



LEICESTER SAFEGUARDING CHILDREN BOARD

Serious Case Review concerning Child B1

Born: Autumn 2011

Significant Incident August 2014

April 2016

Independent Author: Safron Rose

Child B1 - Serious Case Review

Overview Report

1. Introduction

1.1 This Serious Case Review is conducted under the statutory guidance of Working Together to Safeguard Children 2013 which states that a serious case review should take place “for every case where abuse or neglect is known or suspected and...a child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

1.2 This review is about Child B1 who was admitted to hospital on 27-08-2014 following a pre-hospital cardiac arrest. It is believed that the child choked on a sandwich and as a result, the injury will require long term care due to hypoxia¹ and subsequent brain damage. Child B1 was the subject of a child protection plan at the time of the life threatening injury.

1.3 The guidance is clear that serious case reviews are a part of the learning and improvement framework that all local safeguarding children boards must have in place to identify learning from cases in order that local and national practice to safeguard children can continuously improve.

Reviews therefore must seek to:

- identify precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- understand practice from the point of view of the individuals and organisations involved at the time rather than using hindsight;
- be transparent about the way information is collected and analysed; and
- make use of relevant research and case evidence to inform the findings

1.4 The purpose of a Serious Case Review is to conduct “a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children,” (WTSC 2013, page 65).

¹ Deficiency in the amount of oxygen reaching the tissues.

2. Terms of Reference

2.1 The timeframe for the review will be from 20th October 2010, one year prior to Child B1's birth. It will end on 27-08-2014, the date of the serious incident.

Where relevant information is known before the beginning of the timeframe, agencies are requested to provide a summary.

2.2 Key issues for the review are:

- *How did the first period of Child Protection Planning inform or impact on the assessment and practice of partner agencies? How were the risks and needs of the children understood?*
- *What information did partner agencies have about domestic violence and substance misuse and how did this inform their assessment? How was this shared and understood in relation to the parenting of the children?*
- *What did partner agencies understand by the nature of attachment and how was this applied to this family?*
- *How effective was the escalation policy when it became clear that there were professional differences around the safety plan for the children? Was the policy followed and if not why?*
- *The relationship between legal advice and social work practice. Why did the legal team determine that the threshold for proceedings was not met despite medical advice about the failure to thrive? How was this challenged by social work professionals?*
- *How were racial and cultural issues reflected in assessment and decision making in this case. Was there a gender bias in relation to the care of the children? If so, how did professionals reflect this in their practice?*
- *How effective was the working relationship between partners and parents and what part did this play in managing risk?*
- *How well was the physical and emotional wellbeing of each child understood? How was each child's different experience reflected in assessment and planning? Is there evidence of their voices being heard?*

3. Methodology

3.1 Working Together 2013 allows Local Safeguarding Children Boards to determine their own process for a review. Leicester Safeguarding Children Board established a "specific cases" Serious Case Review Panel to manage the review process. The panel comprised of senior managers of the agencies providing services to children

and families in Leicester and was independently chaired. All panel members were independent of the family and casework. The role of the panel was to assist the lead reviewer in considering the evidence, considering lessons that could be learned to improve practice, formulating the recommendations and quality assuring this report.

3.2 The lead reviewer and author considered the combined chronology and met with the Individual Management Report (IMR) authors to consider in detail the chronology of events and key practice episodes that underpinned the events and to develop hypotheses for further exploration in the overview report. She also met separately on two occasions for development sessions with the multi-agency professionals involved with Child B1 for the same purpose and to consider the lessons learned.

3.3 The panel comprised of:

Organisation	Position
Leicestershire Police	Detective Chief Inspector Serious Crime – Child Vulnerability Crime and Intelligence Directorate
Children Social Care	Head of Service, Children Safeguarding Unit and Quality Assurance
Children’s Social Care	Head of Service Children In Need
Education Learning Quality and Performance	Director
Safeguarding Children Board	Interim LSCB Manager
Safeguarding Children Board	Policy Officer
University Hospitals of Leicester NHS Trust	Head of Safeguarding
NHS Leicestershire Partnership Trust	Senior Nurse – Professional Lead, Health Visiting
Independent	Panel Chair
Independent	Independent Author
Leicester City Clinical Commission Group	Nurse Consultant Safeguarding Children / Designated Nurse Child Protection

3.3 Representatives from the organisations that were involved with the family were requested to provide an agency chronology and to write an (IMR) to address the issues outlined in the terms of reference. Unfortunately the Local Authority Legal Department was unable to comply with the request and their contribution was

discussed at the Serious Case Review panel. A recommendation has been made to address this point.

3.4 The individual chronologies were integrated into a single combined document. *The following agencies provided a chronology:*

- Police
- Early Years Support Team
- Leicestershire Partnership NHS Trust
- General Practice
- Community Paediatric Service
- Young People & Families, Education & Children's Services
- University Hospitals NHS Trust

4. Independence

4.1 Safron Rose child protection consultant was the independent reviewer and lead author. Ruby Parry was the independent chair of the panel.

4.2 Safron Rose is a full time independent child protection consultant and trainer providing a range of safeguarding services to multi-agency managers and practitioners across the England.

4.3 Safron has over twenty five years' experience in child protection social work. She has been involved in a number of serious case reviews since 2010 – quality assuring reports, chairing review panels and producing overview reports. Safron has a Diploma in Social Work, a CQSW and she also qualified as a mental health social worker. She has held various operational and strategic roles and is a former Director at the NSPCC. Furthermore, she was a visiting lecturer at the Tavistock Centre.

4.4 Ruby Parry is a former Assistant Director of Children's Services, and Head of Children's Social Care. She is a registered social worker with forty years of experience and expertise in safeguarding and child protection. She has extensive experience in multi-agency working and in managing serious case reviews either as lead author or chair.

5. Confidentiality

5.1 Working Together to Safeguard Children 2013 clearly sets out a requirement for the publication in full of the overview report from Serious Case Reviews

"All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be

published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.”²

6 Race, language and culture

6.1 Child B1’s parents and siblings are from a minority ethnic background. All of their children were born in England but the parent’s country of origin is unknown. The parents speak both a second language and English and live in an ethnically diverse part of the City.

7. Family Involvement

7.1 The parents were informed of the Serious Case Review and were invited to meet with the lead reviewer and board manager, however they have not responded to the invitations sent to them. The intention was to explain the process and give them opportunity to discuss the issues and share their views.

8 Dissemination of Learning

8.1 The process to disseminate learning from this serious case review has been considered in two phases. Identifying and evidencing actions has already taken place within *early findings* and longer term proposals to deliver work to further embed learning into practice across the Children’s workforce in the Local Authority Area.

8.2 The Local Safeguarding Children Board Learning and Development sub-group will be informed of the outcome of the review and will ensure the key messages of learning are incorporated within its training events. The group has specifically begun planning a training event for the multi-agency children’s workforce in Quarter 3 of 2015.

9 Timescales

9.1 Child B1 was first presented to the Serious Case Review sub-group on 7th October 2014 for consideration as to whether the case met the criteria for a Serious Case Review. The recommendation from the sub-group was presented to the Independent Chair of the LSCB in December 2014. Ofsted was not notified of the Independent Chair’s decision until January 2015. The delay in the progression of the review was due to a number of issues. This included a change of key personnel within the Local Safeguarding Children Board Office and the ongoing criminal investigation and care proceedings for the case. It is also acknowledged that there was a lack of clarity and timelines surrounding the Serious Case Review sub-group’s referral, information gathering and decision making criterion.

² Working Together to Safeguard Children 2013 p71

10 Family composition

Subjects in this overview report have been given the following anonymity:

Name	Relationship
Child B1	Subject
Child 2	Sibling
Child 3	Sibling
Child 4	Sibling
Mother	Mother
	Father 2
	Father 1

11 Background Information prior to October 2010

September 2009 – September 2010

11.1 In September 2009 when Child 4 was three month's old a family member contacted Children's Social Care to report a mark on Child 4's face. The agency sent a letter to mother asking her to make contact but no further action was taken.

11.2 In January 2010 Children's Social Care received an anonymous referral about the welfare of Child 4. At that time Child 4's mother was in a relationship with a new partner who would go on to be the father of the three younger siblings – Father 2. Mother and Father 2 admitted hitting and punching Child 4 and he was arrested and cautioned.

11.3 An Initial Child Protection Conference was convened in February 2010 where Child 4 was made the subject of a Child Protection Plan under the category of physical abuse. Professionals decided that mother should separate from Father 2 although they were unable to enforce this decision.

11.4 In March 2010 Police were called to a domestic abuse incident at the family home. No offences were disclosed; however the incident report includes reference to the smell of cannabis in the home. Child 4 was not present.

11.5 At the Review Child Protection Conference in April 2010 Child 4 was removed from the child protection plan and a Family Support Plan was put in place.

11.6 On 10th August 2010 the GP and health visitor discussed the health visitor's concerns about Child 4's weight loss. The GP agreed to carry out an examination.

11.7 At a Family Support Meeting in September 2010 mother informed the meeting that she was pregnant.

12 Significant Events October 2010 – August 2014

2010

12.1 An Initial Pre Birth Case Conference was held on 15th November where it was agreed that Child 4 and the unborn baby would become subject of child protection plans under the category of physical abuse due to concerns that their mother had continued to facilitate contact between Child 4 and Father 2.

2011

12.2 The Review Child Protection Conference held in February agreed that both children would remain subject of child protection plans for the purpose of completing further assessments of the family dynamics. Concern was expressed that Father 2 had failed to engage with assessments.

12.3 Later that month Child 4 was taken to Accident & Emergency with an arm injury, which mother said was an accident. The explanation was accepted and no concerns were noted by medical staff.

12.4 At the Review Child Protection Conference held in June all professionals agreed that the children should no longer be subject to child protection plans and that the case should close.

12.5 In September Police attended the family home following an abandoned 999 call.

12.6 In November mother rang the Police to report that Father 2 had left the family home with Child 2 following an argument. Officers attended the address where Child 2 had been taken where the child was assessed to be safe and well. It was reported that the couple were in the process of separating.

12.7 In December Police received two 999 calls from the family home. The first was abandoned but in the second, mother stated that her husband was refusing to leave following an argument. Officers went to the home but by that time Father 2 had left the premises, taking one of the children with him. The child was located safe and well at the home of an external family member. A child at risk referral was made to Social Care.

12.8 Another call was made to Police in December. Mother reported problems with Father 2 who was drunk outside the family home.

2012

12.9 In January Father 2 received a Police caution for possession of cannabis.

12.10 Police attended the family home in April following a 999 call from mother who reported that Father 2 was refusing to leave the family home and he had tried to hit her.

12.11 At a GP review in June mother was recorded as depressed.

12.12 In October mother contacted Police to report that she had been assaulted by Father 2. He was arrested, interviewed and cautioned for Common Assault. A referral made to Children's Social Care who decided to undertake an Initial Assessment.

12.13 In November a 999 call was made to the Police but no request was made. The operator rang back the number and mother explained that the Police were not required. No further action was taken.

12.14 Child B1 was seen at home by the health visitor for a 9 -12 month healthy child programme development assessment in November. The child was noted to have dry skin on their face and legs but apart from that it was recorded that the child was meeting age appropriate milestones and described as alert and active. During the assessment, mother reported that she was feeling overwhelmed and low, to the point she went to stay with a friend overnight. The information was passed onto Children's Social Care.

12.15 The Children's Social Care Initial Assessment was completed on 7th December (considerably outside the 10 day timeframe for completion). The process concluded that there were no major concerns for the children and that their parents were no longer in a relationship. The case was closed.

2013

12.16 In January Father 2 received a second caution for possession of cannabis.

12.17 In April Child B1 was seen in the drop in clinic by the community nursery nurse and child health nurse. The child's weight had gone down from the 9th centile to just above the 2nd centile. Mother reported that Child B1 was a "faddy" eater.

12.18 In May during Child 2's two year assessment, mother reported that she was finding it difficult to show love to Child B1.

12.19 The health visitor contacted the Child and Adolescent Mental Health Advice line for advice regarding mother's feelings towards Child B1. The health visitor was advised to encourage parent child bonding and attachment for example baby massage and games that promoted eye contact.

