Safeguarding
Children Board

Independent Chair – Dave Ellis

SERIOUS CASE REVIEW

EXECUTIVE SUMMARY OF
A YOUNG MALE

August 2010

1. INTRODUCTION

1.1 This serious case review (SCR) relates to the life and death of a male child, who will be referred to as "the subject", who lived in Cornwall. The subject was 10½ years old when he died.

1.2 The subject died in January 2010 as a result of a deliberate blow to his head and the effects of smoke inhalation due to a fire started with an accelerant at his home. His mother died at the scene of the fire from her fire related injuries, the fire having been started in her bedroom. His father died, 8 days later, at a tertiary hospital out of the county, as a result of his injuries from the fire. The Police investigation suggests that the father was responsible for the subject's head injuries and the fire at his home.

1.3 No agency reported any child protection concerns regarding the subject and there were no registered concerns for his safety at the time of his death. Throughout his short life the subject was reported to have been appropriately cared for and he enjoyed good relationships with his parents and members of the extended family. For two years prior to his death, his father had experienced mental health problems and his cooperation with treatments to manage his delusional, paranoid and obsessional symptoms was neither consistent nor sustained. The subject's mother was described as a strong and protective parent but at times the father's behaviour did place considerable strain upon her.

1.4 Education was the only agency with contact with the subject throughout the review period. Children's Social Care were involved for just under two months, at the end of 2008, to complete an Initial Assessment. There had been three Domestic Violence incidents reported to Children's Social Care by the Police and in line with local protocols the third reported incident led to an initial assessment of the subject's needs. This identified the subject as having some additional needs but not that he was at any significant risk of harm. Health and the Police had involvement with the parents, concerning the father's mental health issues but no significant contact with the subject. The father had sent two housing applications to the County's Housing department but these were not seen until after the father's death so they had no involvement with the subject or his parents, relevant to this review.

2. HOW THE REPORT WAS PRODUCED

2.1 The way in which SCRs are carried out has been defined by HM Government (2009) in guidance called '*Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children – Chapter 8: Serious Case Reviews*'. Each agency that had contact with the family identified a senior manager, who was not involved with the family, to write a report of their agency's involvement, called an individual management review (IMR). These reports detail the contact that agency's staff had with the subject and his family. The authors of these reports considered whether their agency involvement was appropriate and whether staff did what they should have done. Reports also identified lessons to be learnt for their own agency or to improve multi-agency collaboration. The full overview report summarised the IMRs and the deliberations of the SCR Panel. It also considered the views of maternal and paternal family members, identified as significant, and who wanted to contribute.

2.2 The SCR Panel Chair was Janet Bardsley, Independent Consultant. The SCR Panel commissioned Sue James of Inter-Care, an Independent Consultant, to write the Overview Report.

2.3 Agencies represented at the SCR Panel were:

Cornwall and the Isle of Scilly's Local Safeguarding Children Board - Manager;
Cornwall Council Social Care - Principal Legal Adviser;
Cornwall Children's Social Care: Complex and Acute Services - Senior Manager;
Connexions - Team Leader;
Devon and Cornwall Constabulary - Detective Chief Inspector;
Devon and Cornwall Probation Trust - Senior Manager;
Cornwall Partnership Trust - Medical Director;
Royal Cornwall Health Trust (Health) - Designated Nurse for Child Protection;
Cornwall and Isle of Scilly Youth Offending Services - Deputy Manager;
Cornwall's Children, School and Family, Education Department - Deputy Safeguarding Children Manager;
Cornwall Council's Housing Department - Area Housing Manager; and Barnardo's (representing the Voluntary and Community Sector) – Assistant Director, was invited the third and fourth Panel meetings, having been newly appointed to Serious Case Review Group.

The SCR Panel met on:
22 March, 24 May, 6 July and 26 July 2010.
IMR authors were invited to attend the first, third and fourth of these meetings, to assist in improving the quality and accuracy of agency reports and the overview report. The overview report author, who was not a member of the Panel, was invited to attend at least part of all Panel meetings but was unable to attend the 2nd due to illness.

2.4 As a public document this Executive Summary does not give details that may identify the subject or his family. It concentrates upon what actions the agencies did and did not take and lists all the recommendations made to help agencies improve outcomes for children and young people in Cornwall.

3. THE SUBJECT'S STORY

3.1 The information that follows comes from IMRs, discussions at Panel meetings and conversations with family members.

3.2 The subject was the only child born to his parents, the family coming to live in Cornwall when he was very young. For most of the subject's life only universal services had contact with him and his family. The family situation began to change when the subject was about 8 years old due to his father developing mental health problems. His father moved out of the family home as his mental illness progressed but he stayed in close contact with the subject and his mother, staying with them for weekends and sometimes longer. Agency records indicate that the father had returned, temporarily to the family home, early in December 2009, probably almost continuously until the fire tragedy. Sometimes the father did not cooperate with his mental health treatment in the community and during such periods his well-being suffered. This concerned the mother, as she remained committed to supporting him. The mother's concerns led her to

sometimes contact the Police and at other times Mental Health workers or sometimes both. The mother's contact with agencies was driven by her overwhelming desire to get help for the father. She felt able to support and protect the subject herself.

