14 Professionals working with this family were clearly frustrated by their inability to engage parents and withdrew their involvement, resorting instead to legal measures. The last recorded attempt by the EIT service to visit was in May 2014 and school ceased to visit SB in the spring term 2014. This highlighted to the Review Team that agencies were concerned primarily with school

attendance and having concluded that SB was not going to return to school, saw no need for their continued involvement. Whilst this may have been the desired outcome for the parents and very possibly SB, it nevertheless left the child exposed and vulnerable.

Finding 7*: Parental hostility and lack of engagement impacted on professional confidence and hampered their ability to safeguard and work effectively with SB. This, together with the absence of any structured supervision opportunities, led to work with the family drifting and this left SB vulnerable.*

9.9 ASP 4: Supervision and managerial oversight

Why this was considered significant*: Early Intervention workers were working or attempting to work with this family for over two years without evidence to suggest that the parents were willing or motivated to change their behaviour to meet the needs of their child. The Review Team were of the view that good quality supervision did not take place and this left workers with limited opportunities to reflect on their practice and consider other forms of intervention to secure the well-being of SB.*

9.9.1 For professionals who work with families, regular, good quality, organised supervision is critical, as are routine opportunities for peer learning and discussion. In this review neither the school staff visiting SB nor the EIT workers trying to engage the family had access to reflective supervision or opportunities to explore and reflect on their work with SB and parents. This left them working for over two years without any demonstrable change in SB's school attendance. The EIT workers and school staff who attended the practitioner's group acknowledged that they had never experienced such resistance or frustration in their work with other families and were at a loss as to know how SB's situation could be changed for the better.

9.9.2 The role of the DSL was not utilised by school staff in either SCH1 or SCH2 and again highlights the view that SB's non-school attendance was not seen as a safeguarding concern. However, SB was subject to an initial assessment when attending SCH2 and the welfare queries made by SW2 in BwD should have led to DSL involvement and the opening of a safeguarding file.

9.9.3 Persistent school non-attendance is often maintained by parental neglect, collusion, or wilfulness; or by under-developed parental skills and understanding. What seems clear in this family is that penalty notices and fines were seen by parents as a routine nuisance rather than the behaviour-changing devices professionals hoped they would be. In this respect, legal measures were never likely to be effective in encouraging SB back into school, they were however likely to generate tension within the home and as with the issue of all such notices, generate unintended consequences.

Finding 8*: Where it is not possible to build a cooperative relationship with parents, workers need good quality reflective supervision to explore and establish what actions or intrusive measures should be undertaken to protect a child from harm*.

9.9.4 EIT records indicate some uncertainty by EIT workers and possibly their managers about contacting CSC for advice about whether their concerns necessitated making referrals. In June and November 2013, EIT records refer to EIT3 and EIT 4 contacting the Referral and Assessment team to discuss their concerns about locating SB. EIT 3's contact was not recorded but he told the Review Team that he recalls an informal conversation with a colleague in CSC, the outcome of which he cannot remember but it did not lead him to take any further action on his part. EIT4 spoke with a colleague in CSC who, according to EIT records suggested that she refer SB to CAMHS as it appeared that her concerns related to SB's 'mental health' the detail of that conversation is also not recorded.

9.9.5 There are two issues here. The first is the importance of good record keeping which records the purpose and content of conversations with named colleagues and the outcome of those discussions. The second relates to the importance of professionals understanding the difference between asking for advice and guidance from CSC and making a referral into that service. Although not recorded, the Review Team were told that CSC had informed EIT4 that in respect of SB, her concerns did not reach the threshold for a referral. EIT 4 accepted this, as she believed that her colleague in CSC would be better informed about the appropriate action for her to take.

9.9.6 There are a range of factors, which can affect a practitioners' ability to assess or see clearly what is happening to children including having a view that 'social workers know best'. This is compounded in cases of neglect by the difficulty of determining the threshold for decisive action based on an accumulation of concerns without any one precipitating incident that leads to intervention. It is here where good supervision is needed to assist practitioners take decisions that are in the best interest of the child. Although CSC can offer advice as to whether a referral should be made, the decision as to whether an agency follows that advice remains a decision for that agency based on their understanding of the child's needs and vulnerabilities.