12.20 During a home visit by the health visitor at the end of May, Child B1's mother further disclosed that over the past 8 – 9 months she felt that she had not bonded with Child B1 who was now 19 months old. Mother was offered family support but declined the offer of help.

12.21 At a clinic visit in June, the health visitor observed that the interaction between Child B1 and mother had become tenser. The health visitor made a referral to the Early Years Support Team, which mother accepted.

12.22 Child B1's weight had decreased to the 2nd centile when the child was weighed by the health visitor toward the end of June. The health visitor continued to see Child B1 and the mother almost weekly throughout the remainder of June and July during which time she monitored mother's emotional and physical care of Child B1 and the other siblings.

13 Narrative and Summary of Events within the year preceding Child B1's serious injury.

2013

13.1 In September the GP liaised with the health visitor and queried whether Child B1 had Pica³. A referral was made to the Community Paediatrician for a blood test which concluded that the child had low vitamin D and was prescribed medication. The health visitor also referred Child B1 to a speech and language group because their speech was at the lower range for their development stage.

13.2 During October the Early Years Support Team noted their concerns about Child B1 and the way the child was treated in contrast to their siblings.

13.3 The health visitor noted that Child B1's weight had not increased between 12 and 17 months.

2014

January

13.4 Child B1 and Child 3 started nursery in January. During Child B1's two year assessment the child was observed to be frail, undernourished and their development was not age appropriate. Child B1's weight had noticeably dropped despite mother reporting that the child was eating well.

13.5 The health visitor contacted the Safeguarding Children Advice Line and spoke with the Named Nurse to relay her ongoing concerns for Child B1, which were shared by the Early Years Support Team. Since their involvement with the family in September 2013, the Early Years Support Team had seen little improvement in the attachment between Child B1 and mother. It was agreed that the situation would be discussed with the Named Doctor for Safeguarding Children who advised that Child B1 should be examined by a community paediatrician as a matter of urgency to rule out any underlying medical cause or condition to explain the weight loss. It was also agreed that a multi-disciplinary meeting would be convened between health and teaching staff to discuss concerns regarding Child B1's development and attachment.

³ An eating disorder which is characterized by persistent and compulsive cravings to eat non-food items.

13.6 During this period there were conflicting accounts between staff observations of Child B1's behaviour at nursery and what mother reported when the child was at home.

13.7 Child B1 was seen by the community paediatrician where it was confirmed that there was no clinical reason for their poor weight and the child had a mild vitamin D deficiency. The main cause for concern was stated as failure to thrive. The plan was for the health visitor to carry out monthly contacts for three months to monitor Child B1's weight, height and head circumference.

13.8 A professionals' meeting was held regarding Child B1 and Child 2 at the end of the month. The meeting was attended by mother, nursery, Early Years Support Team and the health visitor. Concern was expressed about the lack of spontaneous interaction from mother toward Child B1 which was in contrast to mother's interaction with her other children.

February

13.9 A meeting was held between staff at the nursery and Early Years Support Team where reference was made to a bruise on Child B1's eye. A staff member from the Early Years Support Team had previously spoken to mother about the bruise and was satisfied with her explanation. No action was taken at the meeting.

13.10 At a Clinical Forum meeting at the beginning of the month attended by health professionals a plan was made which included the following:

- To offer family support with healthy eating via referral to a dietician
- Health visitor to record measurements monthly

13.11 Mother declined the service of family support on the basis that she did not want too many professionals involved with the family at that time but she would reconsider.

13.12 During a health visitor home visit mother once again shared how she had struggled to bond with Child B1 since the child's birth.

13.13 At the second professionals meeting at the nursery on 25th February, concern was expressed that mother was putting on a show for staff. Child B1's speech had improved and there were no concerns about their eating. Two further bruises were noted on different occasions; one on the forehead (date not recorded) and another on 25th February on the left cheekbone. No action in relation to the bruises was taken at the meeting. The agreed plan included the following:

- Mother to take Child B1 to the GP and to increase the fluid intake
- Health visitor to continue to monitor

13.14 It was decided that a further meeting would be held in April or sooner if new concerns were identified.

13.15 At the end of the month staff at the nursery overheard a conversation between Child 3 and mother about an injury to the child's finger. The matter was verbally referred to the Duty and Assessment Service at Children's Social Care two days later, along with reports of the three marks on Child B1 i.e. the bruise to the forehead, cheekbone and a third injury which was a small bruise on the inner left thigh. Staff at the nursery were advised by the social worker to discuss their concerns with mother with a view to her providing an explanation for the bruise. It was suggested that staff could get back to Children's Social Care if they remained concerned. No further action was taken by social care after consultation with team manager.

March

13.16 Child B1 and Child 3 were removed from the nursery by their parents following the referral to Children's Social Care.

13.17 During a home visit by two health visitors, Child B1 was noted to have a very tense, distended abdomen which mother said was normal once the child had eaten. Mother was advised to take the child to the GP.

April

13.18 On 22nd April the health visitor noted that Child B1 had lost weight which did not concern the child's mother, who attributed it to the family recently moving house.

13.19 At the end of the month the outgoing and new health visitors agreed to escalate concerns if there was no improvement in Child B1's weight, dental care, demeanour or interaction with the child's mother.

May

13.20 On 21st May the health visitor made a home visit during which Child B1 was seen to have a facial bruise. Mother reported that the child had fallen down the stairs two days previously. It was recorded that Child B1 weighed the same as they did when they were one year old.

13.21 During this visit both parents were aggressive and mother stated that she would "force feed" Child B1 to get Children's Social Care off her back.

13.22 A Strategy Discussion was held the same day between Police and Children's Social Care where it was agreed that a duty social worker would make an urgent home visit. The social worker concluded that the welfare of the children was adequate and mother was cooperative. It was agreed that Child B1 would undergo a child protection medical the following day. Health professionals were requesting a medical the same day on the basis that Child B1 was the "worst" the health visitor had seen.

13.23 The duty social worker recommended a joint home visit with the health visitor that day because she felt it was a case of long term neglect and wanted to make her

own assessment even though the health visitor was adamant that Child B1 was at immediate risk of harm. The duty social worker made a home visit during which she concluded that Child B1 was a “normal little child”, although she admitted “Child B1 looked unwell”.

13.24 Throughout the course of the day various phone calls were made within agencies and between the multi-agency network to share and exchange information and to escalate concerns.

13.25 On 22nd May Child B1 and Child 3 were medically assessed by a community paediatrician. Child B1 was described as looking emaciated and not interactive. Child B1 was admitted to hospital the same day for further tests and investigation to exclude organic failure to thrive. There were no concerns regarding Child 3.

13.26 An Information Sharing Meeting was held at the hospital on 30th May where it was agreed that Child B1 was failing to thrive due to neglect and therefore should not go home. It was recommended that Child B1 should be accommodated under Section 20 of the Children Act 1989. The parents refused to consent to an arrangement being made and consequently Child B1 remained a patient on the ward over the weekend.

June

13.27 An emergency legal planning meeting was held on 2nd June where local authority legal representatives advised that the harm suffered by Child B1 was clear. However the issue was whether or not there was evidence to demonstrate that the harm was attributable to the care being given or not being given by the parents. Child B1 was discharged home to their parents' care.

13.28 The Named Doctor for safeguarding subsequently expressed their strong disagreement with the decision not to issue care proceedings to protect Child B1.

13.29 An Initial Child Protection Conference was held on 12th June where it was agreed that Child B1 was at risk of significant harm and was made subject of a child protection plan under the category of neglect. Child B1's siblings were made subject of child protection plans under the category of emotional abuse. The outline child protection plan was for Child B1 to be accommodated and a second legal planning meeting was recommended to this effect.

13.30 On 19th June Children's Social Care agreed to issue proceedings immediately despite legal advice stating that it would be difficult to establish that the harm was attributable to the parents' care, in light of information from the social worker who had observed positive parent child interaction and cooperation with the parents.

13.31 Children's Social Care Head of Service and the Team Manager met with a representative from the legal department on 20th June to review the case history, concerns and current social work assessment. The likely plan was to seek removal

of Child B1 under an Interim Care Order and to issue proceedings in respect of all of the children. At that time Children's Social Care were awaiting outstanding evidence from other agencies in support of their plans and a final decision could not be reached until the information was received.

13.32 During the remainder of the month, Child B1's weight continued to fluctuate and at times the child's skin was noted to improve.

July

13.33 On 2nd and 7th July social worker 2 expressed concerns about the intended plan to accommodate Child B1 because she had not observed the concerns that other professional had reported. The case was reviewed by the Service Manager on 14th July when it was agreed to convene a third legal planning meeting the following day where the decisions included the following:

- Case to be reallocated to a new social worker 3
- Obtain birth weight for all children from midwives
- Assessment to be completed on all extended family members

13.34 The Head of Service decided to arrange a further (fourth) legal planning meeting once the social work assessment had been completed. Meanwhile during a home visit on 21st July the health visitor concluded that the parents were giving the children attention for not eating. It left the health visitor in no doubt that the parenting was the issue as opposed to the children's behaviour.

13.35 An unannounced joint home visit by social worker 3 and the health visitor was made on 24th July. Child B1 was still holding food in their mouth from breakfast when they arrived at 14.05. Mother was given advice on behaviour management with a specific focus on mealtimes. The following day an Early Help worker was introduced to the family with a view to visiting daily at mealtimes. On the 31st July mother again shared her feelings of struggling to feel love for Child B1 to the Early Help worker.

August

13.36 On 6th August the health visitor recorded a large weight gain to Child B1.

13.37 A further legal planning meeting was held on 14th August where it was agreed to issue pre-proceedings on 26th or 27th August.

13.38 On 22nd August Child B1 was taken for a child protection medical to determine the cause of her significant weight increase. By the time of the medical the child had lost the weight gained. The local authority considered applying for an Emergency Protection Order but did not proceed as the medical evidence did not support the need for such urgent action.

13.39 On 28th August Child B1 was taken to hospital where the child was unconscious having choked on some food. Child B1 had suffered a cardiac arrest on the way to hospital.

14. Analysis

14.1 How did the first period of Child Protection Planning inform or impact on the assessment and practice of partner agencies? How were the risks and needs of the children understood?

14.2 There is little evidence to indicate that the risks and needs of the children were properly understood during the first period of child protection planning.

14.3 Child 4 was initially the subject of a child protection plan from February to April 2010 due to physical abuse. It is surprising that the plan was discontinued despite the following:

- The child sustained a bruised eye (albeit the cause was unsubstantiated on medical examination) shortly after the Initial Child Protection Conference in February.
- Father 2 had not been assessed within the child protection plan
- There had been a police domestic violence call out within the child protection planning period.

14.4 A second period of child protection planning followed in November the same year when Child 4 and their unborn sibling were made subject of child protection plans again under the category of physical abuse. The plans ended at the second Review Child Protection Conference in June 2011 and it is concerning that the decision was based on limited information about Father 2 who had been a major cause for concern from the outset.

14.5 At the first Review Child Protection Conference in February it was noted that more time was needed to complete assessments of family relationships and dynamics which was a good decision.

14.6 At the time mother was reported to have cooperated with the protection plans and there was evidence that she was no longer in a relationship with Father 2 whose contact with the children was supervised by maternal family members.

14.7 There was no concern regarding mother's relationship with the children or the day to day care she provided to them. However Child 4's fluctuating weight was a cause for concern for which the child was referred to the community paediatrician for assessment.

14.8 Although Father 2 was reported to express remorse, he had failed to engage with assessments and there was evidence that he continued to use drugs which was a significant indicator of risk.

14.9 By the second Review Child Protection Conference in June the parents had resumed their relationship and mother was twelve weeks pregnant with the twins. The paediatric assessment of Child 4 had concluded that there were no health concerns and both children were reported to be healthy and meeting their development milestones. The minutes of the meeting noted that Child 4 was observed to respond well to Father 2.

14.10 It is not known whether Father 2 had fully engaged with the assessments between review meetings and evidently mother had resumed her relationship with him soon after the review conference in February as she met with her GP on 21st March to discuss an unwanted pregnancy, which would suggest an inability on her part to protect the children or prioritise their safety from possible physical abuse from Father 2.