3.3 The only agency with significant contact with the subject was Education, through his attendance at primary school. Staffs at the school were unaware of the father's mental illness or that the subject's parents had separated. Their observations indicate that there were no changes in the subject's attitude or behaviour in school to provide any clues to the events that the Police and Mental Health staff were involved in with the parents. The subject has been described as a bright, engaging child who applied himself well at school and had sporting talent, indicated by his being a member of his town's football team. The Education IMR also states that he had friends to visit and stay regularly, in the family home. None of these reported anything of concern from their visits to school staff.

3.4 Mental Health staff were involved in providing services to the father, who mainly lived independently in the community but did have several stays in a psychiatric hospital. The Police were involved, either when the father went missing and there were concerns for his welfare or when their help was needed to carry out a mental health assessment or to detain him for a return to psychiatric hospital. On other occasions, the mother found the father's behaviour difficult to cope with and rang the Police and although incidents were recorded and dealt with as Domestic Violence incidents, he never used physical violence. His behaviour was described as obsessional and occasionally harassing rather than aggressive. Towards the end of 2008, reports of Domestic Violence incidents, from the Police, triggered Children's Social Care to complete an Initial Assessment but the subject did not meet the threshold for them to remain involved with the family.

3.5 Universal health provision was provided to the family through GP services and hospital staff, who were aware of the father's mental health problems, the former contributing to the treatment of the father and supporting the mother when she experienced feelings of stress, due to his illness. The only other relevant agency indentified was Cornwall Council's Housing department but they had no direct contact with any family member, relevant to this review. After his death, it was discovered that the father had made two on-line housing applications but these had not been processed due to a backlog of applications created by a change to the system for registering housing need.

3.6 The overview author and the Panel have concluded that whilst practice within Mental Health Services and communication within and between agencies had many weaknesses, the violent death of the subject and his mother at the hands of his father could not have been foreseen. Family members did not foresee such a tragic event and did not think the mother had either. No agency had considered the subject to be at risk of serious harm from his father and they thought the mother to be competent and willing to protect him from the excesses of the father's behaviour. As a result, the SCR process has been the vehicle for agencies to share information in order to learn and improve future multi-agency safeguarding children arrangements.

4. ETHNICITY, DISABILITY, FAITH AND CULTURAL MATTERS

4.1 The subject and his parents were described by agencies as white British. The father's mental health problem was the only special need/ disability described. The subject was described by staff at his school and family as above average intelligence. Religious belief was not described as significant to the subject or his parents. In terms of broader identity and culture there was a *"perception of Mother being a caring and protective mother, who held a professional position and was actively involved in the management of her husband"* (Children's Social Care IMR).

4.2 What was described by agencies, in their dealings with the mother, was an assertive, middle class woman, well able to utilise universal services for the benefit of the subject but perhaps less comfortable with the notion that either of them needed additional help to deal with the situation they found themselves in. Although the extended family were aware of the situation and offered what support they could to the subjects mother and father, they all described the mother as strong and protective of the subject. The mother did contact Health professionals and Police to secure assistance for the subject's father but otherwise she appeared to keep the father's mental health problems private.

4.3 During an Initial Assessment, completed in November 2008 by Children's Social Care, the social worker noted "*Mother reports that he* (the subject) *is a mature young person, who does not appear distressed. She reports that the subject just wants to get on with his life"* (Initial Assessment). The mother strove to protect the subject from the worst excesses of his father's behaviour, stemming from his mental health problems. Research would suggest that it would have been difficult for her to shield him completely from either its direct impacts or the burden it placed on her, from time to time.

4.4 *"For a family with children and young people under 18, an episode of mental ill-health can represent a significant crisis, not just in terms of a parent's individual mental health but in family life overall. It may involve a period of hospitalisation, it may have long term repercussions. At the time everyday routines are disrupted, other adults are overstretched, and both parents and children often feel worried and powerless."* (Department of Health, SCIE and Care Services Improvement Partnership 2008). However, whilst the SCR Panel considered relevant research there was no evidence to suggest that the findings could be applied to the subject.

5. WHAT THE OVERVIEW AUTHOR THOUGHT

5.1 The independent overview author developed three key questions from the terms of reference, set by Cornwall and the Isle of Scilly's Local Safeguarding Children Board. The answers emerged during the SCR process and will be reported in this section. Given that the father deliberately killing the subject could not reasonably have been predicted, answering these questions focuses on weaknesses of intra and inter-agency working to help bring about learning and improvement.

