EXECUTIVE SUMMARY

WIRRAL LOCAL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW IN RESPECT OF

Child A, Child B, Child C, & Child D

6 April 2011

1. Decision to undertake a Serious Case Review

1.1 The children A, B, C, and D were subjects of private law proceedings following the separation of their parents.

1.2 The Local Authority issued care proceedings three years later and the children were placed in foster care. In these proceedings, the Judge made a Finding of Fact, which concluded that the father had been sexually and physically abusive towards one or more of the children and requested that a copy of her Judgement was shared with the Director and Assistant Director of Children and Young People's Services in Wirral.

1.3 The Judgement listed a number of criticisms about the actions of the Local Authority and responses to the management of the allegations of sexual and physical abuse of the children. The Director and the Assistant Director considered whether a Serious Case Review (SCR) would be appropriate. Acting in his capacity as Chair of the Local Safeguarding Children Board, the Director of Children and Young People's Department, Howard Cooper, asked the Serious Case Review Sub- committee to consider the matter further.

1.4 The purpose of Serious Case Reviews is to:

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

1.5 The multi disciplinary SCR sub-committee concluded that a SCR should be undertaken and the Chair of LSCB accepted their recommendation.

2. Methodology

2.1 A Serious Case Review Panel was established, and comprised of the following:

- Colleen Murphy, Independent Chair
- Designated Doctor for Safeguarding
- Designated Nurse for Safeguarding NHS Wirral
- Cafcass
- Head of Young People's Services Arena Options
- Head of Branch Wirral Children and Young People's Department (CYPD)
- Detective Chief Inspector Force Crime Operations Unit
- Assistant Chief Officer Merseyside Probation Trust
- Representative for Primary school Education
- Strategic Services Manager Safeguarding CYPD

2.2 The Independent Chair of the panel is an experienced social work practitioner/manager who currently undertakes a range of independent social work activities, predominantly in the field of child care and

quality assurance. She has substantial experience of chairing other SCRs and writing overview reports.

2.3 The independent Overview Report, Linda Richardson, has worked in a range of statutory and voluntary settings and has over 30 years operational and managerial experience of working in child protection. The author was not employed or connected in any way to the agencies contributing to this review.

2.4 The Panel received Individual Management Reports from the following agencies:

Cheshire and Wirral Partnership NHS Foundation Trust (CAMHS)
Children and Family Court Advisory and Support Service (Cafcass)
Health Overview Report for NHS Wirral, and Wirral University Teaching Hospital NHS Foundation Trust
Merseyside Police
Merseyside Probation Trust
North West Ambulance Service NHS Trust
A Children's Centre
Wirral Children and Young Peoples' Department: Learning and Achievement
Wirral Children and Young Peoples' Department Social Care (Social Work Service)
Wirral Children and Young Peoples' Department Social Care (Safeguarding and Review)
Wirral Council Regeneration Department Homelessness and Wirralhomes Services
Wirral Partnership Homes

2.5 The key lines of enquiry for the Serious Case Review were as follows:

1. Whether Agencies had in place policies and procedures for protecting and promoting the welfare of children
2. Whether agencies could effectively demonstrate an understanding of the interface between private law proceedings and the statutory duty to promote and protect the children's welfare
3. Whether any concerns for the children's welfare were identified (with specific reference to sexual abuse, domestic violence, physical abuse and neglect) and subsequent actions accord with procedures?
4. Whether agencies establish and take into account the family's specific cultural, racial, linguistic, and religious needs when assessing need and delivering services?
5. Whether agencies effectively used procedures to ensure a working together approach
6. Did the undertaking of ABE interviews accord with best practice
7. Whether agencies offered appropriate challenge to each other to maximise the safety and welfare of the children
8. Whether agencies undertook robust risk assessments to support key decision making
9. Were all the children's stated experiences and wishes and feelings heard and taken account of in planning and decision making? Concomitantly, did decisions and planning appear to be overly focussed on the adults rather than focussing on the children
10. Whether the level of management oversight and supervision was appropriate to the needs of the case work and the front line staff

11. Whether agencies adhered to the Government Information Sharing Protocol.

and to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children;
- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence;
- Improve inter-agency working and better safeguard children.