14.11 At best the decision to discontinue the child protection plans was based on a partial assessment which also included information from the Police who confirmed that there had been no reported incidents of domestic violence during the review period. This would demonstrate a level of naivety in respect of understanding domestic abuse and reported incidents by victims. Research shows that there is a high level of under reporting by victims. There is no evidence to indicate that the assessments were thorough and they consequently lacked analysis of the children's needs.

14.12 The Children's Social Care IMR author on reflection has acknowledged that the decision to discontinue the plans in June 2011 was incorrect and it is the author's view that professionals were being overly optimistic at the time. Furthermore it is concerning that professionals agreed to close the case and provide universal family support. Health visitor records state that a Child In Need Plan was not considered despite the risk of increased stress, due to the pregnancy and the increased risk of domestic violence during pregnancy.

14.13 It would appear that there was no recognition that the children would need ongoing structured support to ensure their safety, health and development following the period of formal child protection. It is unclear how the children's needs were assessed for universal help and what was identified as appropriate family support in the circumstances. "The conference together with the family should consider the child's needs and what further help would assist the family in responding to them." (*Working Together to Safeguard Children 2010, page 168*).

14.14 At that time the Leicester Safeguarding Children Board Step Down to Support Services policy was not in operation, however good practice and a thorough analysis of the family should have determined that the children still required coordinated, targeted, multi-agency support and close monitoring for a longer period.

14.15 In the author's opinion these two periods of child protection planning did not consistently inform or impact the further assessment and practice of partner

agencies. Consequently the risks and needs of the children were not fully identified or understood at that time or to inform decision making.

14.16 The following are some examples:

- June 2013 the health visitor referred Child B1 to Early Years Support Team home based teaching support. The referral did not contain family background information so neither the Early Years Support Team nor the nursery knew that the older siblings had previously been subject to child protection plans or that there was a history of domestic abuse.
- The delayed response from Children's Social Care to domestic violence referrals from the police
- The failure of Children's Social Care to respond to referrals from the nursery about injuries to Child B1 and Child 3

14.17 Had agencies taken full account of the child protection planning history it should have led to greater concerns for the children's welfare and a more robust response to referrals. An up to date chronology would have aided child-centred practice and informed an overview of significant information and how it was impacting the children's safety and protection. There was an expectation that health visitors would compile a single agency chronology although the practice was not part of the agency's safeguarding policies or procedures.

14.18 The author agrees that it was good practice following the end of the child protection plans in June that the health visitor decided to carry out a targeted antenatal visit to the family in September. Unfortunately this additional visit did not go ahead and there is no record or explanation as to why. Had the additional visit been made, it would have been a good opportunity to assess the family since the end of the child protection plans and prior to the twins' birth.

14.19 There is evidence of handovers between health visitors when caseload responsibility changed. However it is concerning that on more than one occasion practitioners were not aware of the earlier periods of child protection planning. When asked why the following explanations were provided:

- She was mainly accessing the records of Child B1 and Child 3
- She not aware of the national IT child protection symbol

14.20 The electronic health record displays a red and yellow symbol on the record of all children with child protection plans. When a plan is discontinued, the colour fades, but the symbol remains to alert practitioners to previous child protection plans.

14.21 At her booking appointment with the twins, mother informed the midwife that her older children had been subject to child protection plans. The midwife completed a referral form to notify Children's Social Care of the information she had received which was good practice. At the point of delivery the midwife checked the status of any concerns with the specialist safeguarding midwife who in turn contacted

Children's Social Care for an update to ensure that there were no reasons to prevent discharge and there were none.

15 What information did partner agencies have about domestic violence and substance misuse and how did this inform their assessment? How was this shared and understood in relation to the parenting of the children?

15.1 In total Police attended six domestic violence related incidents within the review timeframe.

- 21st September 2011 – verbal argument between parents regarding Father 2 having affairs;
- 23rd November 2011 – mother reported that after an argument Father 2 left the home with Child 2 who was 11 months old;
- 4th December 2011 – mother reported that Father 2 was refusing to leave after an argument;
- 17th December 2011 – mother reported having problems with Father 2 who was intoxicated outside wanting to gain entry;
- 23rd April 2012 – mother reported that she had asked Father 2 to leave and he was refusing to do so;
- 30th October 2012 – mother reported that Father 2 had become violent and assaulted her.

15.2 All of the incidents except 17th December 2011 were recorded as domestic incidents in accordance with Police policy and in three instances, officers identified the children to be 'at risk' and referrals were made to Children's Social Care for follow up action. On 23rd November 2011 officers did not identify any child protection issues and consequently no referral was made to Children's Social Care despite the fact that Father 2 had left the home with Child 2 which was itself concerning.

15.3 Five DASH assessments were completed with the level of risk graded as standard. In every case the attending officer's supervisor would have authorized the risk assessment. However the incidents did not meet the threshold for a domestic abuse Multi Agency Risk Assessment Conference, which at the time were three or more incidents in a twelve month period graded as high risk. There is a sense that the Police call outs were treated as individual episodes and not seen as a pattern which could indicate an escalation of need and potential risk. In the author's view this was the case when Father 2 left the home on more than one occasion with one of the children.

15.4 In respect of the incident dated the 30th October 2012, mother declined to make a complaint but despite this officers arrested Father 2 at a later date (unknown) and interviewed him about the assault. He admitted the offence and received a caution.

15.5 The domestic abuse incidents attended by the Police were predominantly for verbal arguments and apart from the last incident, it was reported that no criminal offences had occurred. When Child 2 was taken by the father, officers located them

and established that the child was safe and well but they had no authority to remove the child from the father's care. The Police IMR states that "The decisions, assessments and plans made by officers in respect of these incidents were appropriate and proportionate to the incidents reported."

15.6 It is the author's opinion that Police took the domestic abuse seriously and acted accordingly. The children were recognized as victims of domestic violence in their own right which initiated the referrals to Children's Social Care. There is evidence of thoroughness in their investigations for example observing and recording home conditions and pursuing Father 2 following the physical assault and proceeding to caution him and locating Child 2 after Father 2 had left with the child following an argument.

15.7 Children's Social Care was aware of domestic abuse incidents during 2010 and 2011 when Child 4 and Child 2 were subject of child protection plans. However Father 2 did not engage with assessments and the agency viewed the parents' separation as a protective factor despite evidence to the contrary as the adults had continued their relationship. Furthermore, it is known that separation and pregnancy can act as catalysts and intensify violence, which the agency evidently did not take account of in the risk assessment.

15.8 Subsequent incidents referred by the Police progressed to the agency undertaking an Initial and Core Assessment. However the social worker concluded that "there was no further violence in the relationship and that the previous incident was minor." Children's Social Care IMR.

15.9 The Core Assessment was a response to the caution for assault issued to Father 2 in October 2012 and so it is worrying to note that there was no rationale for the incident being viewed as "minor". In addition, there is no evidence that mother was offered services or that there was an assessment of her capacity to make safe choices for herself and safely parent the children in light of the abuse. The risk assessment of Father 2 was not thorough and does not appear to have addressed his understanding of the impact of domestic abuse on the children.

15.10 The health visitor service would have known about domestic violence from the first period of child protection planning. It was their belief that "the parent's relationship was a difficult one and on numerous occasions enquired as to the presence of further domestic violence." Leicester Partnership Trust IMR. Mother always denied any violence and said that their relationship had improved since Father 2 went on a religious pilgrimage, which according to Children's Social Care records was in 2009, but clearly the violence continued after this date and practitioners did not appear to challenge this irrational explanation.

15.11 Following the child protection plans, the only report to the health visitor of domestic violence was made on 6th December 2012, when the social worker belatedly informed the health visitor that mother had been assaulted by Father 2 in

October. In response the health visitor made a home visit on 31st December. It was good practice for the health visitor to meet mother as soon as she was made aware of the incident, however the contact was undermined because the practitioner spoke with mother in the presence of Father 2 and was unable to complete the necessary risk assessment. In the circumstances it would have been preferable if the health visitor had arranged to see mother alone as research has shown that women find it difficult to disclose when they are still living with the perpetrator much less in front of the person which could risk provoking further violence or retribution. It appears that no further attempt was made to complete the form later on which was unfortunate. The manner in which the issue was dealt with could have acted as a barrier to her seeking help in the future.⁴ Given that the information had been passed to the health visitor by the social worker, it was the health visitor's impression that the social worker was assessing and managing the potential risks to mother and the children.

15.12 The GP was also notified on 6th December of the domestic violence incident in October and the full history of abuse became known to the GP at the case conference in June 2014 when Child B1 and all siblings became subject of child protection plans. Throughout the review period mother had a high level of contact with the GP in relation to her own health and that of Child B1. However there is no indication that the knowledge of this issue ever influenced or informed their dealings with her or that the question was ever explored as to whether mother's care of the child was compromised by her experience of domestic violence.

15.13 The referral from the health visitor to the nursery and Early Years Support Team lacked significant details about the family background and history of concerns including information about domestic violence or substance misuse. Consequently staff had no knowledge about these issues and the impact on the children's lives. Consequently they were unable to take the factors into account in relation to the parenting provided.

15.14 Father 2 received two cautions for possession of cannabis, one in January 2012 and the second precisely a year later. Children's Social Care recorded that substance misuse was discussed with him although he denied any continued use of cannabis. During a home visit in August 2014 the social worker reported the smell of cannabis. On another occasion Father 2 was intoxicated and trying to gain entry to the home. At no time was there direct work to address the issue with him and therefore there was no understanding or analysis of the risks posed by his use of substances which in all likelihood would have had a direct effect upon the children, his parenting and on the dynamics within the family.

15.15 Based on the information provided by agencies to the review it is not possible to fully understand how the children's needs and risks were effectively assessed in relation to Father 2's drug and alcohol misuse and incidents of domestic abuse

⁴ Children Experiencing Domestic Violence (McGee 2000; Gorin 2004).

between the parents. There does not appear to have been a coordinated exploration of the extent of the children's exposure to domestic abuse or drug taking and its impact.

15.16 It is apparent that little was known about Father 2 and therefore his role within the household needed to be understood in terms of his potential for protection as well as any adverse effect he may have had on the safety of the children and their mother.⁵

16 What did partner agencies understand by the nature of attachment and how was this applied to this family?

16.1 “Young children experience their world as an environment of relationships, and these relationships affect virtually all aspects of their development – intellectual, social, emotional, physical, behavioural, and moral.”⁶

16.2 It is reasonable to assume that as specialists in child development the health visitors, Early Years Support Team and nursery staff had a good basic understanding of attachment theory and were aware that healthy child development depends on a child's relationships, especially their attachment to the primary caregiver.

16.3 However it is questionable if the professionals' theoretical knowledge and understanding in this case, extended to attachment in relation to child protection. It is unclear why the agencies persisted with an approach to promote parent-child interaction in light of the mounting, concerns (including injuries) to Child B1.

16.4 “It is recommended that caregiver-child attachment and bonding be evaluated to determine if there are concerns that are impacting the feeding and developmental interaction”.⁷ In this case after a specific period of time incorporating *SMART* objectives, a Child in Need assessment should have been carried out when there was a lack of improvement to Child B1's health and wellbeing. This did not happen in a timely manner which demonstrates a limited understanding and knowledge of attachment in the context of possible neglect.

16.5 As stated within the Local Authority's Safeguarding Children Board Neglect policy “A pre-requisite in recognising neglect in general terms is a knowledge and understanding of children's development, of their families, their life events and experiences.”

16.6 It is the author's opinion that the health and education professionals were not open-minded early on in considering whether Child B1's failure to thrive was

⁵ Learning from Serious Case Reviews Bandon et al., 2008

⁶ National Scientific Council on the Developing Child (2004)

⁷ Parent-Infant Interaction and Non Organic Failure to Thrive (Coolbear, 1999 [3a]; Ward, 2000 [3a]; Benoit, 1997 [4a])

attributable to neglectful / problematic parenting which went beyond difficulties with bonding.

16.7 In May 2013 Child B1's mother told the health visitors for the first time that she found it difficult to show love and that she felt she had not bonded with the child since birth. By that time Child B1 was eighteen months old. It is not known whether the health visitor explored this statement in more detail to find out what mother meant by "not bonded" and what improvements she was seeking in her relationship with the child.

16.8 It was mother's disclosure regarding a lack of bonding that influenced the specific approach, however as time progressed professionals do not appear to have considered or explored what life was like for Child B1 in relation to mother's parenting capacity or the complexity and potential impact of what appeared already to be very poor attachment to mother.