9.9.7 Whilst the lead agency for making decisions about how referrals progress is Children's Services, they rely on partner agencies to provide much of the information upon which to base those decisions. Without a record of those conversations, it is difficult to ascertain whether enough background information was shared with CSC by the EIT workers for them to make an informed decision about SB. Equally, the advice given by CSC could have been challenged had EIT service been clear themselves about the safeguarding implications for SB. This highlights the importance of managerial oversight when advice from CSC is sought and acted upon.

9.9.8 During conversations with practitioners, discussions centred around whether EIT workers specifically were expected to undertake tasks that were outside their skills and knowledge base and whilst this was acknowledged as an issue perhaps requiring further exploration, the recent re-launch in 2014 of the Framework for Action and Early Help does provide clarity around roles and responsibilities and a clear pathway for referrals into the Early Help process

9.9.9 Frontline professionals working with families that persistently resist or avoid interventions benefit from effective supervision, which allows them to reflect on their practice and have a constructive dialogue with their manager and/or their designated safeguarding lead. The context in which the EIT professionals were working at the time of this review clearly indicate that supervision was not given a high enough priority by the management systems designed to support the workforce and safeguard the needs of vulnerable children. Managerial oversight and supervision is important at all times but especially so in times of transition and periods of change.

9.10 ASP 5: How periods of transitions and change were managed.

Why this was considered significant: *This review has highlighted how during times of transition, important information can be lost or misinterpreted and frequent changes of workers can significantly impact on the ability of professionals to engage parents and gain the trust of children with whom they are working.*

9.10.1 Research studies[23] and file audits have repeatedly shown that historical information is often not given enough attention when assessing the needs of children. These studies found important information was variously lost, missing or not shared, particularly when the family moved geographically across borders and as with this family, where there were several changes of workers over a short period.

9.10.2 There were several points of transition evident during the period under review and these contributed significantly to information being lost, overlooked, or minimised. The family experienced changes in the teams within Children's Services, SB moved schools three times, the family moved into another local authority area and then back again, and they were visited by four different EIT workers over a relatively short period of time. Making the transition to a new school or a different locality can be a significant event for any child and may well have been particularly unsettling for SB.

9.10.3 SB was subject to Child Protection Plan for two years - a significant period. The Review Team was therefore surprised to learn during practitioner meetings and from conversations that the EIT workers were unaware of this aspect of SB's life when they began their involvement shortly after SB's child protection status had been removed. The CP plan had ended not because parents had demonstrated an ability to meet the child's needs to a good enough standard, but because they 'would not engage' thus implying that a sub-standard level of parenting was considered to be acceptable. There was evidence that throughout the period under review, professionals paid little attention to SB's history as a child about whom there had been child protection concerns. Consequently this significant aspect of SB's life seems to have been 'lost' to professionals.

9.10.4 When SB moved to BwD, a referral was made by the social worker from Bolton CSC. This would be expected where there was ongoing work with a

[23] Rose and Barnes 2008, Reder and Duncan 1999

family where a child had 'child in need' status. The referral included relevant background information and child protection documentation, including a copy of the Core Assessment to illustrate the family's history with Bolton. The response to this referral suggests however there was a shift in focus from SB as a 'child in need', to MSB and her request for continued social work support. As the parents later presented the BwD social worker with information that SB was well, they were making a 'fresh start', were now drug free, and were well supported by their family, the social worker concluded in her initial assessment that no further action was required and a management decision was taken that SB no longer required the 'child in need' status he had whilst living in Bolton.

9.10.5 Although the paperwork indicates that the initial assessment was concluded in March 2011, SCH2 and CSC records indicate that inquiries were still being made as part of that assessment in April and May 2011. These inquiries did not however include further meetings with SB either at home or in school. When SB was referred by SCH2 to Education Welfare in December of that year, the background of SB's non-school attendance was not provided to the EWO nor did he seek to establish SB's attendance patterns whilst the child lived in Bolton. As a result, that particular episode of intervention occurred in isolation to SB's long- standing history of not attending school and it did not result in SB returning to school before moving back to Bolton several months later where the child remained out of school for a further four months. The move enabled the parents to evade responsibility for SB's school attendance for a period of six months.