5.2 **Did those agencies working to care and manage the behaviour of the father, focus sufficiently on the needs and potential risks to the subject, given there was regular and sometimes sustained contacts? Did communication between and within agencies make this possible?**

5.2.1 The Police and Mental Health Services were the agencies with most contact with each other but discussions focused on the care and well-being of the father. There was no evidence that they discussed or shared information about the implications for the subject. Sometimes the mother did tell these two agencies of things that the father had said or done that had upset or distressed the subject but this information was not always shared effectively with Children's Services who may have been able to monitor or be more attentive to the subjects views and feelings about the family situation. There was only one formal referral to Children's Social Care, by psychiatric hospital ward staff, in June 2009, when the father's delusional thoughts involved the subject. The nurse who made the referral and the social worker who received it were satisfied that the mother was able to protect the subject. It was unclear from records how risk was affected or whether the professionals discussed this together or with the mother.

5.2.2 When the father returned to live with his family, in December 2009, there was no evidence that Mental Health staff considered the implications for the subject or informed Children's Social Care of this change in circumstances. At the end of December, the Police became aware that the father had been back living with the family, following an incident when they had to remove him at the mother's request. They did not speak to the subject, who was at home at the time, so were not in a position to assess the impact of events on him or make a referral to Children's Social Care. The Police sent a routine Child Incident Report form (121A) and a Domestic Violence Report to Children's Social Care, to inform them they had been called to an incident between the subject's parents. No referral was made. The 121A was also sent to Education Welfare but that agency could not locate it.

5.2.3 The overview author formed the view that Mental Health staff and the Police did not always share information effectively with each other or Children's Services (Education and Social Care) and did not find out how the father's mental illness was impacting on the subject; they did not make sufficient effort or seek opportunities to speak to him. They did not take a child or family centred approach to working with a parent with mental health problems despite there being a lot of research evidence and government guidance that this is the best way to safeguard children.

5.3 **Whether the agency with most contact with the subject, Education, and the agency that was most focused on safeguarding him, Children's Social Care, had sufficient information, from agencies primarily working with his parents, to enable them to make adequate and effective safeguarding arrangements for the subject?**

5.3.1 None of the agencies involved with the subject's family informed his school of events arising out of his father's mental illness so his teachers knew nothing of what life was like for the subject. Children's Social Care contacted the subject's head teacher, at the start of the Initial Assessment. The social worker recorded that the head had no concerns about the subject so no further communication or information sharing took place. This did not follow good practice especially because the child in need plan produced suggested a monitoring role for the school. The social worker expected the mother to agree a plan with the school for if the father arrived there alone and to let them know about the subject's family situation. The social worker did not check the mother had spoken to the head as agreed so didn't know that the school were completely unaware of the subjects home situation.

5.3.2 The only time the Police recorded sending a copy of a Child Incident Report Form (121A) to Education Welfare was in January 2010, after an incident in December when they had had to remove the father from the family home. Education Welfare found no evidence of receiving this information so it did not get passed to the school. Mental Health staff and the subject's GP never consulted with the school or asked Children's Social Care to liaise with the school during periods that research would indicate that the father's mental health and behaviour was disruptive to family life. Cornwall has guidance for agencies working with families experiencing "*early stresses and temporary crises"*, like the subject's, to ensure that they keep the child of the family in mind even if they are primarily concerned with the parents (Children's Trust website 2010). There was no evidence of the agencies involved discussing this way of working together, for the benefit of the subject. It did not require Children's Social Care to be involved, as the approach targets children who do not meet the threshold for their involvement, where there are no immediate concerns that a child is at risk of serious harm.

5.3.3 When completing the Initial Assessment, in 2008, the social worker recorded that relevant Adult Mental Health staff had been informed that Children's Social Care were undertaking an Initial Assessment but there was no evidence that these staff, with knowledge of the impact of the father's mental health on his ability to carry out his parental role, were involved in the process. The Child Plan, which came out of the assessment, was not shared with Mental Health staff. The Police were neither consulted to provide information for the Initial Assessment nor had the Child Plan shared with them.

5.3.4 The pattern continued of Mental Health and Police focusing on the behaviour and needs of the father, without adequately considering potential impacts on the family as a whole and the subject in particular. They did not enlist the support of Child Service Agencies or seek advice on how to be more child focused. The overview author concluded that the agencies which were the most child focused did not have sufficient information from the agencies who understood the family disruption, caused by the father's mental illness, to ensure that the best safeguarding arrangements were in place for the subject. Agencies did not look beyond their view that the subject was not considered at immediate risk of harm and the mother was a competent and protective parent.