16.9 Mother's statements were taken seriously by the practitioner who was advised by the Child and Adolescent Mental Health Service Advice Line to promote attachment between mother and baby through various activities. The health visitor service was aware of the family history and previous child protection concerns, which should have been taken into consideration at the time the advice was given. The approach should have been an initial step towards evaluating and addressing the difficulties in the parent-child interaction.

16.10 At that time mother was also offered family support which she declined but she agreed to a referral to the Early Years Support Team. It was the health visitor's view that the service was well placed to address the issues of attachment.

16.11 Between September and January Early Years Support Team formed the opinion that mother only made an effort to interact with Child B1 to impress a senior member of staff which should have indicated the serious extent of failed attachment, which is known to put children at risk. "Attachment is the specific and circumscribed aspect of the relationship between a child and caregiver that is involved with making the child safe, secure and protected. It is where the child uses the primary caregiver as a haven of safety."⁸ At age eighteen months it is fair to assume that the poor attachment was already so entrenched that it was likely to have needed very intensive therapeutic input if it was to be improved, if at all.

16.12 It was clear that multi-agency strategies to improve parent-child interaction were not sustained by mother and in fact professional concern was mounting, but despite this the focus of work remained the same; without it would appear, any consideration to the danger that the lack of attachment may have had upon Child B1 given the child's physical appearance and demeanour.

⁸ A secure base from which to explore close relationships Waters E, Cummings EM (2000)

16.13 Furthermore, between June 2013 and January 2014 the health visitor service lost sight of Child's 1's faltering growth and the need to review it as a matter of importance. Throughout this time the professional view remained that Child B1 would gain weight if the emotional parent-child interaction improved, which was an error; in that the situation had probably already profoundly deteriorated for the creation of healthy attachment behaviour and the recognition of this should have prompted specialist assessment to safeguard Child B1.

16.14 Health and Education professionals do not appear to have questioned why Child B1's needs were not being consistently met by the parents. It seems that professionals did not consider the implications of this inconsistency for Child B1 despite being "specialists in assessing and communicating with pre-school children." Education IMR. The focus on attachment was too narrow and rigid and therefore detrimental as it did not make the clear link between Child B1's development and possible neglect and therefore the urgency of intervening to protect Child B1.

16.15 There are several examples of mother showing minimal concern regarding Child B1's poor weight gain and being critical of her:

- Lack of concern about Child B1's weight loss in January 2014
- Failure to contact the dietetic department on two occasions following the paediatric assessment in January 2014
- Failure to comfort Child B1 when aggressively hit by Child 3 August 2014
- Taking Child B1 to the maternal grandmother's home as punishment
- Making Child B1 walk long distances whilst the siblings rode in the pushchair

16.16 Mother's inappropriate reaction to professional concerns led them to query whether she was depressed. The health visitor and Named Nurse considered making a referral to Children's Social Care in January 2014 which would have been right in the circumstances but the recommendation changed in consultation with the Named Doctor for Safeguarding which is unfortunate and was a missed opportunity to consider the concerns in the context of safeguarding and child protection. The referral to Children's Social Care should have happened alongside the urgent paediatric examination due to the extent of the weight loss. This would have led to a collaborative, multi-disciplinary assessment into the cause of failure to thrive and possibly led to targeted safeguarding interventions in tandem with the work on attachment. Had the concerns been shared with Children's Social Care the agency could also have provided advice and taken on a lead role to compliment and support the work of Early Years Support Team and the health visitor service.

16.17 The nursery and Early Years Support Team had a number of concerns in addition to poor maternal attachment which should have led them to question and explore the reasons for their concerns. This would have given them a fuller and

more accurate understanding of the problems experienced by Child B1 and whether these were attributable to the parenting provided which may have led to consideration of possible neglect and/or emotional abuse.

16.18 The Early Years Support Team assessment also concentrated on Child B1's speech and language delay. There was some focus on attachment issues in relation to the child's social development but not in relation to how this was affecting the fluctuating weight which was primarily the reason for the referral to the service.

16.19 It is the practice of Early Years Support Team to use lesson plans to record each home visit. The aim is to focus on the details of each recommended activity, observations and progress against identified targets. However it is surprising to note that the template used to record this information did not include a section to record observations of parent-child interactions, environmental factors, concerns and action required.

16.20 Not recording these crucial observations (which are considered central to an assessment of attachment) would have compromised the approach and the ability to accurately monitor progress or regression in this area.

16.21 It is reported that the health visitors recorded their contacts using the Department of Health (2000) Framework for Assessment, which enables a holistic assessment of a child's development needs, parenting capacity and family and environmental factors. However, in the author's opinion, if this tool was used during scheduled developmental assessments and targeted contacts it is difficult to understand why the information gathered did not alter the course of action to a more authoritative approach involving Children's Social Care at an earlier stage.

16.22 As part of the focus on attachment, the health visitor was tasked with exploring mother's own parenting experience and how it may affect her feelings towards Child B1. In response mother provided very little information, stating that she parented in a similar way to her mother whom she valued for advice and support. The health visitor thought that the lack of detailed information could be due to cultural reasons.

16.23 Whilst of course there is a need for practitioners to be culturally sensitive when using attachment based principles to understand different values and beliefs within families, it is important that assumptions about race and culture are not made as these could deflect, over-estimate or minimise the risks to the child. Research evidence confirms that attachment behaviour transcends racial and cultural boundaries, however there are cross cultural variations in attachment styles / behaviours⁹.

⁹ Grossmann et al (1985) Van Ijzendoorn & Kroonenberg (1988)

17 How effective was the escalation policy when it became clear that there were professional differences around the safety plan for the children? Was the policy followed and if not why?

17.1 *“At no time must professional dissent detract from ensuring that the child is safeguarded. The child's welfare and safety must remain paramount throughout.”*

Leicester Safeguarding Children Board Resolving Professional Disagreements Policy

17.2 Within the overarching policy there are separate sections which apply to Child B1's case which should have been used at relevant points to ensure a child centred approach to her safety and protection and to maintain a focus on multi-agency working.

17.3 As stated above Community Health was initially attempting to deal with the concerns regarding Child B1's faltering weight and approaching this as primarily an attachment issue.

17.4 From the visit on the 21 May 2014 by the health visitor to see Child B1, professional differences came to the fore. Following the visit she correctly contacted Children's Social Care who convened a Strategy Discussion with the Police. Health did not contribute to the meeting which was a serious omission and contravened Statutory Guidance (Working Together to Safeguard Children 2013) which states *“A local authority social worker and their manager, health professionals and a police representative should, as a minimum, be involved in the strategy discussion.”* Page 33

17.5 On the basis of the very serious concerns of the health visitor they wanted the child to be medically examined that day but Children's Social Care disagreed and said that the examination would happen the following day. Furthermore, Children's Social Care wanted to undertake a joint visit with the health visitor who disagreed that such action was necessary on the basis that she had already assessed the child as the “worst she had seen”.

17.6 The health visitor appropriately escalated the matter within her line management to the Named Doctor in line with the policy - *Dissent at Referral/Enquiry Stage*. However the Named Doctor should have escalated the matter to the Designated Doctor for timely resolution but this did not happen which was a failure to follow the policy. It is possible that the Named Doctor decided not to follow this course of action since the medical examination was scheduled to take place the following day.

17.7 Following the Information Sharing Meeting on 30th May and the decision of Children's Social Care not to issue Care Proceedings the Named Doctor expressed in writing to Children's Social Care her strong disagreement with that decision. She appropriately then escalated the matter to the Designated Doctor who expected a

meeting to be arranged to resolve the conflict in line with the policy - *Dissent Regarding the Implementation of the Child Protection Plan*. However this is where the policy was not fully applied because the Doctors did not clarify with each other who was going to write formally to Children's Social Care to request a meeting in accordance with the procedure which would have included the Safeguarding Children Board manager and chair.

17.8 There were further occasions during June to August when the escalation policy should have been implemented by Health. For example in the context of inaction in implementing the children protection plan for Child B1 despite mounting concerns about the inadequate parenting provided. Health remained deeply troubled and as a result should have challenged Children's Social Care who at that time were continually reviewing the case via legal planning meetings.

17.9 It is important to note that regular Core Group meetings were not convening at the time and therefore there was no coordinated risk monitoring or management.

17.10 The policy should have been used to challenge the approach by Children's Social Care and if the agency disagreed, consideration should have been given to convening the Review Child Protection Conference ahead of the scheduled date in September to remedy the delay and drift and focus on the immediate need to safeguard Child B1.

18 The relationship between legal advice and social work practice. Why did the legal team determine that the threshold for proceedings was not met despite medical advice about the failure to thrive? How was this challenged by social work professionals?

18.1 It is the role of lawyers to represent practitioners at court and to give advice as to procedure and law and it is the role of practitioners to gather information, assess and analyse the risk and needs as they relate to the child. It is important that these roles remain distinct and it is the author's concern that at times these roles became blurred.

18.2 The legal advice given at the emergency legal planning meeting on the 2nd June 2014 was that the harm suffered by Child B1 was clear, failure to thrive with no medical explanation. However the solicitor considered that there was a lack of evidence to meet the threshold for proceedings since there was insufficient evidence to establish that the harm was attributable to the care given or not given by the parents. As a result information from other professionals involved with the family was requested but not received until July when it was considered at a legal planning meeting on the 15th of that month. In the circumstances this was an inordinate delay and the evidence should have been obtained and considered as a matter of absolute urgency to support the intended plan for Child B1.

18.3 When examined Child B1 was described as “emaciated and not interactive” and on another occasion as “gaunt and undernourished”. This went beyond chronic neglect into the realms of parental care (or lack of it) causing serious physical harm to the child. In the author’s view there seemed to be sufficient evidence to put before the court given the clear position of the Named Doctor and the known history of non-engagement by the parents.

18.4 It appears that there was too narrow a focus on interim removal as the plan rather than the protection that the court could offer in a broader sense through other orders.

18.5 On 19th June, Children’s Social Care challenged the legal advice and decided to issue proceedings immediately. At a meeting between the solicitor, team manager and head of service on 20th June, the solicitor changed her advice and stated that she considered that the interim threshold was met despite no further evidence having been gathered or pulled together at that time. It is difficult to understand what had significantly changed between the 2nd and 20th June and in the author’s view the matter should have been put before the court earlier on to test the threshold. Given that decision-making rested with Children’s Social Care, it was for managers to instruct the lawyers to issue proceedings. This was a critical missed opportunity to protect Child B1.

18.6 Children’s Social Care then went back on the decision to issue proceedings but there is insufficient information for the author to reach a clear view as to why managers went back on their decision at that time.

18.7 The following period was characterised by inefficiency over many weeks as the plan for Child B1 was continually reviewed leading to delay whilst the child continued to be at risk of significant harm.

18.8 Further serious delay arose as the focus extended to issuing proceedings in respect of the whole sibling group and the need for immediate protection in respect of Child B1 was overshadowed. There was sufficient evidence in respect of Child B1 and it appears that the evidence gathering process in respect of the other children delayed bringing the matter to court. This delay and confusion was further compounded by a another allocated social worker who stated that she had not observed the concerns that other professionals had reported and the approach then moved to an empowerment model with mother and it was agreed that a further legal planning meeting would convene once the social work assessment was completed.

18.9 Given the observations of other professionals over a long period and in particular the medical conclusions it is inexplicable as to why this new view in effect dismissed the immediate risks and needs when such a high level of concern had been expressed.

18.10 It is debatable whether the parents fully cooperated with the social work assessment at that time. Consequently in all likelihood the practitioner experienced disguised compliance whereby the parents appeared to co-operate with her in the light of what became the threat of legal proceedings. In reality their commitment was superficial and designed to placate, obscure and disguise their lack of compliance.¹⁰

18.11 Research shows that disguised compliance by parents include those who present as compliant, whilst minimizing harmful behaviours to their child. The result is professionals do not see the reality or impact of the lack of cooperation or compliance. What appeared to be parental engagement in actual fact masked the risks of harm to Child B1 and led to a lack of professional concern and involvement.

18.12 In the circumstances it was the team manager's responsibility to ensure that the social worker remained child-focused by instructing the social worker (notwithstanding her recent observations of the parents) to prepare and file the court papers in respect of Child B1 without further delay.