9.10.6 The Review Team learnt late in this SCR process that in May 2011, an allegation was made to BwD CSC suggesting that an adult male in the family was a possible risk to children. An Initial Assessment was undertaken in respect of Child A and the social worker concluded there was no role for Children's Services. The documentation seen by the Review Team suggests the emphasis for the assessment is the conflict between Child A's parents rather than an exploration of any risks posed by the adult male. There is certainly no reference to SB and family living at that address, or to the Initial Assessment being concluded several weeks earlier in respect of SB. The two processes clearly occurred independently and were not connected through the existing information systems. They were conducted by different social workers and signed off by different managers. SB and Child A also had different surnames. The Review Team was advised that details of FSB and family members and their Bolton address were clearly recorded on MGM and SPGF records.

9.10.7 Seven months later in January 2012, BwD CSC records indicate that a Core Assessment was triggered 'following the initial assessment undertaken in May 2011'. This Core Assessment was undertaken in order to gather more information as the worker undertaking the previous assessment was no longer working for the authority and the team manager wanted to ensure the assessment was robust. There is no indication that additional work was completed in the intervening period. This information came to the Review Team late into the Review, and the Review Team were keen to explore

whether SB could have faced an element of risk or exposure to inappropriate sexual activity which had not previously been considered. The Core Assessment stated that the risks posed by an adult male were 'minimal' but additional information has recently come to light that casts serious doubt about this individual not being a risk to children. Professionals did not know this information until it emerged during a Review Team meeting, but it raised questions about the quality of the assessments undertaken at the time, and the potential risks to SB at the time of the allegation was made.

9.10.8 Upon returning to Bolton, the EIT service worked with SB for over two years, during which time four different workers were involved with the family. There were no underpinning assessments to support the work of EIT and consequently no reference to past history or a framework with which progress could be measured and evaluated. Although there was information about the history of this family, its significance was not accessed or analysed in such a way as to see the patterns of increased risk to SB. As successive EIT workers began working with the family, past interventions and the extent to which these did or did not lead to improved outcomes for SB was never explored; a threshold for taking protective action was not reached and the focus remained on the 'here and now'. During this period the work of EIT provided little more than a chance approach to addressing the surface rather than the depth of issues impacting on SB.

Finding 9: *Where there are a number of significant transitions happening in families, professionals need to ensure information pertaining to history and its significance to present concerns and future harm is carefully maintained and purposefully shared with colleagues. This is especially important when different professionals begin working with families.*

9.10.9 Debates about school non-attendance, and how to tackle it effectively, have been ongoing issues of both public and government concern for many years. The 1996 Education Act states that 'if a child of compulsory school age, who is a registered pupil at a school, fails to attend regularly at that school, his parent is guilty of an offence.' Parents may be fined or be found guilty of the 'aggravated offence' of 'knowingly' not sending their child to school, for which a custodial sentence is possible[24]. It is possible that SB was aware that MSB could receive a custodial sentence and whilst neither SB's thoughts or the outcome of a court case can be known for certain, the fact that a prison sentence was a possibility should have generated concern about how this could impact on SB. The decision to shift from issuing warning letters and withdrawing workers 'for their safety' to a more aggravated, albeit legal, approach should certainly lead to an assessment as what the impact of this action could be on a child. Currently in Bolton a letter notifies Bolton CSC when decisions are taken to move to 'aggravated proceedings'. This it appears is common practice. The letter, which it appears, is standard, asks CSC to indicate if they have information about the family which would lead

[24] Section 444 of the Education Act 1996

them to support an Education Supervision Order[25]. The letter concludes by saying if there has been no response within 15 days, proceedings will go ahead as outlined.

9.10.10 The Review Team had sight of a letter sent to the North Referral and Assessment Team on 30.5.14, advising of the proceedings in relation to MSB. There was no response to the letter and the Review team were informed by EIT that this was not unusual as these letters rarely produced a response from CSC. The letter in relation to MSB could not be found on CSC electronic records but the Review Team were informed that usually when letters are received they would usually be placed on the child's file. This was a missed opportunity to consider and assess SB's situation and the Review Team were left with a sense that these letters were seen more as part of a bureaucratic process rather than as a trigger for further enquiries.

9.10.11 This year there has been an increase in the number of cases where 'aggravated proceedings' have started. However the numbers that result in court action remains low. The review has identified a need for clear guidelines is a matter of some urgency, given that such proceedings by their very nature, will impact on children in the family and in some cases may leave them at greater risk.