2.6 Each contributing agency provided an Individual Management Review (IMR) and chronology of agency contacts with the children and their family.

2.7 The mother and father of the children were informed that a Serious Case Review was being conducted. The Review believed that consultation with each of the parties but particularly the mother would significantly enhance the Review. The mother met with a representative from the panel and expressed her views about how professionals had worked with her and the children, The father was offered this opportunity to meet but did not do so.

3. Summary of events leading to Serious Case Review

3.1 Children A, B, C and D are a sibling group of four children.

3.2 The early years for Child A, B C and D show a continuation of concerns from agencies regarding the physical care of the children and at times poor, cramped and unhygienic living conditions. The concerns about the children's welfare resulted in agencies planning additional support to the parents to improve the standard of care for the children using a family support model of intervention.

3.3 The mother and father separated in early 2006 and the children were then involved in protracted private law proceedings regarding contact and custody during the following three years. The children were mainly resident with the father who was awarded Residence by the Court.

3.4 Between 2007 and 2009 there were many occasions when the children's welfare became a matter for concern. Child D sustained bruising whilst in the care of the father following which a medical examination concluded this injury was non accidental. As a result of this incident a Child Protection Conference was convened. This resulted in all four children being made the subject of Child Protection Plans for physical abuse. The children continued to reside with the father who was offered support in the management and care of the children. Two months later, at the first Child Protection Review Conference, the Children's Child Protection Plans were discontinued.

3.5 Some months later, Child A made an allegation of sexual abuse by a family member. A Child Protection Conference was held and all four children were again made the subject of Child Protection Plans, this time under the category of sexual abuse. The Child Protection Plans were discontinued four months later.

3.6 The following year, the mother reported that Child A had made allegations of sexual abuse by the father. During interview, Child A alleged that Child B had similar experiences. The mother refused to return the children from a contact visit and the father consequently made an application for a Prohibited Steps Order. The Judge ordered that the children reside temporarily with their Paternal Grandmother and they returned to their father several weeks later after consideration of a report prepared by Wirral Children's Social Care for the Court under Section 47 of the Children Act 1989. The Court was led to believe and understood that all investigations had been completed.

3.7 It was concluded that the mother had coerced Child A into making the allegation. The mother was arrested on suspicion of perverting the course of justice, but it was several weeks later later the father was interviewed under caution on suspicion of the rape of Child A. No further action was taken in relation to either parent although there were significant issues that should have resulted in further investigation.

3.8 Further allegations of physical abuse followed and all four children were made the subject of Interim Care Orders and they remained in the care of their father.

3.9 In May 2009, the Local initiated care proceedings and all four children were placed in foster care.

4 Key Issues arising from the Review

There are several areas for learning identified in this review. The failings to safeguard and promote the welfare of these children were not located within just one agency. This is clearly evidenced by the number of recommendations contained in the majority of the IMR recommendations listed in Section 6. The significant themes are identified below:

4.1 Failure to undertake appropriate assessments

4.1.1 Apart from the Initial Assessment undertaken very early in this four year time frame, no other assessments took place during this period either in relation to the needs of the children or the parenting capacities of the adults. Yet there was significant evidence that these children were experiencing neglect and growing up in situations of domestic violence.

4.1.2 Throughout this period there were many concerns raised and shared between agencies during various meetings. The meetings concluded that the father needed practical support to care for his children and this view prevailed despite evidence to the contrary that the children's needs remained unmet. This failure to agree how services would be coordinated and responses measured, resulted in little change for the children over a four year period.

4.1.3 The lack of assessment meant that throughout the period of review, interventions were reactive with too great an emphasis on practical support and little attempt to seriously address either parent's parenting abilities. Research suggests that children in families where

there were safeguarding concerns which did not have a detailed assessment completed were four times more likely than their counterparts to experience recurrence (C4EO Directors Summary March 2010) A serious failing identified in this review is that key assessments were not undertaken at appropriate times and the use of Assessment Interviews and ABE interviews did not follow procedures.