18.13 It is known from the IMR author that social work teams at that time were experiencing a significant period of destabilisation because of an ongoing departmental restructure of personnel and resources. "The experience of some of the workers at that time was that they were working in climate [sic] in which they felt overwhelmed, unable to manage the workloads and working in an unfamiliar environment without appropriate preparation and support.....The workloads of social workers, team managers and service managers during this phase had been described as unmanageable." Children's Social Care IMR

18.14 Furthermore it appears that there was considerable staff turnover across the multi-agency network particularly during May to July which inevitably would have impacted on the continuity of practice and consistent management oversight to ensure that plans progressed effectively.

18.15 It is likely that all of these factors contributed to Children's Social Care not challenging the legal advice in a timely and consistent manner, consequently acting without authority or confidence. Whilst it is acknowledged that such a strained and stressful working environment would have severely affected practice, it raises questions about how the change management process was managed to take account of ongoing complex cases where children and families were at risk.

¹⁰ Beyond Blame (1993), Reder, Duncan and Gray

19 How were racial and cultural issues reflected in assessment and decision making in this case. Was there a gender bias in relation to the care of the children? If so, how did professionals reflect this in their practice?

19.1 Culture is a way of life that is determined and shaped by values, ideas, perceptions and meanings which have evolved over time. It is the first and most important frame of reference from which one's sense of identity evolves.¹¹

19.2 Child B1 and the family lived in a large ethnically diverse city. 36% of the residents are from Black Minority Ethnic backgrounds compared with only 13% in England overall. In the author's view professionals were mindful of the family's race and took this into consideration. In the author's opinion however it is considered that there was an inadequate understanding of the family's culture.

19.3 The following are some references of how agencies attempted to take account of the family's race and culture:

- *Children's Social Care made attempts to identify a culturally appropriate placement for Child B1 when the plan was for Section 20 accommodation*
- *The early help worker was matched to the family to offer a culturally sensitive approach that was child focused*
- *Many of the Children's Centre staff came from a similar background to mother's*

19.4 These examples demonstrate a level of thoughtfulness around race and culture. It is apparent however, that there was a lack of understanding in relation to the family's individual cultural identity and how this influenced and contributed to the parenting style.

19.5 It is the author's opinion there was confusion about race and culture. For example, allocating ethnically matched staff would not necessarily ensure knowledge and understanding of the risks to and needs of the children. It is known that many BME practitioners are rejected by black families¹². Although this was not the case with this family, it was nevertheless simplistic to think that the ethnic match of a worker would in itself ensure a more appropriate and relevant service.

19.6 The professionals appear to have been committed to diversity in meeting the needs of the children; however they lacked sufficient knowledge which may have led to cultural misunderstanding or misinterpretation. The assessment process should have included consideration of the way cultural traditions, values and beliefs influenced attitudes towards parenting and the way in which family life was structured.

¹¹ Cultural Competence in Caring Professions, O'Hagan (2001)

¹² Private Risks and Public Remedies, Farmer and Owen 1995

19.7 What was known of the family's culture?

From the documentation reviewed for the Serious Care Review process there is very little information about Child B1's mother and consequently it has not been possible to obtain a detailed sense of her as an individual and her cultural background in its widest sense. There is scant information about her upbringing or life experiences, although the focus of interventions was with her in relation to Child B1.

19.8 Mother told the health visitor that she valued the support and advice of her mother, however during the course of the review timeframe her relationship with extended family members at times was strained due to the dynamic between her and Father 2.

19.9 Even less is known about Father 2 who was very rarely seen by professionals and did not cooperate with assessments. The Police domestic violence incident report September 2011 states that Father 2 did not have the support of his family because Child 2 was born outside of wedlock. However he did take Child 2 to his parent's home on more than one occasion.

19.10 Within the Individual Management Reports there are several references to extended family members but there appears to have been a lack of professional curiosity about their relationship with Child B1 and the family. For example, there was no exploration as to why Child B1 was taken to the maternal grandmother's home as a punishment when the parents could not cope with their behaviour. It is surprising that a Family Group Conference was never convened as a means of assessing and evaluating what support they could have offered to assist the parents in caring for and protecting the children. In addition the process could have assisted the multi-disciplinary network in finding out more about the family's experiences and culture.

19.11 Evidently, the parents were living with a high degree of stress. The extent to which domestic abuse and alcohol misuse was potentially related to any cultural factors was not explored. In addition the assessments do not appear to have considered the implications of them being young parents.

19.12 Crucially how they perceived themselves and how they were perceived by their extended family and the wider community was unknown and seemingly unexplored.

19.13 Issues around food and feeding were a significant concern for practitioners who came into contact with the family but almost nothing seems to have been known about what part cultural values and beliefs influenced behaviour and decisions in relation to food.

19.14 Further there was a lack of knowledge or exploration of what the children meant to these parents and what these parents meant to the children. It is of note that mother had enquired about a termination when she found out that she was

pregnant but had decided to go ahead with the pregnancy when she found out she was pregnant with twins. It is possible that her initial feelings may have affected her future relationship with Child B1. Studies indicate that questioning the meaning of the child for the parent is a good way to make sense of children's development, their care and nurture and to understand the child in the context of their caregiving environment¹³, which relates to and will vary across race and culture.

19.15 This lack of knowledge was possibly detrimental because it did not enable professionals to understand the presenting circumstances in the context of the parent's individual histories or cultures. Consequently there was limited depth in the professionals' grasp of the situation to inform effective risk assessment and decision making.

19.16 As stated elsewhere there is evidence that the nature of attachment and its approach to improving the parent child interaction in this family was not sufficiently culturally sensitive and relied on some racial and cultural assumptions. Conversely it is positive to note that the health visitor was clear that Child 4 fasting was potentially abusive for such a young child and was confident in challenging this with mother; thereby not condoning the practice on religious grounds.

19.17 Gender bias

The health visitor and Early Years Support Team staff believed that there was preferential treatment of the siblings in the family although once again the assessments did not address this. There is no explanation from the parents as to why Child B1 was made to walk whilst the siblings were carried in the pushchair or why Child B1's clothes were shabby in comparison to theirs. When asked, Father 2 explained that he wanted to care for Child 2 because he did not feel able to look after the twins.

19.18 In discussion with professionals it is evident that there is a difference of opinion as to whether there was a gender bias towards the children. In conclusion, so little is known about the family's culture that it is not possible to form a clear or informed view in respect of this question.

20 How effective was the working relationship between partners and parents and what part did this play in managing risk?

20.1 With reference to the working relationship between partners it would be fair to say that it was at times close but generally ineffective to protect Child B1.

20.2 Mother's ability to share with health visitors her lack of bonding with Child B1 demonstrated an element of trust and an ability to ask for help from the service and it is noteworthy that this followed a previous contact in 2012 when the health visitor

¹³ Decision-making within a child's timeframe Brown and Ward (2012)

had met with mother following a domestic violence incident but it was not appropriate to discuss the incident because Father 2 was present at the time.

20.3 Health visitors were initially focusing on “attachment” with a view to addressing failure to thrive. There is evidence of considerable information sharing between the health visitors and community paediatricians for example referrals to a dietician, speech and language, audiology and clinical forum. However when improved parenting and weight gain were not sustained the case should have been referred to Children’s Social Care for assessment of the issues, appropriate support and intervention.

20.4 There was sufficient indication following a visit at the beginning of January 2014 that there were safeguarding concerns based on parent / child interaction, and case history. Had health involved Children’s Social Care at that time there may have been an alternative and wider professional perspective.

20.5 Further as stated above the health visitor service made a referral to the Early Years Support Team but did not include significant relevant information about the family and history which was ineffective practice which meant that Early Years Support Team and the nursery were unable to take factors of domestic violence and previous child protection concerns into account when understanding and managing risk.

20.6 There are examples of agencies not working together because of a lack of trust between professionals. Most notably the examples are when the social worker insisted upon the health visitor carrying out a joint visit to assess Child B1, which would have been a reassessment and in effect undermined the health visitor’s initial assessment. In complex cases it is helpful for practitioners to visit together with a view to pooling expertise and knowledge to assess difficult situations; however this was not the case in this particular instance.

20.7 Further delay was caused by the social worker in July disagreeing with other reported professional concerns so much so that she would not support the plan for removal. In the context of multi-agency working such certainty and mis-placed confidence would have had a potentially divisive impact on partnership working. Ultimately, the parents may have taken advantage of the split in the professional network.

20.8 The contradictory messages from Children’s Social Care to the parents regarding issuing care proceedings and then a message of partnership working through an empowerment model would have been confusing and potentially frightening to the parents who would have felt under pressure to be seen to comply with professionals.

20.9 This extended period of uncertainty would have itself increased the levels of parental anxiety and thereby the risks to the child. It is noted that mother had said that she would “force feed” the child to get Children’s Social Care off her back. It is not known whether or how this comment was risk assessed. In the context of the inexplicable short term weight gain and loss shortly before the serious incident this is deeply troubling.

21 How well was the physical and emotional wellbeing of each child understood? How was each child’s different experience reflected in assessment and planning? Is there evidence of their voices being heard?

21.1 There is little evidence to indicate that the risks and needs of the children were properly understood, for example as stated above during the first period of child protection planning.

21.2 During the review timeframe there is considerable reference to the children’s physical wellbeing mainly in the context of the health visitor assessments for the 3 youngest siblings. However there is less reference of the children’s emotional needs being understood or reflected in assessment and planning. In respect of emotional development research demonstrates that this can receive less recognition because it is largely unseen in contrast to other highly visible skills such as mobility and language¹⁴

21.3 The majority of contact took place within the family home where the children were observed and assessed within a familiar environment and in the context of family functioning. Given their ages the three youngest siblings were too young to vocalise their views and wishes. Consequently professionals relied on observation to gain insights and understanding of the children’s experiences. However these observations do not appear to have extended to critical reflection on what life was like for the children within the home and in relation to the parenting provided. There is minimal evidence of their voices being heard.

21.4 Observations of the children included the following:

Child B1:

- Initially achieving developmental milestones until the child was eighteen months old
- Later the pale and weak appearance and general demeanour
- Poor attachment – no eye contact or interaction during feeding with mother
- Frail, undernourished and development not age appropriate
- Child B1 made no attempt to be comforted by mother after being aggressively hit by their sibling

¹⁴ (Blair, 2002)

21.5 The other children were predominantly described as happy, sociable children who interacted well with adults and other children. There is little sense that they were assessed as individuals (particularly in relation to their emotional wellbeing) since the focus was on Child B1, except that it is also noted that Child 2 had very limited speech and language for their age, for which the child received support.

21.6 At a later date, when asked what they would use a magic wand for, Child 4 replied “if a little child was hungry they would get something to eat.” This is a highly unusual comment for a child to make and was not said in relation to a religious observation which may suggest that the child had experienced hunger or that they had seen siblings denied food which would have had an emotional impact on Child 4.

21.7 It is unlikely that the children were unaffected by the domestic violence incidents between their parents which in all likelihood would have been a frightening experience for them. Even if they did not witness the arguments and assault, at the very least the atmosphere at home and between their parents would have been tense. Research has shown that the impact of domestic abuse on children includes conveying a message that violence is acceptable and an effective way of expressing emotions or resolving conflict. Evidence indicates that this form of abuse harms infants and preschool children the most, but the effects are often only noticed during the teenage years.¹⁵

21.8 Until the Initial Child Protection Conference in June 2014, there is a sense that the professional network probably overlooked and underestimated the impact to the children’s emotional wellbeing in light of domestic violence, Father 2’s drug use, and mother’s periodic low mood. The situation was further compounded by the family’s living conditions which were described as overcrowded and vermin infested. The stress and strain of these factors would have undoubtedly impacted the atmosphere within the home and would have affected the parents’ emotional wellbeing and ability to be consistently emotionally available. As a result the children’s emotional wellbeing would have been affected but this is not reflected at all in assessment and planning.

21.9 Evidently, at the Initial Child Protection Conference in June 2014 the children’s emotional needs were then fully taken into consideration which led to the three siblings being made subject of child protection plans under the category of emotional abuse. This was a definite acknowledgement by the professional network that the siblings were indeed affected by the neglectful parenting experienced by Child B1.

