Independent Report

Regarding the implementation of the MAR re

Child M

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December 2014

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1. Introduction

Purpose

1.1 Working Together 2013 is clear that 'professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children' (Working Together, March 2013, Chapter 4 Para 1).

1.2 Serious Case Reviews (SCRs) and other case reviews should be conducted in a way which:

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

2. About the Author

2.1 I, Glenys Johnston, am the author of this report. I am an Independent Social Work Consultant with extensive experience in undertaking reviews and of chairing LSCBs; I have had no previous involvement in any aspect of the previous Multi-Agency Review (the MAR).

3. Terms of reference

Background

3.1 Case M involves the sexual abuse of a child by her siblings, over a significant period of time. This case has been reviewed before, after it was referred to Norfolk's Serious Case Review Group (SCRG) in May 2011.

3.2 At this point it was agreed that although the criteria for an SCR were met the Board would exercise its discretion and undertake a MAR instead as it was felt this was the most appropriate method to identify any learning.

3.3 The MAR was initiated in Sept 2011 but did not conclude until March 2013. There were a number of reasons for this delay including change of staff. In March 2013, the report was taken to the Board in an exceptional meeting to look at learning from both this case and a similar one that had been signed off the previous year.

3.4 The case was re-referred to the SCRG in March 2014. This referral was related to a further incident of sexual abuse, involving a second brother.

Terms of reference

3.5 The review has followed two parallel lines of enquiry.

1. The practice in relation to this case, i.e. what happened to the children and how effective agencies were in protecting them from harm, i.e. the extent to which the abuse could have been predicted and/or prevented. This is covered in a separate Overview Report
2. The organisational response: why did protective arrangements not happen following the MAR? :
   - The Board's process to implement the recommendations from SCRs and Multi-agency Reviews.
   - The processes that partners use to disseminate learning with their own agencies.
   - How were recommendations from the previous review taken forward (or not) in the management and decision-making for this case?

4. Methodology

4.1 The review was commissioned by Norfolk Safeguarding Children Board on March 2014. It was overseen by Russell Wate who is an Independent Consultant with no previous involvement in the case; he chaired the Serious Case Review Panel which was made up of senior managers from each agency/department that had been involved in the case.

4.2 I interviewed by telephone, or in person, the following professionals:

AGENCY	Name	Title
Children's Social Care	Sheila Lock	Interim Director of Children's Services
	Wendy Dyde	Head of Independent Services & SCRG Member
	Jackie Cole	Specialist Adviser, Child Protection, & SCRG Member
	Catherine Mouser	Operational Divisional Manager, North & East
Great Yarmouth & Waveney Clinical Commissioning Group	Jane Black	Designated Nurse, Safeguarding & SCRG Member
	Cath Gorman	Director of Quality & Safety

AGENCY	Names	Titles
Norfolk Community Health & Care	Sue Zeitlin	Paediatrician
	Anna Morgan	Director of Nursing, Quality & Operations
NSCB	Abigail McGarry	NSCB Board Manager

5. The Multi-Agency Review

5.1 The MAR dated November 2012, but not accepted by the NSCB until March 2013, examined the events up until October 2011. At this point there was clearly a significant, worrying and complex social care history in relation to the life experiences of all four children. These concerns included significant trauma in relation to:

- Repeated allegations of sexual abuse –sibling on sibling and a query re possible 'other' unidentified abuser/s;
- domestic abuse;
- physical abuse;
- neglect-characterised by a chaotic and hostile home environment;
- children with special needs; and
- concerns regarding Mother's mental health /depression.