5.4 **Whether adult mental health staff had adequate understanding of research and Government guidance to protect the subject? This relates to *'Think Family'* (Cabinet Office 2007) and immediately prior to the incident, the Rapid Response Report, NPSA/2009/RRR003 *"Preventing harm to children from parents with mental health needs"* (National Patient Safety Agency, May 2009).**

5.4.1 It was not normal practice for Mental Health staff to share information about a patient unless the patient had consented or there were urgent safety matters. When the father's mental health and behaviour was disruptive to family life, they did not check out the impact on the subject themselves or ask other Children's Services (not Children's Social Care) to do so. This may have brought about safeguarding benefits to the subject. *"Cornwall's Integrated Children's Service Framework Toolkit"* (Children's Trust Cornwall website, 2010) shows how agencies can work together for the benefit of children experiencing "*early stresses and temporary crises"*, using a *"Team Around the Child"* approach. This approach targets children who do not meet the threshold for Children's Social Care involvement, like the subject. There was no evidence

of this being considered. Previous SCRs in the County have found a weakness in inter-agency safeguarding cooperation at this 2nd level of the *"Framework Toolkit"* (Raynes and James 2009 and James and Bardsley 2010). What appears to be a theoretical approach, described on a website (the apparent outcome of the first SCR) needs to be turned into effective multi-agency safeguarding practice.

5.4.2 The overview author would suggest that Mental Health staff need to continue working towards adoption of the *'Think Family'* messages that began in 2004 from the Social Exclusion report and have threaded their way through much research, government reports and guidance. There was no evidence of joint working between Mental Health Services and Children's Services (not necessarily Children's Social Care) being considered or an awareness of the more positive outcomes research indicates this can achieve. In terms of the Rapid Response Report NPSA/2009/RRR003, this was issued to Chief Executives, responsible for Mental Health Services, in May 2009, with an expectation that actions would be complete by November 2009. For the full safeguarding benefits to be achieved, the LSCB needed to be involved in its implementation to support Mental Health organisations (National Patient Safety Agency 2009). Their lack of involvement may have contributed to the social worker not placing sufficient weight on the information about the father's delusional beliefs involving the subject, at the time of the referral from the ward staff member, in June 2009.

5.4.3 The overview author came to the view that Mental Health Services and Children's Services had not adopted good practice to work jointly with families where a parent has mental health problems, to improve outcomes for the whole family.

6. CONCLUSION

6.1 The Initial Assessment completed by Children's Social Care, towards the end of 2008, did not gather sufficient information from other agencies to fully assess the subject's situation and did not share the Child Plan with relevant agencies. This does not meet the good practice expectations of *"Working Together to Safeguard Children"* (HM Government 2006).

6.2 When Mental Health staff and the Police were dealing with the behaviour of the father, arising from his mental illness, they paid insufficient attention to the potential impact on the subject. They did not always communicate effectively with Children's Services. Agencies focused too much on the father's behaviour and needs and not enough on the family as a whole and the subject in particular.

6.3 Panel meeting discussions indicate that *"Preventing harm to children from parents with mental health needs"* issued by the National Patient Safety Agency (2009) has not been adequately shared beyond Mental Health Services. In particular, agencies involved in safeguarding children have not been involved in the implementation process by Mental Health Services, as they should have been, through the Local Safeguarding Children Board.

6.4 The subject did not visit his father whilst he was in psychiatric hospital although he did see him during periods of home leave. Arising from discussion of the subject's contact with his father at these times, the Panel realised that Mental

Health Services had produced their patient's visiting policy alone. The relevant Code of Practice requires that they be drawn up with Children's Social Care, to ensure arrangements focus adequately on what is best for children (Department of Health 1999).

6.5 Problems with communication between agencies has been a common theme in SCRs nationally and locally. This one has been no exception. The specific issues from this review are that agencies did not sufficiently understand each other's statutory and legal obligations where a parent with mental health needs was having contact with their child; and that risk assessment information, when shared, often stated a level of risk without giving specific information about the nature of the risk and who might be affected.

6.7 Cornwall has a good Framework to help agencies understand the options for working with children in the county (Children's Trust Cornwall website 2010). The subject's situation was best described by the 2nd level of the framework, as a child with additional needs. Whilst this did not mean he needed the services of Children's Social Care it describes good processes, like forming a Team Around the Child, that may have helped agencies focus more on the subject. The Framework promotes good safeguarding arrangements but was not considered for the subject.

7. RECOMMENDATIONS

7.1 The recommendations from the overview report are repeated here in full.

7.2 This SCR concludes at a time of significant financial constraints for Public Sector organisations and where strategic bodies are either in a final period before abolition or uncertain of their long term future. In Cornwall, this will be the third SCR to be published within a year. The previous SCR commented on *"Agencies swimming in a sea of recommendations"* so it restricted *"the number and nature* (of recommendations) *to critical areas that should help agencies to make significant change*" (James and Bardsley 2010). Only two single agency recommendations are offered, beyond those already committed to in IMRs. Multi-agency recommendations draw from suggestions in IMRs, Panel meetings and the findings of this overview report. Some multi-agency recommendations have national dimensions.