22 Conclusion and Learning

22.1 This section will summarise and collate the main conclusions from the analysis and related key learning to improve practice.

¹⁵ Beyond Violence – Breaking the cycles of Domestic Abuse 2012

22.2 Child B1 was seriously harmed as a result of choking. As a result of the injury the child is profoundly disabled and will require long term care to ensure ongoing health, development and ongoing safety.

22.3 The serious incident was a terrible tragedy and based on the information spanning the timeframe of the review, it is the author's opinion that Child B1 was likely to suffer significant harm in view of the medical facts and proven evidence of non-organic failure to thrive, although the specific harm that occurred was not predictable. Removal from the parents' care in May 2014 in all likelihood would have prevented Child B1 from being injured and this was a missed opportunity to protect the child.

22.4 The preceding analysis concluded that –

- i. The previous periods of child protection planning did not sufficiently inform the further assessment, decision making and practice of partner agencies. The risks to Child B1 and the siblings were not adequately identified or fully understood. The assessments were not thorough and lacked analysis of the children's needs. There was over optimism about the family at the time of the first child protection plans which led to the plans' discontinuance. There was a lack of information sharing between agencies, most notably the health visitor's referral to the Early Years Support Team in June 2013. Had agencies taken full account of the child protection history and effectively used chronologies, it should have alerted professionals to increased concerns for the children's welfare and a more vigorous response to referrals.

Key lessons learned:

- Any assessment should be completed in a time frame consistent with the needs of individual children and actions required to progress plans should be based on a *SMART* approach.
- Managers should be accountable for monitoring practice compliance, ensuring the progression of plans and supporting workers to complete tasks.
- High quality, child centred assessments should be holistic in accordance with the Department for Education *Framework for Assessment*. Information gathered should lead to analysing risk, identifying protective factors, prognosis for change and support to address the child's needs and improve outcomes to protect and keep them safe.

- It is essential to document the parents' history to inform risk analysis and decision making.
 - A single agency chronology and / or combined multi-agency chronology of significant information in the child's life should be produced to create an overview of all relevant information and how this may impact the child's safety and protection.
- ii. In relation to domestic violence there is evidence that the Police took it seriously and acted accordingly but Children's Social Care incorrectly viewed the parents' separation as a protective factor which in itself was dangerous. The Children's Social Care assessment was incomplete due to Father 2's non engagement and the risks were not assessed thoroughly. The GP practice does not appear to have sufficiently taken domestic violence into account in their dealings with mother. Due to poor information sharing between the health visitor and the Early Years Support Team and nursery these organisations were unable to take this specific risk factor into account. The risks of Father 2's substance misuse to the children were unexplored and there was no direct work with him to address the issue which was a significant omission. Ultimately little was known about Father 2 in terms of him either being a protective or risk factor.

Key lessons learned:

- Professional response to a denial of domestic violence should be challenged and reflect the impact of harm on the children within the household.
- Agency responses to domestic violence should always result in the victim being provided with advice or signposting to other services. A proactive response can offer the opportunity to engage parents in services that could empower them to safeguard their children. This includes helping them to understand the impact of domestic violence on their children.
- Assessments should include information about all members of the household and there should be a detailed assessment of the family dynamics to identify risks and protective factors. Agencies should consider the role of fathers and ex-partners with whom the mother has resumed a relationship to inform decision making and service provision. Information about who lives in the home and who has contact with the children should be up dated in the chronology.
- Considerable work has been completed by the Police to identify repeat victims of domestic violence. Attending officers are reminded not to

deal with the incident in isolation and to review the history of domestic reporting from the persons involved. Officers should be mindful of identifying factors that contribute to the incidents, for example alcohol, and ensure that all referrals are completed for all incidents at the time.

- In October 2013 a process was developed to identify repeat victims and to flag these to the local Safer Neighbourhood Team for further management and support to reduce the impact on victims of domestic violence.
 - Also in October 2013 referral routes into MARAC were updated to include three or more incidents in a twelve month period which provides evidence of escalation not merely repeat episodes. However a further filtering process is required because the system would not be able to cope with the number of police call outs based on this criterion.
 - Project 360 pilot was an Early Intervention Team that focused on standard and medium risk victims of domestic abuse who were allocated to the Early Intervention Team immediately following the third police call out in a 12 month period. Victim Engagement Workers made contact with the victim to offer information, advice and support to encourage individuals to engage with the Police, Crown Prosecution Service and local support services. Children and young people within the family were referred to a related Family Service. The pilot ceased at the end of March 2015 and will be independently evaluated by Leicester University academics.
- iii. It appears that practitioners from the health visitor service, Early Years Support Team and the nursery had a limited understanding of attachment in relation to child protection. Had they understood the implications of poor attachment in relation to neglect they should have involved Children's Social Care earlier. There was a prompt reaction to mother's statements about not loving or bonding with her child, but the limited understanding of neglect had serious implications for the response and this was the initial missed opportunity to effectively safeguard Child B1. There was a delay in recognising the nature and seriousness of the situation in the face of mounting concerns. There was confusion between the health visiting service and the Early Years Support Team as to the focus of intervention; consequently the service was not addressing the primary reason for referral. Furthermore the inadequacy of the recording template meant that crucial parent-child observations were omitted.

Key lessons learned:

- A shared understanding of the specific consequences of non-organic failure to thrive and most importantly the child's timescales for change is necessary so that all interventions and planning can be informed by this. Joint work between the wider health community and Children's Social Care professionals should begin at a much earlier stage in case management for children in such circumstances. This should focus on creating a shared understanding of the concerns and ensure effective exchange of information to prevent delay and inform risk assessment and related decision-making.
 - Early Years Support teachers and nursery staff require training and good quality reflective supervision to support them in dealing with complex child protection cases for pre-school children. Practitioners need to understand how to make accurate holistic assessments and take appropriate actions to safeguard and protect children.
 - Decision making within a child's timeframe is essential. Understanding of what changes are required by when is crucial. The serious incident to Child B1 may not have been predictable; however the effects and consequences on the health and development of failure to thrive due to neglect and emotional harm should have been recognised as part of attachment based practice. There was a lack of understanding of their daily lived experience, the harm experienced and related risks.
 - The local safeguarding children board should consider how to improve knowledge and understanding of neglect across universal and targeted services.
 - Referral information should be a thorough and accurate process that considers all factors and engages the referrer in considering how the child's needs should be met. The safeguarding history should be thoroughly considered in relation to how this may affect the current situation for the child.
 - If an initial referral is not considered to meet the threshold for Children's Social Care intervention a proactive approach should be taken to how the child's needs can be met by other services and what may constitute a re-referral or step up to Children's Social Care involvement in the future
- iv. The local safeguarding children board's escalation policy was not used effectively to ensure that Child B1 was protected. Professionals were aware of the policy's existence and there is clear evidence that concerns

were at times properly escalated within individual agencies, but there were also at least two occasions when this did not happen. Further there were instances of a lack of escalation between organisations and at crucial times. In particular, in June 2014 when agencies were aware of the delay in progressing the child protection plans the policy should have been used to safeguard Child B1. This was a missed opportunity to keep Child B1 safe. At this point in time, there appears to have been a lack of understanding of how the policy could be used.

Key lessons learned:

- When professional disagreements could not be resolved the safeguarding children board '*Resolving Professional Disagreements*' procedure should have been initiated with the aim of challenging decisions and resolving professional differences in the best interest of the child. Ultimately any continued professional disagreement should be escalated to the safeguarding children board manager to determine a course of action including reporting concerns to the LSCB Chair.
 - Health professionals must ensure that there is a clear plan of action in accordance with the procedure. Designated and Named professionals must clarify and confirm with one another the person responsible and accountable for escalating concerns between agencies until all areas of disagreement are resolved.
 - The child protection plan is the key planning process for safeguarding children in need of protection. When a plan is not effectively implemented or is not assessed to be keeping a child safe the review conference must be brought forward to review the plan and make the necessary adjustments to ensure the child's safety.
- v. There was at an early stage sufficient concern to put the matter before court following discharge from hospital and it was a failing that this did not take place and was a missed opportunity to protect Child B1 as their interim safety was paramount. It appears that the interface between Children's Social Care and the Legal Department was ineffective. Lawyers should be respected for their expertise in the law and Children's Social Care should consider legal advice as such and not as an instruction. Social worker managers must retain responsibility for case work decision-making including whether or not to issue proceedings. There was inordinate delay in bringing the matter to court. Knowing that Children's Social Care felt overwhelmed in a period of restructuring which was described as "unmanageable" it is questioned whether Children's Social Care felt confident enough to challenge the legal advice provided.

Key lessons learned:

- Children's Social Care practitioners and managers are reminded of the three key principles under the Children Act 1989 which would have informed child centred practice to protect Child B1.
 - i) The welfare of the child is paramount*
 - ii) Delay is likely to prejudice the welfare of the child*
 - iii) The court shall not make an order unless to do so would be better for the child than making no order.*
 - Children's Social Care managers are responsible for and have authority to instruct lawyers to issue care proceedings in circumstances where they consider such proceedings necessary to protect the child even when the legal advice does not support the social work plan to safeguard the child.
- vi. There is evidence that agencies did take account of the family's race and culture. However there was a lack of understanding of the family's individual cultural identity and how this contributed to and affected the parenting style. It is the author's opinion that professionals confused race and culture. There was little knowledge of the parents' individual histories and their extended families. There was no understanding of what the mother actually meant when she said she had not bonded with Child B1 in terms of her own cultural frame of reference and how she wanted their relationship to change. The issues affecting this family were never understood within a cultural context. There is insufficient evidence to form a view as to possible gender bias.

Key lessons learned:

- Working in partnership with safe family members can be valuable in coordinating the help and support to children and parents. Family Group Conferences can assist in identifying protective factors for children, planning and decision making involving the skills and experiences of the extended family alongside professionals. To instigate direct work with safe family members at an early stage can increase the safeguarding of children.
- Family members need to be able to understand what the issues are from the perspective of the professionals and professionals need to understand the safeguarding issues in the context of the family's cultural identity and unique individual situation.

- vii. At times the working relationship between agencies was close but generally ineffective to protect Child B1. There is evidence of close working between health professionals but as concerns increased, there were failures in mounting a robust co-ordinated, multi-agency approach. At times there was poor information sharing between agencies. The threat of legal proceedings combined with the unacceptable delay in issuing an application for a Care Order potentially added to the risks to Child B1 and may have contributed to the serious incident, due to heightened anxiety in the mind of mother over an extended period.

Key lessons learned:

- Effective information sharing between multi-disciplinary professionals is essential for the identification of risks, thorough assessment and targeted service provision.
 - In June 2015 Children's Social Care implemented a system using the Integrated Children's System - Liquid Logic whereby a letter is automatically generated following a contact / referral from a professional agency. The content includes the agreed outcomes based on the discussion between the Duty Assessment Service social worker and referring professional. Incorporated in the letter are agreed next steps for both agencies.
 - There is a requirement for Children's Social Care to effectively share safeguarding information during an antenatal and early post-natal period with midwifery services.
 - Strategy discussions must include health professionals. This will benefit a shared understanding of needs and risks and will provide a forum to plan how to progress enquiries and assessments. This will help to reduce delays later in the process for safeguarding children.
 - In accordance with the safeguarding children board policy, all referrals to Children's Social Care must be confirmed in writing, irrespective of whether the child and their family are already known to the department.
- viii. There is little evidence to indicate that the risks to and needs of the children were properly understood. There is considerable reference to their physical development in contrast to their emotional wellbeing which seems to have been overlooked. Given the children's ages professionals relied upon observations to gain insight into their wishes and feelings. These observations fell short of reflecting upon their daily lived experiences in relation to the parenting provided.

Key lessons learned:

- Record keeping and lesson plans should be reviewed and improved within the Early Years Support Team.
- All services and settings should keep an up to date chronology of concerns that include actions taken and progress toward outcomes being achieved. Best practice would also include recording “the voice of the child” to prompt practitioners to always consider and reflect upon the child’s lived experience.