Finding 10 *Persistent failure to send children to school is a clear sign of neglect and every effort should be taken to work with parents to address this issue. When a decision is taken by the local authority to escalate intervention to 'aggravated proceedings', the current processes rely on custom and practice and do not take into account the need to safeguard children who may be affected by these proceedings.*

10 Context in which professionals were working

10.1.1 The practitioners in the review process spoke openly and honestly about some of the barriers they faced which impacted on their ability to work with families responsively and effectively. There was an acknowledgment that with increasingly busy workloads just getting on with 'what needed to be done' was sometimes easier than collaboration, as multi-agency working can often require more time and maintenance.

10.1.2 At the time SB was reallocated to the EIT team in May 2012, there were only two managers in the service managing around over 50 members of staff. At that time, EIT workers were allocated to schools and were commissioned to address attendance issues as and when they arose in school. Assessments were not undertaken, as the 'focus' of their work had already been identified. Supervision was not a regular occurrence and rarely offered scope to discuss in any detail welfare issues relating to pupils.

[25] An Education Supervision Order is an order granted in the Family Proceedings Court requiring parents to follow directions made in the Order and work with professionals, to improve your child's school attendance

10.1.3 In 2013, a service review was undertaken in EIT and this has led to significant improvements. There is now a clear pathway for Early Help within the service and Early Help Assessments are undertaken for every child accessing the service. Supervision now happens regularly. These changes did not however impact on work with SB as the service ceased trying to engage with parents in July 2014 and pursued parental non co-operation through legal channels.

10.1.4 In the practitioners group, SCH1 discussed the need to use resources to support the welfare needs of children who were not attending school rather than spending budgets on for example, improving literacy and maths. The challenge of supporting children and families in an area with high levels of deprivation was clearly an issue and not one always recognised by the inspection bodies.

10.1.5 Information from the Practitioners Group touched on the impact of diminishing budgets and competing priorities on their work in general. Research by Brandon et al (2008)[26] suggests that these factors along with increased pressures of work can result in a tendency to raise thresholds for access to services as a way of rationing responses. This view of 'rationing responses' was endorsed by many of the practitioners who contributed to this review, although this was not evidenced particularly in this review. There continued to be misunderstandings around roles, responsibilities and thresholds and these challenges were thought to be compounded by the growing number of families referred for services in Bolton.

11 Findings and Recommendations

11.1.1 The following findings have been grouped to highlight underlying patterns which impact upon practice. The findings and the recommendations that flow from them are relevant to Bolton LSCB but the learning may also be pertinent to Blackburn with Darwen LSCB.

Patterns in Assessments and Decision-Making

Finding 1 (Page 22)
Despite the family's social history, poor school attendance was continually perceived as being the 'problem' within this family, rather than it being considered as a symptom of what was happening in SB's life. The sole focus on school attendance obscured and hid the effects of cumulative adversity, which SB experienced, and this left the child vulnerable.

Finding 5 (page 27)
Effective recording systems support good practice by the inclusion of succinct and updated chronologies, sound assessments, regular summaries of the work undertaken with families. This was not evident in this review.

[26] Brandon, M ET al:(2008) Analysing Child Deaths and Serious Injury through Abuse and Neglect: What Can We Learn? A biennial analysis of serious case reviews 2003-2005. Research Report DCSF-RR023. University of East Anglia

Finding 10 (page 37)
Persistent failure to send children to school is a clear sign of neglect and every effort should be taken to work with parents to address this issue. When a decision is taken by the local authority to escalate intervention to 'aggravated proceedings', the current processes rely on custom and practice and do not take into account the need to safeguard children who may be affected by these proceedings.

Recommendation 1
The Board needs to be assured that when there are significant concerns about school attendance:

- Assessments are always undertaken which take into account the family background and history and include an assessment of the motivation, capability and willingness of parents to change their behaviour to support their child back into school
- Plans to support children and young people not attending school are robust, smart and child focussed and do not focus solely on symptomatic behaviours and these plans, together with the assessments are recorded and regularly reviewed

Recommendation 2
The Board needs to produce procedures and guidance for professionals about responding effectively to non-school attendance to ensure there is clarity about roles and responsibilities especially where decisions are taken to move to 'aggravated prosecution'. These procedures should stipulate that a referral to or contact with Children's Social Care is required to determine if a further assessment is needed to safeguard the child given a possible outcome of those proceedings could be a custodial sentence for the parent.