7.3 Recommendations will be assigned **a level of urgency** of low, medium and high. Low would tend to be more strategic matters, expected to take up to 12 months to develop and implement (that does not mean that work should not be commenced immediately). Medium should have an implementation date of no later than 3 months after the review is completed and high needs urgent and immediate action. Progress in implementing the recommendations to be monitored through the Serious Case Review sub-group audit arrangements.

7.4 Single Agency Recommendations

7.4.1 Cornwall Partnership Foundation Trust to ensure that all their staff involved with safeguarding children have access to and understand *"Preventing harm to children from parents with mental health needs: Rapid Response Report NPSA/2009/RRR003"* (National Patient Safety Agency 2009). **Medium**

7.4.2 That the Chief Executive responsible for Mental Health Services to ensure that Children's Social Care are consulted over arrangements for children visiting the

psychiatric hospital (patients generally and parents in particular), in the County. Arrangements to comply with the Department of Health Revised Code of Practice to the Mental Health Act 1983 (1999) and Health Service Circular and Local Authority Circular (HSC1999/222 LAC(99)32) *'Mental Health Act 1983 Code of Practice Guidance on the visiting of psychiatric patients by children'* (1999) **Medium**

7.5 **Multi-Agency Recommendations**

7.5.1 Agencies, through the LSCB, review protocols and guidance to embrace *"Reaching out: Think Family"* (Cabinet Office 2007), *Care Programme Approach Briefing: Patients with mental health problems and their children"* (Department of Health, SCIE and Care Services Improvement Partnership 2008), *"Improving opportunities and outcomes for parents with mental health needs and their children"* (Fowler, Robinson and Scott 2009) and *"Think Child, think parent, think family: a guide to parental mental health and child welfare"* (SCIE 2009).

This recommendation to be progressed through the South West Child Protection and Safeguarding Steering Group. **Medium**

In addition representation to be made to the Munro Review (Department of Education website 2010) to ensure that *"Think Family"* is reflected within the re-write of Working Together. **High**

7.5.2 Agencies, through the LSCB, to arrange training for all relevant staff involved in completing risk assessments. The purpose of this training is to reinforce that assessments must clearly identify the risks in terms of: what is the risk; who poses the risk; and the specific circumstances related to the risk. **Medium**

7.5.3 LSCB to consider joint training necessary for relevant adult and children's services to improve practice and understanding of each other's statutory and legal obligations where an adult with mental health needs has significant contact with a child (normally within a family relationship). **Medium**

7.5.4 Agencies, through the LSCB, to make representation to the Munro review to clarify information sharing between Adult Mental Health Services and Additional Support Children's Services. This review has raised the issue around what information adult mental health services can provide to children's services where there are safeguarding concerns rather than child protection concerns and they do not have parental consent to share information. **High**

7.5.5 Agency Senior Officers, currently represented on the Children's Trust Board Cornwall, to ensure that their staff implement and work to *'Cornwall's Integrated Children's Service's Framework Toolkit'* (Children's Trust Cornwall website 2010) and that multi-agency training be considered in conjunction with the current review of Common Assessment Framework training. **Medium**

8. REFERENCES

Cabinet Office (2007) Social Exclusion Task Force *"Reaching Out: Think Family Analysis and themes from the Families At Risk Review*"

Children's Trust Cornwall website (2010) *"Integrated Children's Services Framework Toolkit"*

Department of Education website (2010) *"Review of Child Protection: Better front line Services to protect children"* (to be conducted by Professor Eileen Munro)

Department of Health, SCIE, and Care Services Improvement Partnership (2008) *"Care Programme Approach Briefing: Patients with mental health problems and their children"*.

Department of Health (1999) *"Revised Mental Health Act 1983: Code of Practice"*.

HM Government (2006) *"Working together to safeguard children: A guide to inter-agency working to safeguard children"* and the revised Chapter 8 on Serious Case Reviews, (December, 2009)

James, S and Bardsley, J (2010) *"SCR into death of male child aged 10 years and 5 months"*.

National Patient Safety Agency (May 2009) *"Preventing harm to children from parents with mental health needs: Rapid Response Report NPSA/2009/RRR003*

ODPM (Office of the Deputy Prime Minister) (2004) *"Mental health and social exclusion"*, Social Exclusion Unit Report

Raynes, B and James, S (2009) *"SCR into death of female young person aged 17 years and 4 months"*.