5.2 The MAR made several recommendations/comments in relation to the need to:

- Establish specialist services, either for advice or for direct work for professionals dealing with Child Sexual Abuse (CSA) especially abuse committed by siblings.
- Improve the experience of children who are medically examined for CSA.
- Reflect on the reunification of children with their family being the default position in Norfolk and to ensure a clear process for re-unification which includes all professionals involved in the case.
- Reflect on high thresholds for initiating a Child Protection Conference.
- Address the over-reliance on written agreements and a lack of monitoring of the compliance of parents with them. It was also noted that this was a long-standing concern with little progress being made since 2011
- Audit cases to identify whether Working Together 2010 is being implemented
- Audit cases that fall between s17 and s47 to ascertain whether there is consistent practice across Norfolk.
- Review supervision arrangements and survey worker's experience of supervision.
- Ensure that the Resolving Professional Disputes Policy is being appropriately used.
- Consider the provision of consultation support to professional networks that struggles with complex cases, does not share a unanimous view and makes no progress.

Following the MAR

5.3 The MAR was presented by the report author, to an extraordinary meeting of NSCB, during my interviews professionals commented that several people at the meeting had been on the MAR Panel so were familiar with the recommendations however, some appeared not to have read the MAR report and could contribute little to the discussion; overall, the meeting was poorly attended.

5.4 It was agreed the Monitoring and Evaluation Subgroup of NSCB would implement the recommendations in relation to the NSCB and monitor the implementation of non-NSCB recommendations by partner agencies.

5.5 Some managers shared the report with the professionals directly involved in the case and to key managers/designated professionals.

5.6 A professional Learning Day was held to bring past and current professionals working with the case together to share the learning.

5.7 Eight "road shows" to disseminate the findings were held across Norfolk. Two of these were aimed at managers and six at practitioners.

6. Comment

6.1 Although the meeting to present and accept the MAR did not function well, the process of disseminating the findings of the MAR reached a wide range of professionals and was well delivered. However, some key professionals were not informed of the MAR or the recommendations.

6.2 Professionals I met described the shock they and their colleagues felt when the discovered that the abuse had continued. Several continue to have concerns about the management and practice in the case. They accepted that raising disputes remains difficult and that knowledge of CSA especially by siblings remains weak.

Why then was the implementation of the recommendations and an increase in professional learning and understanding so weak?

6.3 During the course of my interviews a number of factors emerged which contributed to these failings:

- Prior to the Ofsted Inspection of 2013 Norfolk Children's Social Care was characterised as a dysfunctional organisation that found challenge difficult, was unwilling to listen to partner agencies and act on what it heard, an organisation which appeared to other agencies to be arrogant and the decision maker in relation to child protection. This led to some agencies not raising concerns or addressing disputes.
- The Ofsted inspection of January 2013 had a considerable impact on CSC and some other agencies not only in hosting the inspection, which was unannounced but also in addressing the outcome and recommendations-this diverted attention from the findings of the MAR.
- Norfolk has had a history of tolerating poor practice.
- The NSCB has had three Independent Chairs in recent years, some less comfortable with open challenge in meetings and addressing this, than others.
- The NSCB had an unmanageable number of recommendations from reviews, some of these recommendations were unclear and they had been difficult to design and implement. The monitoring of the implementation was very challenging and although

there has been a process for giving staff feedback there has been no feedback loop to senior management on their views or experience.

- The NSCB SCR Subgroup was not a robust forum for discussing and agreeing cases, this led to a number of reviews that were not Serious Case Reviews and should have been.
- It is unclear how recommendations from reviews contributed to training.
- The MAR met the criteria for a Serious Case Review but the decision was made to undertake a discretionary review.
- The status of the MAR was unclear and unhelpful; it was not published and although a learning summary was prepared, this was not published following legal advice which advised that the learning summary as drafted could not be published as it would be very difficult to protect the identity of the child and the family. This made it difficult to share the learning to wider groups of professionals.
- It is apparent that learning identified *during* the completion of the MAR was not addressed and implemented as described in Working Together 2010.
- Until some of the recommendations of the MAR were implemented such as training, professional consultative support for complex case, professional knowledge and understanding of CSA, child protection thresholds, good supervision and written agreements were put in place the practice of professionals in relation to the family concerned could not change and improve.
- Managers told me that their staff were extremely busy with considerable demands on their capacity.
- The transfer of the case within CSC was not effective, it was hampered by missing files which made reviewing on the past difficult and a lack of a shared understanding of the MAR recommendations.