Patterns of gaps in provision

Finding 3 (page 24)
There is a mismatch between available resources and the needs of young people who need access to mental health services but who do not or cannot meet the criteria for CAMHS support.

Recommendation 3
The Board needs to ensure that CCGs are giving sufficient priority to the development of mental health services for those children who do not meet the threshold for CAMHS or who for whatever reason are unable to access that service.

Patterns in communication and collaboration in multi-agency working

Finding 6 (page 29)
The failure to collaborate within a multi-agency context means that key information is not shared or discussed. This leaves professionals working in isolation and highlights vulnerability in multi-agency systems designed to safeguard children. This was evident in this review.

Finding 9 (page 36)
Where there are a number of significant transitions happening in families, professionals need to ensure information pertaining to history and its significance to current concerns and future harm is carefully maintained and purposefully shared with colleagues. This is especially important when different professionals begin working with families.

Recommendation 4
The board needs to be confident that there are management systems in place to ensure and encourage recourse to multi-agency processes to facilitate better information sharing and more effective ways to work with families where professionals are 'stuck'

Patterns in family-professional interactions

Finding 2 (page 23)
Children who live in families where there is co-morbidity of parental substance misuse and violence within the home are known to be at risk of significant harm. This review has highlighted that when the 'child' is a young adolescent, the impact of these adversities can be overlooked or minimised by professionals who are then less likely to refer their concerns to children's social care.

Finding 4 (page24)
A lack of knowledge among professionals about the evidence base related to risk indicators for adolescent suicide could leave them ill equipped to discuss and/ or recognise signs and respond accordingly.

Finding 7 (page 32)
Parental hostility and lack of engagement impacted on professional confidence and hampered the ability to safeguard or work effectively with SB. This led to work with the family drifting and left SB vulnerable.

Finding 8 (page 33)
Where it is not possible to build a cooperative relationship with parents, workers need good quality reflective supervision to explore and establish what actions or intrusive measures should be undertaken to protect a child from harm.

Recommendation 5
The Board needs to develop an authoritative mandate for professionals who need to engage with hard to reach and hostile parents and ensure that whatever their role, professionals have access to quality supervision to support them in this work.

Recommendation 6
The Board should examine the current training programmes available to professionals to ensure these provide opportunities for

- The development of skills in working with hostile parents and resistant adolescents
- Gaining knowledge about the impact of long-term neglect on adolescents and the associated risks

12 Concluding Comments

12.1.1 The death of a young person is always tragic and especially so when death occurs because of their own actions. This review has highlighted a number of shortcomings in practice, which contain important lessons for agencies although it cannot be said they would have prevented the death of SB. Two broad themes emerge; the need for improved understanding by professionals of the impact on children, including adolescents, of the co-morbidity of domestic violence and substance misuse; and the challenge of working with resistant and hostile parents.

12.1.2 The Review Team concluded that whilst there were no obvious or outward indicators of SB's vulnerability and intentions, professionals were totally unaware of what life felt like for this young boy. SB did not want to see or engage with professionals and most of what was known about the child was actually told by MSB. However, SB's lack of engagement with agencies should have heightened professional realisation of risk. Professionals viewed SB as a very likeable young person and although they wanted to get him back into school, this became their sole purpose in trying to engage with him and consequently and perhaps inevitably, he became lost to the very systems designed to secure his welfare and keep him safe.

'*Neglect and emotional abuse are often not recognised in teenagers and even where they are they may not be taken seriously by professionals. Not much is known about their personal experiences, as there is a lack of research which identifies the feelings, or experiences of this population. Many of the behaviours exhibited by emotionally abused or neglected teenagers may be interpreted by others as a lifestyle choice or 'acting out' when they may in fact be an indicator of neglect or emotional abuse… A better understanding of teenage neglect and emotional abuse may enable teenagers to access appropriate and timely help.'*

Neglect or Emotional Abuse in Teenagers aged 13 – 18[27]

[27] Core – Info NSPCC November 2015

APPENDIX 1

Single Agency Learning
(Identified by agencies through their participation in the SCR, with additional learning identified by the report author)