SCIE Guide 30: (2009) *"Think child, think parent, think family: a guide to parental mental health and child welfare*"

Cornwall & Isles of Scilly Safeguarding Children Board

Serious Case Review Multi-Agency Action Plan – Multi-agency recommendations

Recommendation 1: Agencies, through the LSCB, review protocols and guidance to embrace "*Reaching Out: Think Family"* (Cabinet Office 2007), *Care Programme Approach Briefing: Patients with mental health problems and their children"* (Department of Health, SCIE and Care Services Improvement Partnership, 2008), *"Improving opportunities and outcomes for parents with mental health needs and their children"* (Fowler, Robinson & Scott, 2009) and "*Think Child, think Parent, think Family"* (SCIE, 2009).

Agency	Lead Professional	Action	Timescale	Audit	Outcome	Conclusion
LSCB Green	LSCB Manager	Representation made to the Munro Review (Department of Education) to ensure that "Think Family" and associated research is reflected within the re-write of Working Together, 2010 Appropriate to address this recommendation regionally given there are common issues arising from serious case reviews. Local guidance to be tabled at the appropriate meeting of the South West Child Protection and Safeguarding Review Group.	Complete	LSCB response to consultation	Learning from serious case reviews influences national and local guidance and practice.	Relevant literature and research embedded in national guidance Generic guidance agreed for implementation by all agencies around the interface between Adult Mental Health Services and Children's services published on website link http://www.online-procedures.co.uk/

Recommendation 2: Agencies, through the LSCB, arrange training for all relevant staff involved in completing risk assessments. The purpose of this training is to reinforce that assessments must clearly identify the risks in terms of: who is perceived to be at risk; who poses the risk; and the specific circumstances related to the risk.

Agency	Lead Professional	Action	Timescale	Audit	Outcome	Conclusion
All agencies Green	LSCB Training Manager	Training & Development sub-group to agree content of training to reflect learning arising from serious case review.	Complete	Single agency managerial oversight	Risk Assessment training agreed and arranged. Core element of future LSCB Multi-agency Training Programme.	Learning from serious case review embedded in practice. Reflected in LSCB Training Programme for 2011/12

Recommendation 3: LSCB to consider joint raining necessary for relevant adult and children's services to improve practice and understanding of each other's statutory and legal obligations where an adult with mental health needs has significant contact with a child (normally within a family relationship)

Agency	Lead Professional	Action	Timescale	Audit	Outcome	Conclusion
LSCB Green	LSCB Training Manager	Training & Development sub-group to review current training provided to reflect recommendation	Complete	Single agency supervision arrangements and managerial oversight	Adult Mental Health & Child Protection Training improves practice and understanding	Learning from serious case review embedded in practice. Joint training arranged for 2011/12

Recommendation 4: Agencies through the LSCB, to make representation to the Munro review to clarify information sharing between Adult Mental Health Services and Additional Support Childrens' Services.

(This review has raised the issue around what information adult mental health services can provide to children's services where there are safeguarding concerns rather than child protection concerns and they do not have parental consent to share information)

Agency	Lead Professional	Action	Timescale	Audit	Outcome	Conclusion
LSCB Green	LSCB Manager	Representation made to the Munro review (Department of Health)	Complete	LSCB response to consultation	Information sharing between adult mental health services and children's services is clarified	Review of Working Together due June 2012

Recommendation 5: Cornwall Children's Trust Board to ensure that all staff implement and work to the "Integrated Children's Services Toolkit" and that multi-agency training be considered in conjunction with the current review of Common Assessment Framework training.

Agency	Lead Professional	Action	Timescale	Audit	Outcome	Conclusion
All agencies Green	Children's Trust Board Chair	CTB to re-launch the toolkit and embed within CAF training	Complete	Single and multi-agency referral/case audits LSCB QAAG will audit multi-agency practice and report to LSCB	Agency Senior Officers to ensure that all staff are aware of and work to the Integrated Children Services Toolkit	Builds upon the recommendation from a previous serious case review.

EDUCATION – Single Agency Recommendations Action Grid

Recommendation: *That 121a communication between Police and Education Welfare Officers is reviewed at the point of delivery to ensure that notifications reach the correct EWO, allowing for district and area.*

Agency	Lead Professional			Audit	Outcome	Conclusion
Children, Schools & Families Directorate Green	Police Public Protection Unit Lead & CSFD Lead	Police and Education Welfare Officer to agree an information sharing process regarding 121a notifications	Complete	Audit of information received Managerial oversight	Education Welfare Service is able to inform schools where there are identified risks to individual pupils as a result of domestic violence at home. 121a protocol between Police and Schools drafted	Education Welfare Service receive appropriate information from the Police with regards to incidents of domestic violence.

HEALTH – Single Agency Recommendations

Recommendations:

1. Cornwall Partnership NHS Foundation Trust to report on progress in implementing the recommendations of the National Patient Safety Agency report 'Preventing harm to children from parents with mental health needs' (NPSA RRR003 2009)

   Cornwall Partnership Foundation Trust to ensure that all their staff involved with safeguarding children have access to and understand *"Preventing harm to children from parents with mental health needs: Rapid Response Report NPSA/2009/RRR003"* (National Patient Safety Agency 2009).