4.2 A lack of clarity about the interface between private law proceedings and Local authority responses to safeguarding concerns within this framework

4.2.1 Whilst private law proceedings were ongoing a high level of parental dispute about the children's welfare was evident. The Local Authority's approach to these disputes was to view them as being 'tit for tat' and attached little if any weight to them. With hindsight this view ensured that the very serious allegations that were made throughout the latter part of this period were not thoroughly investigated at the times of their occurrence so appropriate protective measures could be put in place.

4.3 Failure to Challenge and Bias

4.3.1 Within the IMRs, there is evidence that good quality supervision was not always available. In social care, supervision appears to be collusive, non challenging and task related. Two Team Managers took decisions which left children in high risk situations. They appeared to adopt a particular mindset about the nature of this case which was either shared by frontline practitioners or not challenged by them. This "mindset", lacked a healthy skepticism which one would expect to see in managers supervising frontline practitioners.

4.3.2 There was strong evidence of confirmation bias[1] whereby practitioners re-enforced already held views or preconceptions and ignored evidence which contradicted this view.

4.4 The limitations of Procedures, Policies and Protocols

4.4.1 Procedures play a key role in clearly stating what should be done and by whom. Professor Munro's[2] review suggests that procedures have become too extensive and leave little space for professional judgement. However, the review found evidence that it was not just a lack of clarity about, or absence of, procedures which led to poor practice, it was simply that the most basic procedures outlined in Working Together to Safeguard Children had not been followed when significant events had occurred or new information emerged.

4.5 Poor application of guidance when interviewing children

4.5.1 During the timescale identified in this review, Child A was interviewed on 9 occasions in relation to allegations of abuse. The standard of recording for each of these and the rationale for each being undertaken in the first place is extremely poor.

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[1] Gambrill, E.D. (2005) 'Decision-making in child welfare: errors and their context', *Children and youth services review*, vol 27, 4, 347–352.

[2] Professor Eileen Munro. Interim Report The Child's Journey February 2011

4.5.2 The use of an 'assessment' interview prior to any formal interview lacked clarity and there was confusion about their purpose and function within the investigatory process. These interviews appear to have been undertaken with a view to seeking evidential reliability rather than as a means by which the child's experiences can be understood and decisions made about future actions. It is noted that there have now been changes to these procedures including a change from the title 'Assessment Interviews' to 'Seeing and speaking to the Child'.

4.6 Inter-Agency Working

4.6.1 A key factor in work with this family is the extent to which agencies appear to have worked in isolation and yet there are some examples of good multi agency working, notably between key professionals. Joint visits took place between health and social care on occasions, and teachers appear to have been very pro-active in keeping social workers informed about the children and their contact with parents. It is clear that school staff were concerned about the lack of physical care the children were experiencing and the impact this was having on their development. The work undertaken by Family Support workers however, was particularly adult focussed and this is recognised as an area for learning in the IMR.

4.6.2 The single agency determination of the view held by social care that this was a case of borderline neglect exacerbated by parental disputes did bring some challenges from other agencies. However, when these were not addressed or accepted , concerns were not escalated either to a more senior level or where this did occur, the issue was not taken forward through the appropriate channels. Whilst it is acknowledged that WSCB introduced and implemented an escalation procedure in 2009 and now offers training around 'Courage to challenge', the Board would be well advised to explore this issue in greater depth to satisfy themselves that the recurrent and significant failing thoughout this review.

4.7 Resistant Parents

4.7.1 The prevailing view of the father as the caring parent and the mother as the unstable obstructive parent was evident across agencies. Comments about the father's willingness to engage with professionals were repeatedly reported. 'Disguised compliance' occurs when parents want to draw attention away from allegations of harm. Brandon et al (2008)[3] found that where this occurred it often prevented or delayed understanding of the severity of harm to a child. With this father having skillfully and firmly engineered the focus away from the allegations of harm, the children in this family went unseen and unheard.

[3] Brandon, M. et al. (2008a) Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005. Research Brief DCSF-RB023 (PDF). London: Department for Education and Skills (DfES).