BOLTON

Children's Services – Social Work

1. An Initial Assessment must always be considered when a child makes a 999 call and where the family is or has been known to Children's Services an Initial Assessment should always be undertaken
2. Their needs to be an urgent review of how information relating to the children of family members who live separately is recorded so clearer links can be made when concerns arise
3. When families with children on CP or CIN plans move geographical areas, there should be a joint meeting with the family and key professionals to ensure appropriate information is shared and well understood by the receiving authority
4. Where police make referrals to CSC and a child has been on a previous CP plan, the information and context of the call should be considered to determine if a visit and assessment is required
5. Duty Officers should be aware of the impact of co-morbidity of toxic trio and social history when responding to calls from other agencies for information

Children Services - Early Intervention Team

1. Senior Management needs to have a strategic overview of pupils with low attendance
2. Closure reports or summaries are required when families are 'handed over' or closed
3. A way forward with families who display persistent non-engagement
4. Need to continue to monitor and QA Early help processes
5. All files should include regularly updated chronologies outlining significant events in a child's life. There should also be summaries and analysis of work undertaken and clearly defined SMART plans for work with families.
6. The pathway for when Early Intervention workers should refer to CSC needs strengthening
7. Staff need to develop skills and improve their knowledge basis about impact of parental behaviours and capacity to change
8. Although not social workers, the principles of social work apply to these roles and staff need access to quality supervision which encourages reflection

Bolton Integrated Drug & Alcohol Service (BIDAS)

1. Clients can decline elements of the integrated service such as psychosocial interventions but we need to review the impact of these refusals, where it is known that there are children are in family
2. There is no standardised guidance of when CSC should be contacted when it becomes known that there are children living with substance – misusing clients
3. Need to confirm when, how and if we should clarify information when told there is a child in the family
4. Need to ensure we know who to contact when there is need to discuss concerns about children or seek information
5. The Early Help pathway to services need to be better understood
6. System for seeing clients every 12 weeks rather than in response to need does not help engagement or timely interventions with clients

Bolton NHS Foundation Trust

1. Health professionals should make direct contact with their counterparts when transferring information about children and families where there are or have been safeguarding concerns
2. 2. The impact of paper-free/paper- light systems may impact on timely information sharing between professionals and agencies and this should be recognised when requesting records from another authority

School 1

1. Where queries are made to school staff about safeguarding or CP issues, the Designated Safeguarding lead must always be notified
2. Review transition template for children where there are safeguarding and CP issues
3. Review guidance for transition procedures for vulnerable children
4. Review sample of records for vulnerable children
5. Early help training to the behaviour and Safety team and Student Support team
6. Update guidance and roles and responsibilities of staff I Early help
7. Review caseload of children with long term persistent non-attendance
8. When a child is or has been subject to CP or CiN plans, the DSL should always be informed and a safeguarding file opened. The child's personal file should be tagged
9. When there is persistence non- school attendance and a failure by parents to engage with services or support processes, this should always lead to a referral to CSC
10. Records of all meetings with parents, even where parents do not attend should be minuted and places on pupil files

BLACKBURN WITH DARWEN

School 2

1. Where information is required for welfare checks, this should prompt the school to set up a safeguarding file and the child's personal file tagged.
2. Where queries are made to school staff about safeguarding or CP issues, the Designated Safeguarding lead must always be notified
3. Where conversations take place about a pupil and safeguarding concerns, the nature, content, and outcome of those conversations should be included in the pupil file
4. When children transfer to another school, the originating school should transfer safeguarding records as outlined in national guidance. However they should also retain basic safeguarding information in school to assist with any future enquiries or reviews relating to the actions and decisions taken
5. There should be earlier notification to EWOs/Early Intervention teams when there are attendance issues
6. School staff should be mindful when recording absences as authorised or unauthorised with families where attendance is an ongoing concern
7. Improve communication and sharing of information across different professionals in school

Learning Access Service

1. Where there are concerns about school attendance of a child who has recently changed schools and/or moved areas or has previously been subject to a CP Plan, direct contact should be made with the previous authority to ascertain details
2. Where there have been concerns that about school attendance and a child moves across geographical boundaries, the EWO should make direct contact with their corresponding agency in that authority

GREATER MANCHESTER POLICE (GMP) –

Public Protection Division

1. Importance of police officers recording they have observed and spoken with children including adolescents, who are present when police are called out to incidents involving drugs or violence in the home
2. Police to clearly record the presentation and demeanour of child
3. Ensure there is follow up by Police when they respond to a 999 call made by a child or young person