23 Recommendations

23.1 I fully support the individual agency recommendations which are listed together with the individual agency action plans attached at Appendix 1. The recommendations reflect changes some of which have already taken place in agencies as a result of analysis and learning from this review and local practice developments. In addition I recommend the following:

- i. That the Safeguarding Children Board through its Learning and Improvement Framework set out a plan of audit against the actions set out for individual agencies to satisfy itself that safeguarding practice has improved and that children in such circumstances as Child B1 and their siblings are adequately protected.
- ii. That Risk Assessment and Analysis training for multi-disciplinary practitioners’ addresses culturally sensitive practice to ensure that professionals take into account a family’s cultural identity when undertaking assessments and offering support.
- iii. That the Safeguarding Children Board agree a clear protocol with legal services about how they will take part in Serious Case Reviews.

23.2 It is of note that there are aspects of Child B1’s case that are similar to *Child A* and *Child Q* which also highlighted weaknesses in multi-agency working. These recommendations are repeated below as they are relevant to this Serious Case Review and therefore the author would reiterate them to the Board and request that these are further progressed as necessary.

- i. The Independent Chair of a child protection conference must review the invitation list and ensure it is sufficient to provide the full range of information required to safeguard the child/ren and promote their welfare. This must include General Practitioners.
- ii. Prior to agreeing the cessation of Child Protection Plans the Independent Chair must check that all elements of the Child Protection Plan have been completed, unless there are strong reasons for discontinuing them.

iii. In relation to assessment of parents, the Independent Chair must be satisfied that assessment includes all relevant history of both parents, analysis of the potential impact on parenting capacity and what supports are required for the child/ren.

iv. All professionals in the agencies, which are members of the Leicester Safeguarding Board, must be supported by their agencies to develop the confidence to work constructively together which includes challenging each other's decisions effectively when necessary. The current LSCB chapter 9.2 'Resolving Professional Disagreements' should be reviewed and updated with the aim to develop a 'Good practice' model for the use of staff and managers across the agencies.

v. All agencies involved in this Serious Case Review (Child Q) should participate in a series of multi-agency workshops targeted to front line managers and supervisors, including Chairs of Conferences, to review, reflect on and update the purpose and practice of undertaking Parenting Capacity Assessments to ensure that good quality standards are complied with including:

- Assessment of a mother's experience of being parented
- Assessment of a father's and/or partners history and experience
- The parent/s capacity to meet the child's full range of needs
- The compilation of a Chronology
- Working with grandparents in assessments and the family context and history
- Supervision and management of assessment of cases, where neglect and clusters of complex problems are present.

Safron Rose
Independent Overview Author
September 2015

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Working Together to Safeguard Children 2013

Appendix 1:

Recommendations
(General Practitioners)

i	If a child is suspected to be failing to thrive he/she should be referred for a second medical opinion with a paediatrician.
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Appendix 1:

ACTION PLAN FOR CHILD B1 SERIOUS CASE REVIEW
(Leicester City CCG)

No.	What is the recommendation? (This should be lifted directly from the IMR)	What is the desired Aim / Outcome from the recommendation? What do we want to achieve?	How will change be achieved? What are the actions that need to take place?	Leadership Who will chase progress and be responsible for completion of the action?	Timescale By what date will the action be completed?	Outcome Measure How will you know and what difference has it made? (for agency and for children)
1	Children with suspected failure to thrive should be referred for a paediatric assessment	Early assessment of failure to thrive	Through level 3 child safeguarding training	Lead professionals for safeguarding children	8/04/2015	

Appendix 1:

Recommendations
(Leicestershire Partnership NHS Trust)

2.	If a child is failing to thrive and a non-organic cause is thought likely a referral for assessment by children's social care should be made	Early social services involvement with the child/ren and family	Through regular level 3 safeguarding training for GP's and health visitors	Lead professionals for safeguarding children	8/04/2015	
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i	Should develop a Safeguarding Children Supervision Pathway which includes:- professional autonomy, simplified processes for supervision with less emphasis on face to face meetings and less dependence on the Safeguarding Advice Line for decision making. In addition the system must include a method of recording via uLearn to monitor practice compliance.
ii	The Professional Lead for Health Visiting and Professional Lead for Safeguarding Children should ensure that the Standard Operating Guidance for Health Visiting is compliant with safeguarding procedures and signposts staff to safeguarding pathways.
iii	Health visitors and their teams to be reminded not to share copies of child health records with partner agencies without consent of the parties involved (Record Keeping and the Management of the Quality of Health Records Policy) through the Safeguarding Children Briefing.
iv	The Safeguarding Children Briefing should be used to remind practitioners to always use an 'alert note' when entering information within the hidden, ' <i>Record Safeguarding Child Information</i> ' on the SystemOne electronic health record.
v	Managers to ensure that practitioners use the staff ledger on the SystemOne electronic health record to enter all details of a child's review to ensure that the review process is covered in the event of allocated staff absence.
vi	Managers to update service safeguarding policies for health practitioners to include reference to staff producing and keeping an up to date accurate chronology to inform the process of risk assessment and review to safeguarding children.

Appendix 1:

ACTION PLAN FOR CHILD B1 SERIOUS CASE REVIEW (Leicestershire Partnership NHS Trust)

No.	What is the recommendation? (This should be lifted directly from the IMR)	What is the desired Aim / Outcome from the recommendation? What do we want to achieve?	How will change be achieved? What are the actions that need to take place?	Leadership Who will chase progress and be responsible for completion of the action?	Timescale By what date will the action be completed?	Outcome Measure How will you know and what difference has it made? (for agency and for children)
1,	Where professional disagreement with another agency emerges the LSCB policy should be	That the agreed LSCB procedure for resolution of professional disagreement is	LSCB Guidance will be considered by LPT to determine if routes of escalation and accountability are clear	Di Postle/Rachel Garton.		

	followed.	followed.	for staff. To raise with LSCB for review if changes for clarity are recommended. Staff will be reminded to utilise the LSCB professional disagreement process via Trust Staff briefing.	Named Professionals		
2.	To develop a Safeguarding Children Supervision Pathway which includes:- professional autonomy, simplified processes for supervision with less emphasis on face to face meetings and less dependence on the Advice Line for decision making and including the method of recording via uLearn to monitor compliance	Less dependence on the Safeguarding Children Advice Line for decision making.	Audit of Advice Line calls. Agree triage requirements. Trial period of restricted access hours to monitor effect for adverse incidents. During the trial period completed Standard Operating Guidance for staff to include alternative sources for advice.	Carolyn Corbett, Professional Lead Safeguarding Children and Named Nurses Safeguarding Children	31.07.2015	Practitioners will be signposted to safeguarding children supervision when required enabling a comprehensive review of the case.

3.	Practitioners are to be reminded not to share copies of child health records with partner agencies without consent of the parties involved (Record Keeping and the Management of the Quality of Health Records Policy) through the Safeguarding Children Briefing.	Practitioners are compliant with Record Keeping and the Management of the Quality of Health Records Policy.	A reminder to be placed in the Safeguarding Children Briefing sent out electronically across LPT. Clinical Team Leaders for health visiting and school nurse teams to highlight in team meetings.	Named Nurses Safeguarding Children. Clinical Team Leaders	31.03.2015 31.05.2015	No further incidents of failure to adhere to record keeping policy are identified.
4.	Practitioners to be reminded to always use an 'alert note' when entering information within the hidden, 'Record Safeguarding Child Information' on the SystmOne electronic health record, through the Safeguarding Children Briefing.	Practitioners are aware of the correct process of recording sensitive safeguarding child information on SystmOne.	A reminder to be placed in the Safeguarding Children Briefing sent out electronically across LPT. Clinical Team Leaders for health visiting and school nurse teams to highlight in team meetings.	Named Nurses Safeguarding Children. Clinical Team Leaders.	31.03.2015 31.05.2015	No further records are identified where the process has not been followed
5.	When practitioners plan to review a child, the date of the review, or planning of the review, is to be entered on the staff ledger on the SystmOne electronic health	When practitioners are absent from work, colleagues will be able to identify what work needs covering and this will prevent contacts from being overlooked.	To agree a clear process between the Named Nurses Safeguarding Children and Locality Managers and Clinical Team Leaders.	Carolyn Corbett, Professional Lead Safeguarding Children, Named Nurses Safeguarding Children and a Locality Manager.	31.07.2015	All practitioners will plan their work using the electronic leger and will review the leger of colleagues when absent, to ensure that work is covered.

	record to ensure it is covered in the event of staff absence.					
6.	The Professional Lead for Health Visiting and Professional Lead for Safeguarding Children to ensure the Standard Operating Guidance for Health Visiting is compliant with safeguarding procedures and signposts staff to safeguarding pathways	That staff will have an understanding of earlier risks to inform present care planning for children.	<p>To be incorporated in the Initial Level 3 Safeguarding Training.</p> <p>A reminder to be placed in the Safeguarding Children Briefing sent out electronically across LPT.</p> <p>Reinforce the Early Help Offer within the City locality and supporting Leicestershire Families in the County</p>	<p>Named Nurses Safeguarding Children.</p> <p>Named Nurses Safeguarding Children.</p> <p>Professional Lead Health Visiting</p>	<p>30.04.2015</p> <p>31.03.2015</p> <p>30.04.2015</p>	All staff will be compliant with the Early Help Offer and the safeguarding thresholds.

Appendix 1:

**Recommendations
(University Hospitals Leicester NHS Trust)**

i	Midwives are reminded to proactively follow up referrals with Children’s Social Care where they have outstanding safeguarding concerns for a mother.
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Appendix 1:

**ACTION PLAN FOR THE CHILD B1SERIOUS CASE REVIEW
(University Hospitals of Leicester NHS Trust)**

No.	What is the recommendation? (This should be lifted directly from the IMR)	What is the desired Aim / Outcome from the recommendation? What do we want to achieve?	How will change be achieved? What are the actions that need to take place?	Leadership Who will chase progress and be responsible for completion of the action?	Timescale By what date will the action be completed?	Outcome Measure How will you know and what difference has it made? (for agency and for children)
1	To ensure the findings from this review are effectively disseminated to Safeguarding Leads across UHL	Practitioners continue to learn lessons from Serious Case Reviews	Presentation of Review report at Trust Safeguarding Assurance Group	Michael Clayton Head of Safeguarding UHL	Dependent on release of report	Through minutes of meetings and spot check audits and regulatory inspection findings

Appendix 1:

Recommendations (Early Years Support Team)

i	EYST staff should be able to demonstrate a knowledge and understanding of the LSCB Thresholds Guidance
ii	The EYST should review and update the Safeguarding Policy and make sure it is relevant to those practitioners. Managers should ensure that it is widely understood and followed.
iii	EYST should review the following records: 1. Referral to EYST to include relevant family history with regard to safeguarding. 2. Lesson plans to be revised to ensure that record of visit of visit includes safeguarding issues, child's voice, outcomes and further actions
iv	Record to include a chronology of safeguarding concerns with actions and outcomes
v	Supervision in EYST should include reflection. Management oversight and supervision of individual cases should be recorded on the child's file in accordance with the supervision policy
vi	Review of safeguarding training needs and consider training needs in terms of multi-agency training on neglect for key staff

Appendix 1:

**ACTION PLAN FOR CHILD B1 SERIOUS CASE REVIEW
(Early Years Support Team)**

No.	What is the recommendation? (This should be lifted directly from the IMR)	What is the desired Aim / Outcome from the recommendation? What do we want to achieve?	How will change be achieved? What are the actions that need to take place?	Leadership Who will chase progress and be responsible for completion of the action?	Timescale By what date will the action be completed?	Outcome Measure How will you know and what difference has it made? (for agency and for children)
i	EYST staff should be able to demonstrate a knowledge and understanding of the LSCB Thresholds Guidance	All staff in EYST and SEND services understand and operate safeguarding procedures.	<p>Threshold guidance was given to the whole service staff meeting 14.4.15.</p> <p>All EYST have accessed guidance on line, read and discussed as a team.</p> <p>Team Leader is attending inter agency Early Help training in October 2015 and will disseminate to the team.</p>	Team Leader – Sarah Mounsey reporting to service Manager and HoS	September 2015 and ongoing CPD element	All EYST staff show an awareness of the safeguarding thresholds and operate implemented systems effectively.