4.8 Records, record keeping and sharing information

4.8.1 An issue of poor records and recording practices was identified in each of the IMRs in this review. Well kept records are an essential component in work with vulnerable children and allows professionals to see patterns and trends which are not at first obvious. Each agency held information which had it been used to inform assessments, would have made a valuable contribution to meetings when concerns about these children were discussed.

4.9 The Child's Perspective

4.9.1 Understanding what is happening to a child when there are concerns that the child's health and development are being impaired remains a core professional activity for those working with children and families. A significant factor in this review is the extent to which practitioners 'lost sight' of the children. There is substantial evidence that decisions and planning centred largely on the needs of the father rather than on the needs of the children.

4.9.2 No agency recorded much detail about the children other than their appearance, attendance and academic progress (in school). It is difficult to envisage how the children made sense of the various adults who appeared and disappeared in their lives and who mostly engaged not with them but with their father. The experiences of Child A, being interviewed and examined on so many occasions and being caught in the middle of parental and family disputes is a sharp reminder to practitioners of what happens to children when they are not kept firmly in focus.

5 Conclusions

5.1 During the conduct of this serious case review, several areas of practice have changed and various procedures and protocols have been reviewed, revised and amended. These have occurred both in responses to learning from this review and also in the light of other emerging issues.

5.2 The circumstances which led to this review are somewhat unusual in that the concerns about the children's experiences were identified during public law proceedings. Had this SCR not been prompted by a finding of fact of hearing, the failings for these children would have gone unnoticed. It should also be stressed that the number of recommendations identified in most of the IMRs highlight that failings were not linked to just one agency and that all agencies involved had lessons to learn from this serious case review.

5.3 Each agency has approached this review with a genuine determination to learn. Through the Individual Management Reviews each agency has identified failing in their own practice and have been open to accepting and addressing the constructive criticism of the panel and Independent Author.

6. Multi Agency Recommendations

Recommendation 1
Wirral Safeguarding Children Board should renew its focus on quality assurance processes and on 'practice evaluations' to ensure the quality of frontline safeguarding practice.

Recommendation 2: *WSCB should identify what they regard as basic living conditions for children in Wirral against which concerns about neglect can be measured.*

Recommendation 3
a) WSCB should ensure multi agency training programmes supports the acquisition of skills and knowledge around work with 'highly resistant and manipulative' families

b) WSCB should ensure its multi agency training programmes equip frontline practitioners and their managers to understand bias in it various forms and the impact this can have on professional judgement.

Recommendation 4
WSCB should examine what barriers exist which prevent effective and robust interagency challenge taking place and consider what steps it might take to remedy these.

Recommendation 5
WSCB should consider other models for offering support and challenge to practitioners in addition to the traditional one to one approach, for example exploring the value of multi agency consultation forums and group or case supervision

Recommendation 6 *WSCB should consider how they might review practice and outcomes of ABE interviews during this period to assure them that children subjected to these processes have been protected*.

7. Single Agency Recommendations

Wirral Children and Young People's Department: Social Care Branch

1. The child protection procedures should be reviewed and more specific guidance should be produced for Social Care staff in respect of their roles and responsibilities. The accessibility of the procedures should be addressed to ensure they are easily and readily accessible to all staff.

2. The training programme for Social Workers, Family Support Workers and Managers should be reviewed and revised to ensure it provides all staff who are, or could be asked to carry out child protection investigations, with a clear understanding of the procedures, roles and responsibilities and the issues to be considered with different types of abuse. This training programme should be mandatory for all relevant staff with a requirement to undertake regular updates.

3. The central importance of the Strategy Discussion to the management of child protection investigations should be confirmed with the Police and

Partner Agencies, which includes commitment to attendance and resourcing the process.

4. The new scheme of delegated responsibility for decision making should be issued, which ensures there is clear accountability for decision making in relation to child protection investigations and clarification of the role of the Safeguarding and Quality Assurance Unit in respect of advice and scrutiny. The scheme of delegations should clarify responsibilities for the scrutiny of Child Protection Conference and Review reports and the production of draft responses for elected members.

