Leicester Safeguarding Children Board

Serious Case Review

Nadiya

Final Version December 2018

Foreword

Response from the Chair, Leicester Safeguarding Children Board

This review was originally commission by the previous Independent Chair in February 2015. Serious case reviews are sometimes carried out when a child or young person dies or is seriously injured, neglect or abuse is suspected and there are concerns about the way agencies worked together to keep them safe. They are written by independent authors and look at the role played by any professionals involved with the child and their family, to see if lessons can be learned and ways of working can be improved.

This review relates to a baby who was taken to hospital with injuries when they were too young to have harmed themselves accidentally. The review tells a distressing story of children harmed by parents who should have been protecting them, and this has saddened us all.

All the agencies involved in these reviews accept the findings of this review. Since these cases there has been a major overhaul of the LSCB's policies and procedures, reflecting the need for all partners to work more closely together to identify early on when children are at risk. The learning from both this review and a similar Serious Case Review (Robyn 2018) carried out at the same time have identified several actions which have now been implemented by the partner agencies involved.

The guidance on non-accidental injuries in babies, pre-birth assessments and neglect has all been updated, while robust procedures have been put in place to check on the progress of child protection plans. The LSCB has also hosted learning events for other agencies.

There were also parallel processes taking place which prevented the publication of any report until they were concluded. This learning and improvement summary is now published setting out the findings and outcomes of the review and to provide assurance of the learning and improvement undertaken and its impact on current child safeguarding practice.

Jenny Myers
Independent Chair
Leicester Safeguarding Children Board

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1. Introduction

1.1. This report summarises the findings of an independently-led Serious Case Review which was commissioned by the previous Chair of Leicester Safeguarding Children Board (LSCB) in February 2015.

Background

1.2. This Serious Case Review is in respect of four children, the subject child is known as Baby Nadiya and her siblings Adrian, Jana and Mohini. The review was instigated because Nadiya was taken to hospital by their mother aged four months old with unexplained injuries to her nose and face and bite marks to her limbs. Further examinations identified a lower leg fracture, several brain haemorrhages and retinal haemorrhages in both eyes. Nadiya subsequently made a full recovery and has, since the time of the injury, been in safe and appropriately assessed care.

1.3. The older children had all been subject to Child Protection Plans from November 2011 to March 2014. All the injuries to Nadiya were believed to be non-accidental in origin and while it remains unclear how these injuries were caused, Nadiya's mother and the person with whom she was in a relationship at the time were both subsequently convicted of serious offences in relation to the child. Both the mother and her relationship partner were sentenced to several years custody.

1.4. All the children live away from their mother and respective fathers and are permanently placed with assessed and appropriate carers.

1.5. The report sets out the scope of the review, provides a brief background and synopsis of the case, and concludes by outlining the key findings and recommendations to the LSCB.

2. Scope of the Review

2.1. The Serious Case Review scope covered information regarding professional involvement with the children from August 2011 to the point of the injuries to Nadiya.

2.2. A multi-agency review panel, chaired by the lead reviewer and Composite Overview Report Author, was established at the outset. The Panel, which met on three occasions, comprised of senior leads from the following agencies and organisations:

- DNLR Community Rehabilitation Company
- DNLR National Probation Services
- Housing Services
- Leicester City CCG
- Leicester City Council
- Leicestershire Partnership NHS Trust
- Leicestershire Police
- Nursery Services
- Surestart
- University Hospitals of Leicester NHS Trust

2.3. The review process was supported by the Interim LSCB manager in post at the time, LSCB Policy Officer and an LSCB admin and business support officer.

2.4. The findings of the review have been reported to a full Board meeting of the LSCB.

3. Brief family background and synopsis of the case

3.1. Nadiya who is of dual heritage, lived at home with their mother and three siblings, their putative father remains unknown. Little was known about mother's childhood or her family background prior to the time under review. Mother reported to the police in Summer 2009 that she had been subjected to an arranged or forced marriage overseas whist still a child herself and she had returned to the UK a month later to escape her husband and found she was pregnant with Adrian. Mother later said that she had exaggerated these claims to gain assistance with housing.

3.2. Mother started a new relationship in Spring 2010 while still under the age of eighteen and heavily pregnant with Adrian. She sought help from Children's Social Care when Adrian was five months old according to the records because she feared her own Mother (MGM) would take her baby away because she perceived that she was not coping. No action was considered necessary and Mother later said she had made these allegations up to access new housing.

3.3. Mother had her second child in Summer 2011 by which time she was now an adult but was still a teenager. However, she and the father of Jana separated, most likely before Jana was born. It appears in the period just before or after she had Jana, mother started a new relationship with the assumed father of Mohini. Little is known about any of the adults or their extended family. The father of Jana lived in another local authority area and although he had parental responsibility for Jana, his family did not know about this child. The family of the father of Mohini did not know about his relationship with Mother or their child until sometime after Mohini was born.