Agency	Lead Professional	Action		Audit	Outcome	Conclusion
Cornwall Partnership NHS Foundation Trust Green	Medical Director	Report to Health Executive Safeguarding Group on effectiveness of CPFT implementation plan on compliance with NPSA RRR003	Complete	Audit of implementation plan.	Health managers are informed of progress on professionals' understanding of the needs of children in families where parental mental illness.	Recommendations of report embedded in practice
Cornwall Partnership NHS Foundation Trust Green	Medical Director	Policy and guidance taken to Policy Development & Implementation sub-group	Complete	Single agency audit of staff awareness and understanding	LSCB endorses policy and guidance	Recommendations of report embedded in practice

2. That the Chief Executive responsible for Mental Health Services to ensure that Children's Social Care are consulted over arrangements for children visiting the psychiatric hospital (patients generally and parents in particular), in the County. Arrangements to comply with the Department of Health Revised Code of Practice to the Mental Health Act 1983 (1999) and Health Service Circular and Local Authority Circular (HSC1999/222 LAC(99)32) *'Mental Health Act 1983 Code of Practice Guidance on the visiting of psychiatric patients by children'* (1999)

Agency	**Lead Professional**	**Action**		**Audit**	**Outcome**	**Conclusion**
Cornwall Partnership NHS Foundation Trust Green	Medical Director	Initiate consultation with Children's Social Care – document circulated to appropriate CSFD Managers for comment.	Complete	Audit of practice to ensure arrangements are working	Children's social care workforce are aware of code of practice and guidance is implemented	Visiting arrangements comply with guidance

3. Cornwall Partnership NHS Foundation Trust (**CFT**), to develop with primary care services, a protocol governing care and treatment of service users who regularly move between geographical areas and teams.

Agency	**Lead Professional**	**Action**		**Audit**	**Outcome**	**Conclusion**
Cornwall Partnership NHS Foundation Trust Green	Chief Operating Officer	Protocol to be developed and agreed across relevant health areas. Consideration to be given to engaging primary care services at a time of significant change	Complete	Audit of practice to ensure arrangements are working	Protocol is embedded within relevant health services	Care and treatment of services users who move between geographical areas and teams is co-ordinated and monitored

4. CFT continues implementing recommendations of SCIE Report " *Think child, think parent, think family: a guide to parental mental health and child welfare"* (July 2009) (links to multi-agency recommendation 1& 4)

Agency	Lead Professional	Action		Audit	Outcome	Conclusion
Cornwall Partnership NHS Foundation Trust Green	Chair of CFT Operational Safeguarding Children Group	Review current safeguarding children training provided through the Trust CFT Safeguarding Children Group consider SCIE recommendations and agree an Action Plan	Complete March 2011	Incorporated into training Supervision process Managerial oversight Progress audited	Recommendations from SCIE report are embedded in all safeguarding children training Action Plan implemented	Learning from serious case review embedded in practice.

HOUSING – Single Agency Recommendations

Recommendation: To make other agencies aware of the duties and responsibilities Cornwall Council Housing has to applicants in housing need.

Agency	Lead Professional			Audit	Outcome	Conclusion
Housing Green	Housing Options Manager	Through Area Team meetings and other multi-agency meetings, share information about the roles and duties of Housing and other agencies to enable front line staff to understand each others services.	Complete	Managerial oversight	Partner agencies are aware of the Councils Housing responsibilities and duties.	Increased awareness across agencies regarding role of Cornwall Council Housing

Housing Green	Housing Needs Manager	Before and since its introduction the Homechoice service has been advertised in One Stop Shops and Libraries. Training of One Stop Shop staff has covered all aspects of Homechoice, specifically reference identifying vulnerable applicants. Information is shared with Heads of ACS and CSC via emails and a weekly Newsletter; regular liaison meeting and held with Learning Disability teams and Women's Refuges; Homeless Centres; fortnightly welfare panels in each major town with ACS, Occupational Therapy and Mental Health; and regular liaison meetings with housing/landlord partners.	Complete	Managerial oversight	Partner agencies are aware of the Councils Housing responsibilities and duties in relation to Homechoice.	Increased awareness across agencies regarding the Homechoice scheme
Housing Green	Housing Needs Manager and Housing Options Manager	Ensure the triage protocols are understood and implemented across Area Housing Offices.	Complete	Managerial oversight	Housing Service aligned across Cornwall.	Triage protocol embedded

POLICE - Single Agency Action Grid of recommendations

Recommendation 1:
Public Protection training relating to risk management of all safeguarding areas (Child Abuse, Vulnerable Adults, MAPPA, Domestic Abuse and Missing Persons) to be delivered to all appropriate members of staff (frontline officers and police staff) within the Devon and Cornwall Constabulary.