5. A procedure for the allocation and management of requests for the provision of information in Private Law cases and for responding to requests for Section 7 and 37 reports is to be produced. This should identify the quality standards expected, the processes to be followed and the role of Legal Gatekeeping in providing scrutiny and oversight.

6. The policy and procedure in relation to chronologies on case files should be reviewed and reissued with practice guidance and a clear audit process that ensures compliance

7. All Social Work Managers should receive training, and a programme of refresher training in the effective use of supervision in the management of child protection cases

8. A clear process of risk assessment and risk management that is integrated with the Initial and Core Assessment and Section 47 process should be developed to ensure that the issue of risk is appropriately considered, identified and managed.

9. Social Care should review the current Service Level Agreement used in the commissioning of Family Support Work services to ensure that it effectively covers all relevant issues.

10. Social Care should audit the case file transfer process to ensure that the requirements of the procedure are being adhered to.

11. Social Care should implement a case weighting process for Social Workers to ensure that caseloads can be realistically managed and that cases have been allocated in accordance with the level of skill, experience and training of the Social Worker.

12. The joint protocol between the Department of Regeneration, Children and Young People's Department and Registered Social Landlords should be reviewed and re-issued to ensure the relevant staff are aware of and making use of the protocol

Wirral Children and Young People's Department: Social Care Branch Independent Reviewing Officers (IRO)

1. The Safeguarding and Review Unit must assure the LSCB that Conference chairs are appropriately trained to the Standards laid out in Chapter 5, Paragraph 5.90 of Working Together to Safeguard Children 2010. To also include the interface between private law proceedings and safeguarding.

2. The Safeguarding and Review Unit must take action/ensure the administrative arrangements and recording keeping of Conferences is in

accordance with Chapter 5, Paragraph 5.111 of Working Together to Safeguard Children 2010.

3. Information provided to Conference, including the written report provided by Children's Social Care must summarise and analyse information as laid out in Chapter 5, Paragraphs 5.91, 5.92, 5.94, and 5.96 of Working Together to Safeguard Children 2010.

4. The Safeguarding and Review Unit Manager must ensure that Conference chairs conduct conferences in line with LSCB procedures on quoracy, Child Protection Plans and Core Group Minutes.

5. Children's Social Care Branch must ensure that Safeguarding and Review Unit staff are familiar with key processes relating to Achieving Best Evidence interviews.

6. Wirral LSCB to re-issue the Escalation Procedure for those cases where there is a challenge between agencies outside of the conference arena.

7. Wirral LSCB to develop minimum standards applicable to all agencies when it is felt that a child no longer requires a child protection plan.

8. Refresher training to be provided to social work teams around the safeguarding procedures - Managing Individual Cases and Child Protection Conferences

9. Safeguarding and Review Unit to develop an audit framework/process for evaluating the quality and conduct of CP Conferences and LAC Reviews.

10. The ICS Project Steering Group to detail a time line and implementation plan for recording information on ICS in the Safeguarding and Review Unit.

11. Safeguarding administration procedures and templates regarding inviting relevant professionals to initial case conferences to be updated so there is a prompt to ask the social worker if the Examining Dr and representatives from other agencies are to be invited to the Initial Conference. If the answer is no, then a record should be kept of the reason.

12. LAC Procedures and Guidance for IROs relating to Looked After Children must be updated by April 2011 to ensure compliance with the Care Planning, Placement and Case Review Guidance and Regulations 2010. Briefings on the Guidance and implications for social work practice to take place, with a particular focus on Care Planning and the cycle of assessment, planning and review as set out in Chapter 2 of the Case Planning, Placement and Case Review Guidance and Regulations 2010.

13. LAC Review Records of discussion and Recommendations must comply with the existing Local 'Good Practice' Guidance but by April 2011 comply with Chapter 4 paragraph 4.31 of the Care Planning, Placement and Case Review Guidance. Briefings to take place with IROs on both aspects.

Wirral Children and Young People's Department: **Learning and Achievement**

1. Standardise across all schools the methodology by which potential safeguarding incidents are recorded, actioned and monitored. Ensure that

agencies are able to communicate promptly when there are instances of non-engagement by parents, carers or schools.

