# Local Safeguarding Practice Review
# Terms of Reference

# Children: C92/C93

**March 2022**

## 1. Reason and Context for Review

1.1. This review relates to two siblings who have been given the pseudonyms C92 and C93. A Rapid Review was initiated by the TSCP following their mother's arrest on 17th December 2021 for the attempted murder of C92. The alleged incident took place in the family home where both siblings were living in the sole care of their mother following the death of their father in Torbay Hospital on 8th December 2021 from Covid 19.

1.2. Further concerns regarding the children's welfare were identified within the Rapid Review process, with examples of these being:

- The mother's apparent poor mental health and supporting of conspiracy theories.
- The mother removing C93 from hospital against medical advice when he was suffering from Covid 19
- The mother's alcohol consumption.
- Medication being stockpiled in the family home that the mother appears to have stolen from her place of work (Torbay Hospital).
- Both children reporting that their mother had been forcing them to take the stolen medication.
- Relationship difficulties in the parental relationship, including previous reported domestic abuse.
- C93 being 'invisible' to education services across two Local Authorities, with his EHE status exacerbating this concern.
- Opportunities appearing to have been missed by services to offer/provide family intervention at an Early Help level.

1.3. The Rapid Review meeting was held on 5th January 2022, with the associated report being submitted to National Panel on 10th January 2021 recommending the undertaking of a local CSPR. National Panel responding to the TSCP on 4th February concurring with this view. National Panel agreed with the lines of enquiry identified by the TSCP and Siobhan Burns was confirmed as the Independent Reviewer on 10th February 2022.

## 2. Purpose

2.1. This review will be based on the key lines of enquiry recorded in section four below. However, during the review, if further learning opportunities are identified these will be added at the discretion of the TSCP review panel. The key purpose of the review is to prevent future similar harm and learn lessons where appropriate to further safeguard and promote

the welfare of children. The review should aim to identify systematic learning, rather than holding individuals or organisations to account for their actions.

2.2. If concerns are identified within the review process that fall outside these terms of reference, such as those of a safeguarding or misconduct nature, the Independent Reviewer will refer to the TSCP who will then consult with the relevant body to consider appropriate responses and processes.

## 3. Period under Review

3.1 The period under review is from 26th April 2008, the date of the family's first recorded non-universal service 'intervention', until 17th December 2021, the date of the alleged attempted murder of C92.

3.3 The Independent Reviewer may also request summary background and contextual information outside of this period and analyse as relevant.

## 4. Key Lines of Enquiry

The following key lines of enquiry have been established, based on the findings of the Rapid Review, and have been noted by National Panel. Further questions have been agreed by the TSCP review panel and are recorded under their linked line of enquiry via bullet points.

1. **Determine how C93 appeared 'invisible' to education services across two Local Authority areas, report on the effectiveness of communication processes between the relevant education professionals and identify how oversight and safeguarding can be improved in respect of children who are EHE.**

    - Do agencies in Torbay have robust and effective policies and procedures for the identification of children who are EHE?
    - Do agencies in Torbay have robust and effective policies and procedures for the identification of children who transition between schools/education provisions into or out of Torbay from other Local Authority areas, including children who are EHE?
    - Do agencies in Torbay have robust mechanisms in place to identify and manage school absenteeism?

2. **Report on partner agencies understanding and level of consultation with the LADO and how LADO intervention may have improved safeguarding in a situation where an employee in a position of trust was displaying concerning personal behaviour and had been convicted of a criminal offence.**

    - Is the LADO process, including LADO threshold, understood by professionals in Torbay?
    - If LADO consultation had taken place, would this have made a difference to the risk/experiences posed to C92/C93? Was there a missed opportunity for the LADO to intervene?

3. **Ascertain how medication, including controlled drugs, was removed from a hospital setting, stockpiled in the family home, and administered to the children.**

- Does Torbay Hospital have robust and effective policies and procedures regarding the safe storage and access to medication, including controlled drugs?
- If the hospital's policies and procedures regarding the storage of, and access to, medication are robust, how did the mother circumvent them?
- What was the impact on the children of their mother administering them with unprescribed medication?

4. **Report on partner agencies understanding of the role of services, how to support families to access support when needed and what to do if concerns persist.**

    - Did agencies miss opportunities to recognise and respond to the mother's deteriorating/poor mental health?
    - Were there missed opportunities to identify and respond to the mother's potential alcohol misuse and/or substance misuse?

5. **Analyse the level of communication and information sharing between professionals in Torbay to identify if there were missed local opportunities to support/safeguard the children.**

    - Was communication/information sharing between agencies responsible for EHE and school admissions/transfer into area, regarding C93, effective?
    - Was communication/information sharing between education, school, and social care agencies effective in Torbay?

6. **Review and comment on the impact of Covid 19 and whether this may have affected the level of service/s the family received.**

7. **Did agencies have an effective understanding of the lived experiences of the children?**

## 5. Methodology:

5.1. This review will be carried out according to statutory guidance and using best practice to ensure appropriate learning opportunities are identified and analysed. The final report should identify recommendations that can be converted into SMART actions to assist learning. It is anticipated that the review will be conducted remotely, however if 'face to face' meetings are required the need for these will be evaluated in advance by the TSCP review panel.

5.2. The Independent Reviewer will feedback progress to the TSCP at regular planned intervals via the TSCP review panel or the TSCP Business Team in situations where urgent/unplanned feedback is necessary.

5.3. The TSCP review panel will meet monthly, however meetings can be held more frequently if required at the discretion of the Chair.

5.4. The TSCP review panel will consist of:

- Divisional Director, Safeguarding (Chair)
- Children's Social Care

- Police
- Designated Health Professional (covering the health system)
- Education
- Independent Reviewer
- TSCP Business Team
- Additional members as deemed necessary

5.5. Legal advice will be provided by the Local Authority Legal Department.

5.6. Communications/PR support will be provided by the Local Authority communication lead for Children's Services.

5.7. Learning from the review will be presented by the Independent Reviewer in the form of a CSPR report that will be completed to timescale as far as is practicable. The final draft report will be agreed by the TSCP review panel before being presented formally to TSCP Executive Group for review and sign off via partnership business channels. Any agreed amendments to the report will be required to be undertaken by the Independent Reviewer.

5.8. The timescale for submitting the final version of the report to National Panel is six months from the TSCP being notified of the need to complete the local CSPR. The submission date to National Panel is therefore considered to be 4th August 2022.

## 6. Review of Existing Materials and Papers

6.1 The Independent Reviewer will identify the information they require to undertake the review, with the support of the TSCP review panel. The information will be sourced and provided by the TSCP Business Team and partner agencies will be expected to comply with information requests (where legally permitted) in a timely manner.

## 7. Involvement of Practitioners and Staff

7.1. The Independent Reviewer will identify and engage with relevant practitioners, managers, and key workers to ensure any learning opportunities are fully incorporated into the reviewing process. It is anticipated that there will be at least one 'practitioner event', combined with the offer of 1:1 or small group sessions for workers to meet with the Independent Reviewer where this is deemed more conducive to the identification of learning. The TSCP Business Team will coordinate these events.

## 8. Involvement of Families/Other Parties

8.1. Parents, carers and family members of the siblings will be notified of the review by the TSCP and invited to participate at an appropriate time.

8.2. Involvement of other interested parties will be considered as appropriate by the TSCP review panel.