Agency	Lead Professional			Audit	Outcome	Conclusion
Devon and Cornwall Police Green	D/Supt Public Protection	Research undertaken. Training plan/Strategy completed. Training plan implemented. Training review to be conducted.	Complete	Take up of training Post course evaluation	Improved awareness re: safeguarding issues. Improved safeguarding for adults/children. Improved opportunities for early intervention. Improved Community Confidence.	Training commenced in April 2010 throughout the Force area.

Recommendation 2:
The Force should consider the Police resources required to implement the principles of Multi- Agency Safeguarding Hubs (MASH) in respect of adult safeguarding following the evaluation of the pilot of the process in Devon.

Agency	**Lead Professional**			**Audit**	**Outcome**	**Conclusion**
Devon and Cornwall Police Green	D/Supt Public Protection	Review: • Current arrangements/practices. • IT compatibility/opportunities. • legal position. • Pilot model. Evaluate Pilot	Complete	Legal position re information sharing. Staffing and compatibility of agency working practices/procedures.	Provides improved opportunities for multi agency information sharing and increased opportunities for early intervention. Potential to improve safeguarding procedures and provide an holistic overview of individuals/families	Cornwall & IOS BCU undertaking scoping exercise re multi agency working.

Recommendation 3:
The Force should review the current child referral form (121a) to include the details of vulnerable adults.

Agency	Lead Professional			Audit	Outcome	Conclusion
Devon and Cornwall Police Green	D/Supt Public Protection	Review existing Form/working practices. Review capacity of existing resources- Police/Multi agency. Implement working practices/multi agency procedures.	Complete	Capacity of staff to process forms.	Improved safeguarding for adults. Improved recording practices. Early identification of others at risk within the family. Comprehensive referral process.	Review of 12a commenced. Further work being conducted to look at feasibility of the process.

Recommendation 4:
All officers to be reminded by Forcewide circulation/briefings of the importance of submitting intelligence on a person that suffers from mental illness or capacity issues. Intelligence submission to include contact details of SPOC within mental health (where appropriate).

Agency	Lead Professional			Audit	Outcome	Conclusion
Devon and Cornwall Police Green	D/Supt Public Protection	Circulate Forcewide email. Circulate briefing sheets.	Complete	Staff performance processes	Accurate recording of information. Increased awareness amongst officers/staff. Improved availability of information to operational staff.	Information provided to Police Officers

Recommendation 5:
Mental Health Training to be delivered to all frontline staff within the Force area (to include the use of Barnardos risk assessment where children and young persons are identified as being affected).

Agency	Lead Professional			Audit	Outcome	Progress
Devon and Cornwall Police Complete	Supt TP	Research undertaken. Training plan/Strategy completed. Training plan implemented. Training review to be conducted.	Complete	Take up of training Post course evaluation	Improved awareness re safeguarding issues. Improved safeguarding for adults/children. Improved opportunities for early intervention. Improved Community Confidence.	Training plan being completed. Awaiting further national guidance

Recommendation 6:
To review CIS (Crime Information System) training to ensure it includes an input on the use of the 'G' Screen.

Agency	Lead Professional			Audit	Outcome	Conclusion
Devon and Cornwall Police Complete	D/Supt Public Protection	Undertake Review. Implement changes.	Complete	None	Improved awareness of facility amongst staff. Improved information recording.	Work in progress

Recommendation 7:
Publicise through the Force intranet and briefing sheets the existence of the 'G' Screen to all staff.

Agency	Lead Professional			Audit	Outcome	Conclusion
Devon and Cornwall Police Green	D/Supt Public Protection	Circulate Forcewide email. Circulate briefing sheets.	Complete	Staff awareness	Accurate recording of information. Increased awareness amongst officers/staff. Improved availability of information to operational staff.	Publicity campaign completed

SOCIAL CARE– Single Agency Recommendations and Action Grid

Recommendation: To clarify the 121a – Domestic Violence information process and build on the work arising from a previous serious case review which identified this as an area of concern

Agency	Lead Professional		Timescale	Audit	Outcome	Conclusion
Children's Social Care (CSF) Green	Senior Manager (Acute and Complex)	To clarify policy, procedures and processes and disseminate in conjunction with Police colleagues re:121a and domestic abuse summaries.	Complete	Case/referral audit Review of frontline practice and information sharing	The 121a process is reviewed and clarified with a clear process that all agencies understand. Establishment of Single Referral Unit and co-location of Police Officers and Social Workers has improved communication and information sharing around domestic violence and allows for multi-agency discussion around agency response and service provision.	Information from the Police regarding incidents of domestic violence is provided to Children's Social Care in a timely manner with a clear risk assessment.