2. Ensure that when staff leave a school or change responsibilities, the arrangements allow for a smooth and accurate transition of information from one person to another.

3. Ensure that there is a clear definition of what constitutes a contact, a consultation and a referral in order that there can be a common understanding between schools and social care about the prioritisation of reported concerns.

4. Examine ways in which concerns that present as 'neglect' may be monitored more effectively by schools in partnership with other agencies to ensure that the 'root' causes of neglect are identified and addressed; Ensure that any child in a school who appears to be neglected is monitored carefully and that evidence is documented of these concerns and the actions that each and every agency will/would take.

Health Overview Report

1. NHS Wirral and WUTH to request that the LSCB training sub-group facilitates multi agency training of the 'Neglect Tool.'

2. NHS Wirral Safeguarding Service to revise the Safeguarding Child Protection Conference proforma.

3. NHS Wirral and WUTH to review Health Visitor and School Nursing documentation to include the recording of a child's religion.

4. NHS Wirral should update the audit tool used as part of the supervision process to reflect the timescale regarding the practitioner receiving a copy of the Child Protection Plan.

5. NHS Wirral and WUTH to amend existing safeguarding children training packages for all Health Visitors and School Nurses to incorporate the use of their respective Trust's Escalation process.

6. NHS Wirral to ensure that all GPs can evidence that they have Safeguarding training within recommended timescales. This should be recorded at GP annual appraisal and audited to ensure compliance.

7. NHS Wirral pursues with the Safeguarding Unit a review of the process for sharing information in between agencies to ensure that minutes from all safeguarding meetings are always copied to the family GP.

8. Every GP must have in place a system for recording children subject to a Child Protection Plan with the ultimate aim of developing an electronic flagging system.

9. WUTH and NWAS clarify the status of the Child Welfare Report Form and agree a written procedure for actions and roles and responsibilities when a form is completed. WUTH should ensure staff in AED are trained in the use of this procedure. The use of the Child Welfare Report Form should be audited to ensure safeguarding concerns raised by the ambulance service are acted upon appropriately.

10. WUTH to ensure that a standard procedure is followed for the management of cases by Paediatric Liaison regardless of who is covering this role and that the Paediatric Liaison nurse should deliver training to other staff covering this role in her absence. WUTH develop an electronic system for recording the actions taken by Paediatric Liaison Nurse

11. WUTH and NHS Wirral consider the feasibility of an electronic process for transfer of information to HV's and SN's regarding attendances at AED at WUTH for children under the age of 16 years.

12. WUTH conducts a record keeping audit of the Child Protection proforma used by the Community Paediatricians for Child Protection medicals and with the result of the audit deliver a training update to the Community Paediatricians on the completion of the proforma.

13. WUTH ensure that a request for invitation to Child Protection Conference is included in the conclusion of all child protection medical reports.

14. WUTH to work with the Safeguarding Unit to ensure that the Community Paediatrician on call for Child Protection is invited to strategy meetings convened to decide whether a Child Protection medical is required.

15. WUTH to include in Safeguarding medical proforma the importance of taking a history from the child in safeguarding cases. This can also be audited as part of the Child Protection proforma audit (recommended above under TOR1)

16. WUTH and NHS Wirral review the notification process when children become subject to a Child Protection Plan or when children become no longer subject to a Child protection plan. This needs to be audited to ensure the process is reliable.

Cheshire and Wirral Partnership NHS Foundation Trust (CAMHS)

1. That measures are taken to ensure that all clinicians are reminded of their duty to inform and or seek advice from the safeguarding team, in the event of concerns of domestic abuse, child abuse or neglect as trust Policy indicates..

2. That CAMHS staff document all discussions between professionals related to clients / families that are open to services and that relevant content of the discussion or key information shared is documented.

3. That measure are taken to ensure that CAMHS staff are compliant with record keeping in particular timing of entries and countersigning of student entries by supervisors.

4. That CAMHS consider when working with children and families how each individual child and their case information is identified separately and not lost in their siblings case folder

5. That measures are taken to ensure that a child's religion is recorded within case records to ensure that children's religious needs are acknowledged and facilitated.