6.4 The July DFE "Study to Investigate the Barriers to Learning from Serious Case Reviews and Identify Ways of Overcoming these Barriers" provides a useful summary analysis, several aspects of which are applicable to the difficulties Norfolk faced in implementing the learning from the MAR and other reviews; these have been extracted from the report thus:

SCR (and other review) Processes and Publications

- *The numbers of recommendations that generate new policies and procedures is overwhelming.*

Learning Culture and Training

- *There is insufficient regular, appropriate and purposeful training across and within disciplines.*
- *Not all training is appropriate for different roles and responsibilities of staff within and across different disciplines and agencies including the Private, Voluntary,*
- *Independent sector of private, community and voluntary organisations.*
- *The learning from reviews is repetitive and can lead to lack of attention and engagement.*
- *Front-line staff have limited involvement in the generation of learning and ensuring its relevance and applicability.*

Policy and Procedures

- *Policy and procedures development and implementation are not proportionate or sensitive to the scale, locality and context of the case.*
- *Rapid policy and procedural change and implementation impacts significantly on frontline staff creating confusion and tensions relating to workload, roles and responsibilities and accountability.*
- *Change takes time to embed and too much change nationally and locally is destabilising and undermining.*
- *Policies and procedures do not always recognise the human and emotional aspects in terms of interpretation, judgement and decision making.*
- *Policies and procedures may not be sensitive to what is able to be actioned by practitioners with large workloads and who are already very busy.*
- *Communication systems are currently ineffectual in ensuring that learning from SCRs/reviews informs practitioners within and across disciplines, agencies and sectors.*

7. Conclusion

7.1 The MAR considered the practice in a very complex and challenging case for all professionals. It involved a mother, four different fathers and four children, three of whom had special needs and behavioural difficulties.

7.2 It was a good review; it included professional practitioners and made a number of recommendations and several comments on how the review process could be improved to improve the quality and the learning. These included an earlier involvement of practitioners, and consistent attendance at Panel meetings it also commented on the difficulties of undertaking the review with a number of files missing from CSC and a lack of focus on the victim.

7.3 The dissemination process was good but was less effective than hoped for, not all professionals were included or able to attend, and the fact that the MAR was not published made it difficult for managers to know what they could share with whom.

7.4 The management of the recommendations by the NSCB was a challenge given the number of recommendations from previous reviews.

7.5 The culture within Norfolk CSC was not conducive to effective learning, the Ofsted inspection diverted resources from implementing the recommendations so some of the structural aspects that needed to be put in place to support practice were delayed.

8. Recommendations

8.1 There have been several improvements put in place by the Director of Children's Services to address the culture of the organisation, the quality of recording, the use of written agreements, child protection thresholds, improved analysis of risk and the wishes and feelings of children becoming more visible.

8.2 The Norfolk Safeguarding Children Board has a new Independent Chair who is comfortable with inter-agency challenges, the Serious Case Review Subgroup is more effective and there is now an improved system for monitoring the implementation of recommendations from reviews.

8.3 The Norfolk Safeguarding Children Board should.

1. Ensure that all the recommendations from the Multi Agency Review and the subsequent Serious Case Review are implemented fully, by reviewing both sets.

2. Monitor the use of the Resolving Professional Differences Policy.

3. Agree how to disseminate the learning from reviews that are not published

4. Ensure that all reviews learn from the comments made in the Multi Agency Review and the Serious Case Review, about the reviews process.

5. Consider the 'DfE research report "A Study to Investigate the Barriers to Learning from Serious Case Review Reports and Identify Ways of Overcoming these Barriers" and apply this to the dissemination of learning.

6. Ensure that Serious Case Reviews and other multi-agency reviews are completed within timescales, that a senior manager from all agencies involved in the case being reviewed attend SCR Panel meetings, that emerging recommendations are implemented as they arise and the learning from reviews whether published or not, is disseminated promptly.

7. Secure evidence from each agency to demonstrate that they have learnt from this and other SCRs and have, or are, pro-actively addressing the actions and issues.

Report Ends