ii	EYST should review and update the Safeguarding Policy and make sure it is relevant to those practitioners. Managers should ensure that it is widely understood and followed.	A reviewed safeguarding policy which is updated, shared and understood by all staff. A consistent and shared policy across SEND Services	SEND Support Service has adapted the policy written for PS which gives us a generic policy across the service. Team Leader has adapted it further for EYST and Pindar Nursery. This was shared with the team at our CPD day on 27/09/15. Service manager has a copy of the adapted EYST policy,	Team Leader – Sarah Mounsey reporting to service Manager and HoS	September 2015 and ongoing CPD element	An updated policy is prepared and shared with all staff.
iii	EYST should review the following records: 1. Referral to EYST to include relevant family history with regard to safeguarding. 2. Lesson plans to be revised to ensure that record of visit of visit includes safeguarding issues, child's voice, outcomes and further actions 3. Record to	Referrals to have a family history as part of the referral Lesson plans to be used for lesson planning and other relevant forms to be used appropriately. A separate form is to be used for recording safeguarding concerns/discussions (yellow form)	<ul style="list-style-type: none"> • All EYST referrals now include space for the referrer to provide family history re safeguarding • All EYST staff using lesson plans understand that notes around safeguarding are not to be recorded on lesson plans. Any safeguarding concerns are to be recorded on a yellow sheet kept in the child's file which include a space for outcomes and further actions. This will provide a chronology of safeguarding concerns and also highlight when there has been a low 	Team Leader – Sarah Mounsey reporting to service Manager and HoS	Immediate – completed by July 2015.	Clear information on referral forms to include family history. Yellow forms introduced and being used (seen through case examination by Team leader) to record any safeguarding concerns.

	include a chronology of safeguarding concerns with actions and outcomes		level concern around a child which individually would not be an issue but build a bigger picture when there are a few. (James Diamond advised us to do this on the DSL training I attended). Any children where there are low level concerns are discussed at supervision. Although the child's voice was mentioned as something that was missing within this case we do feel as a team we are quite good at recording this. We have a 'listening to children's policy' as a team and work very hard to represent the child's voice in our work which often can be quite tricky when a child has communication difficulties resulting from SEND.			
iv	Supervision in EYST should include reflection. Management oversight and supervision of individual cases	More reflective supervision sessions and must be recorded in the child's case file if the child has been discussed at	The service supervision policy has been reviewed and tightened up our systems. Individual cases are now all recorded separately on the caseload supervision form. Low level	Team Leader – Sarah Mounsey reporting to service Manager and HoS	In place for the beginning of the new academic year (September 2015)	Supervision records clearly indicate more reflective supervision. Safeguarding is discussed by all Team leaders with service Mangers and HoS will

	should be recorded on the child's file in accordance with the supervision policy	supervision (including using the yellow form for safeguarding concerns/discussions).	concerns are highlighted and cross referenced on the yellow form and caseload supervision form to enable supervisor and supervisee to focus on reflect on these children. Cases with regular low level concerns are discussed with Team Leader as DSL.			discuss safeguarding issues as a regular item on SEND management meeting agenda.
v	Review of safeguarding training needs and consider training needs in terms of multi-agency training on neglect for key staff	Key staff in EYST have attended multi-agency training and are up to date and knowledgeable regarding neglect.	<p>The Team leader has completed the designated safeguarding lead training along with 3 other senior teachers within the EYST who will provide back up for team members in the event of the Team Leader's absence</p> <ul style="list-style-type: none"> •All EYST have reviewed the E learning around safeguarding on LLP •All EYST have identified where they are on the competency framework and have completed the 	Team leader (Sarah Mounsey and Service Manager reporting to HoS)	Review completed by September 2015 and ongoing training programme.	Key staff are up to date and able to operate the safeguarding policy. Reduce the number of children and young people at risk by earlier identification and signposting.

			<p>competency framework grid with support of their line managers.</p> <ul style="list-style-type: none"> •EYST are starting to access multi-agency training. The Team leader has attended training around allegations against staff with the LADO. Staff are aware of the Leicester city Safeguarding Board site and have followed links to information about training. This year the Team leader aims to get at least 8 members to attend inter agency training. •The Team leader has also discussed with Emma Ranger for the LLR LSCB about the needs of our team and she has identified that some of the bespoke training she has done with the disabled children's services maybe relevant to our team due to the unique nature of our job and the possibility of getting 			
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			together with them in future.			
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Appendix 1: Recommendations (Children's Social Care)	
i	Regular supervision of social workers and managers will take account of practice compliance with procedural expectations and ensure that the voice of the child is reflected in risk assessment, analysis, decision-making and planning.
ii	All assessments undertaken that involve domestic violence will result in advice and signposting to services and consider the impact of on children.
iii	All practitioners will demonstrate a greater understanding of how to respond to failure to thrive and the link to emotional abuse and neglect.
iv	Strategy discussions when a child is suspected or is likely to suffer significant harm will be held with health professionals as well as police and any other relevant agencies.
v	The Local Authority will promote an assessment and intervention model that enables workers to complete well informed assessments that focus on risk, protective factors, desired outcomes and specified timeframe.
vi	Social Care Managers to ensure that social workers complete training on the Early Help Module for Liquid Logic (2 hour briefing) and the Early Help Assessment Training (one day course) so they can develop their understanding and competence of Early Help services and referral pathways.
vii	If a child protection plan is not implemented or is not assessed to be safeguarding a child, the review conference must be brought forward to review the plan.
viii	Assessments must be completed in a relevant timescale for the individual child's needs and be informed by: a good chronology,

	understanding of the child and family history and multi- agency information and views. The information should be made available for decision making and case management meetings to inform planning.
ix	Each referral taken within Duty and Advice will take account of the family history and link the current and historic factors to assess current risk and need. Referrals that do not meet the threshold for Children's Social Care intervention will be signposted to appropriate services and include early help packages.
x	The professional disagreements procedure will be initiated if there is an unresolved disagreement about the safety of a child. The Safeguarding Children Board manager will determine any required course of action to resolution.
xi	Family members will be considered early on in all assessments and interventions to consider if they can be involved in the protection of the child.
xii	Managers will be made aware of the importance of case management meetings and multi-agency meetings as significant turning points in cases. Such meetings must take account of and include representation from multi-disciplinary agencies to ensure the quality of decision making and related actions are implemented in a timescale that safeguards the child.
xiii	<u>Senior managers within Children's Social Care should ensure that practitioners and front line managers are supported to provide good quality, safe services to children and families during times of restructure and reorganisation. Such managers should risk assess and produce risk management protocols to ensure that the workforce is sufficient to meet the demands of the service to ensure confident practice to protect children.</u>

Appendix 1:

ACTION PLAN FOR CHILD B1 SERIOUS CASE REVIEW (Social Care)

No.	What is the recommendation? (This should be lifted directly from the IMR)	What is the desired Aim / Outcome from the recommendation? What do we want to achieve?	How will change be achieved? What are the actions that need to take place?	Leadership Who will chase progress and be responsible for completion of the action?	Timescale By what date will the action be completed?	Outcome Measure How will you know and what difference has it made? (for agency and for children)
1	That supervision of social workers and managers both considers compliance with procedural expectations, the voice of the child and is reflective.	That all workers receive supervision that helps them reflect on complexities of a case and ensure s procedures are followed.	The supervision policy will be used with each worker on each case regularly.	All managers	Already actioned see 8.5.2	Children's case records will evidence that regular supervision has taken place, the child's voice is noted and there is reflection in relation to assessing risks and strengths.
2.	All assessments undertaken that involve domestic violence will result in advice and signposting to services and consider the impact on children	That a child's parents who suffer domestic violence receive appropriate support to help safeguard their children.	Social Workers will be provided with training in relation to the impact of domestic violence on children/.	Workforce development and Service managers CIN teams	By September 2015	Single assessments will demonstrate that parents signposted or referred to support services. Social workers will attend training
4.	The local authority will promote an assessment and intervention model that enables workers to	That all services within the organisation can work to an agreed model of practice that focuses on risks and strengths and	A model will be agreed and staff and managers trained to enable implementation.	Heads of service	April 2016	That assessments will be evidence based and plans informed by good quality assessments. Audits, MACFA will evidence.

	complete well informed assessments that focus on risk, protective factors, what needs to change and in what timeframe.	can inform good planning for children.				
5.	If a Child Protection Plan is not implemented or is not safeguarding a child the review conference must be brought forward to review the plan.	That Child Protection plans that are not 'working' will be reviewed.	The safeguarding unit will be clear in child protection conference plans that this is the expectation.	Lesley Booth Service Manager	April 2015	Audits of child protection plans. Noting at review conferences.
6	Assessments must be completed in the appropriate time frame for the individual child's needs and be informed by: a good chronology, understanding of the child and family history and multi-agency information and views. The information will be available for decision	All decision making meetings and children's plans are based on a good quality assessment.	Social workers will be given the tools and support to complete timely and good quality assessment.	Jasmine Nembhard CIN Head of Service	Has begun May 2015	Audits of single assessments Monitoring of timescales for assessments Chronologies evident in meetings and in case files.

	making and case management meetings to inform planning.					
7	Managers will be aware of the significance of case management meetings and multi-agency meetings being turning points in cases and ensure that these meetings receive the appropriate information and assessments and ensure actions from these meetings are implemented in a timescale that is appropriate to the child.	That delay is not built in to child's journeys by case management processes and actions not being completed.	At each case management meeting the implications for any delay for the child will be explicitly considered and recorded and actions taken to address these issues...	Jasmine Nembhard and Elizabeth Best	May 2015	LPM notes to record any delays and implications for the child CPC's will note any delays and the implications for the child There will be less alerts sent to CIN teams in relation to delays.
9.	Each referral taken within Duty and Advice will consider the family history and link the current and historic factors to assess current risk and need. Referrals that do not meet the threshold	That referrals for children are dealt with by the right service at the right time	That all staff working in the duty and advice service consistently provide robust referral taking.	Karen Dawson and Jasmine Nembhard	Already in place March 2015	Dip sampling Auditing of cases Less re referrals

	for social care intervention will be signposted to appropriate services to include early help packages.					
10.	Family members will be considered early in all assessments and interventions to consider if they can be coordinated to increase the protection of the child.	Families will be supported to safeguard their children within the family	The family group meeting service will be promoted within social care and early help services to maximise use in prevention.	Julie Jordan/Jackie Difolco	May 2015	The family group meeting service will have increased referrals from early help and social care.
11	Strategy discussions when a child is suspected or is likely to suffer significant harm will be held with health professionals as well as police and any other relevant agencies.	That health information will be a part of the planning at an early stage in the child's journey within social care. This will inform assessment and highlight information that is still required or interventions needed	All managers undertaking strategy discussions will be reminded of the procedures and the relevance of strategy discussions being undertaken with relevant professionals.	Jasmine Nembhard	April 2015	Reminders will be completed Audits will show strategy discussion involve other professionals Delays will be less as health information planned early to be gained.
12	The organisation will ensure that the social workers and	That social workers and managers have the support and tools to provide a	Leaders and senior managers are working with an improvement plan to address the	Leaders and Director of Children's' Services	See 8.5.1	

	managers are supported to provide good quality and safe services to children and families and that the workforce is sufficient to meet the demands of the service	good service to children and families and that there is appropriate level of workers to meet demands.	deficits that came about following organisational change.			
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Appendix 1:

ACTION PLAN FOR CHILD B1 SERIOUS CASE REVIEW
(Local Safeguarding Children Board)

No.	What is the recommendation? (This should be lifted directly from the IMR)	What is the desired Aim / Outcome from the recommendation? What do we want to achieve?	How will change be achieved? What are the actions that need to take place?	Leadership Who will chase progress and be responsible for completion of the action?	Timescale By what date will the action be completed?	Outcome Measure How will you know and what difference has it made? (for agency and for children)
1.	All practitioners will have a greater understanding of how to respond to Failure to Thrive and the links with emotional abuse and neglect	Social workers and managers will be able to recognise, assess and respond appropriately to children who are failing to thrive	A guidance tool and training will be provided for multi-agency groups of professionals	LSCB	December 2015	Guidance will be completed and training provided.
2.	Professional disagreements procedures will be initiated and escalated as appropriate if there is an unresolved disagreement about the safety of a child. The LSCB board manager will determine any required course of	That any disagreement about the safety of the child that cannot be resolved is dealt with timely and independently.	LSCB will promote the procedures and their role in resolving professional disagreements	LSCB board manager	June 2015	The procedures will be promoted with clarity about the LSCB role in resolving professional disagreements

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