6. That measures are taken to ensure that staff access both child safeguarding and domestic abuse training appropriate to their needs.

7. Measures should be taken to ensure that clinicians access supervision that includes discussion related to specific safeguarding issues when working with complex cases that include safeguarding children issues for any child or family.

8. That measures are taken to ensure that staff are trained and supported in challenging other professionals safeguarding processes and decision making in line with the appropriate multi-agency 'Escalation procedures' now in place

Merseyside Police

1. Merseyside Police should take steps to remind officers and staff of the policies and actions required and expected when dealing with vulnerable adults and children

2. Merseyside Police should seek to clarify, with partners and agencies, the definition, understanding and purpose of 'Strategy Discussions' and 'Strategy Meetings'. This definition and understanding should include the role/rank of the person who has the responsibility to lead.

3. Where Police or any other Agency have concerns regarding the safeguarding of children or vulnerable adults, there needs to be an 'Escalation Policy' to ensure that senior officers and staff are aware of these concerns and appropriate action taken.

4. Merseyside Police must ensure accurate recording of data on PROtect and other Force systems. There must be a robust quality assurance and control of sensitive data, and ensure officers and staff comply with the conditions of use.

5. Merseyside Police should ensure that interview strategies take account of the number/frequency of previous interviews of victims. ABE interviews must only be carried out by suitably trained staff and be subject of dip sampling and audit.

Merseyside Probation Trust

1. The recommendation emanating from this review of practice is that the LSCB's escalation procedure should be re-issued to managers and staff practicing on the Wirral and a check made that they fully understand what is required of them in relation to this process.

Children and Family Court Advisory and Support Service (Cafcass)

1. Evidence based assessment: Ensure that all FCA's within C7 are recorded on Q4C as satisfactory or above in relation to case analysis.

2. Case Recording and CMS: Ensure that all FCA's within C7 are adhering to Cafcass case recording policy and that information is transferred onto CMS to capture court hearing outcomes.

3. Supervision: Ensure that all FCA's within C7 have a supervision agreement. Clear model of supervision to be stated in procedures to include reflective practice.

4. Court Timescales: Cafcass to share lessons learned with the Judiciary to keep cases child focused and raise awareness of risks in cases drifting.

Seacombe Children's Centre

1. Ensure a consistent and detailed recording protocol which includes an effective call log system with details of conversations and a clear follow up system to ensure that telephone calls are returned.

2. Examine the ways that inter- agency communication can be further developed in order to ensure transparency and effective working

3. Ensure that the level of management oversight and supervision is appropriate to the needs of the case work and the front line staff

4. That all Children's Centre staff continually focus on the needs of the children in the family, through communication and observation

Wirral Council Regeneration Department Homelessness Service

1. It is recommended that the Joint Protocol between the Regeneration Department, the Children and Young People's Department and Registered Social Landlords is revised and updated and training rolled out to all appropriate social care and housing practitioners and managers and is extended to cover cases where:

    - a household with children is found to be intentionally homeless, so that the statutory guidance is followed to best effect and
    - households where private law proceedings are underway are in housing need, so that the housing needs of each household in the short and longer terms are met

2. It is recommended that if the Wirralhomes Service becomes aware of a Registered Social Landlord (RSL) tenant living in severely overcrowded conditions (i.e. by 2 or more bedrooms), they notify the landlord, and if they award urgent need status to an RSL tenant, they notify the landlord.

Wirral Partnership Homes

1. Assist partner agencies to understand the role of housing in safeguarding

2. Improve Inter-agency working

3. Implement a reviewed training programme

4. Explore ways of reconciling a property and tenancy database with the requirements of a casework approach

5. Adopt recommendations from a previous serious case review

6. Ensure technical and contract staff carrying out repairs & servicing, to alert housing management in the first instance of potential issues.

7. Develop an escalation procedure for no access visits to ensure other sections are alerted to potential difficulties.

North West Ambulance NHS Trust

1. To ensure referral protocols/pathways for vulnerable children are understood and followed through by ambulance practitioners.

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