3.4. There were significant concerns about the father of Mohini's violence to Mother. Between December 2011 and March 2013, the police received fourteen reports of domestic abuse incidents. He was arrested for assault on five occasions and Mother made allegations to the police and then retracted them and no convictions were pursued. Mother attended the emergency department with injuries on four occasions between January 2012 and March 2013. Information has become available through the process of the review that the Father of Mohini was known to a local authority Children's Social Care as a teenager as someone exposed to domestic violence.

4. Discussion of key findings

4.1. This review raises several significant and worrying practice issues which were considered in detail in the background overview report to this review. The key themes identified were:

- Ineffective Child Protection Processes
- The Investigation of Injuries - potential for physical abuse.
- Pre-birth Assessment Processes
- The Marginalisation of Fathers
- Parental risk Factors
- Working with Parental non-compliance and hostility
- Ineffective Information sharing

5. Conclusion

5.1. The four children in this Review were known to Child Protection Services for most of their early lives for neglect, poor supervision and the impact of domestic abuse. Each child was taken to hospital in a one-year period with injuries which indicated either very poor supervision or deliberate abuse. Except for the injury to Nadiya, all the other injuries received limited attention from professionals. This was not in line with expected practice as it left them all at continuing risk of harm.

5.2. Although the subject of seven Child Protection Conferences and over thirty Core Group meetings during the period under review there was not a clear and proactive Child Protection Plan in place as there was no assessment or analysis of the nature of the risks facing the children and Mother and the Father of Mohini were never challenged about their non–engagement with the very few demands made upon them within the Child Protection process.

5.3. These four children lived most of their lives in chaotic circumstances and the services provided to also mirrored that chaos as there was a lack of coordination of assessment and planning across agencies. This appears to have produced a Child Protection process which was not effective in the main goal of keeping children safe from harm and did not provide the context for any professional to deliver a high-quality service.

Could the child have been protected earlier?

5.4. There were opportunities to have acted sooner to protect the children from harm. When mother was pregnant with Nadiya, all of the siblings were subject to Child Protection Plans, and there were a number of known risk factors and a young mother who was already struggling to parent three very young children. However, there was no comprehensive pre-birth assessment to establish how mother might cope with a fourth child, or consider the risks posed by the Father of Mohini or other partners of mother living in the household.

5.5. Despite escalating concerns and increasing non-engagement, a decision was taken by all involved professionals for the siblings to no longer be subject to Child Protection Plans and thus the needs of Nadiya were not considered in a multi-agency context. This decision to remove the plans was incorrect and appears to have been influenced by the interaction of two

issues. One was workload pressures on Children's Social Care at the time and the need to reduce the number of children subject to plans and the other was the over optimism of some professionals about Mother's capacity to cope and a belief that she loved her children, and this was enough to ensure their wellbeing.

5.6. The decision not to convene a Child in Need meeting and to close the case was made probably due to the capacity issues at the time, and a mistaken belief that it would not be possible to work with parental resistance. This decision influenced the Health Visiting service which also reduced their involvement. There was no professional challenge regarding either of these decisions, despite continued concerns of some agencies, which left Nadiya and the other three children at continuing risk of harm. It took a crisis and injuries to Nadiya to ensure that all four children were effectively safeguarded despite known risks to the children due to lack of supervision, drugs and alcohol use, lifestyle and patterns of disguised compliance and behaviour that indicated neither parent placed the needs of their children as a priority.

6. Recommendations

6.1. As part of this Serious Case Review all agencies involved with the family at the time completed Information Management Reports (IMRs) on behalf of their agency and have worked to an action plan reporting on its progress at successive intervals so that the LSCB could be assured the single agency learning identified had been progressed and embedded in practice. At an Extraordinary meeting of the Serious Incident Review Group held in July 2018 each agency reported on the impact of their actions for a final time. All actions were reported as having been completed (or in some instances superseded by other reviews or structural changes) and the impact. The summary of multi-agency learning, response and assurance report was noted and acknowledged by the group. It was agreed this would form the basis of the report to Board with the learning distilled into the report for Board.

6.2. The following LSCB recommendations which were part of the original individual overview report for this case were also monitored and evaluated:

Recommendation1: The LSCB must reassure itself that all member agencies are clear about the need to fully investigate injuries to children when they are already subject to Child Protection Plans. It is important that University Hospitals of Leicester NHS Trust has a process which flags CP Plans *As described above the LSCB has received ongoing assurance regarding the need to fully investigate any injuries to children and consideration of them in the wider context of neglect or lack of supervision. There have been several revisions to the Bruising and Injuries in Babies Who Are Not Independently Mobile procedure* http://llrscb.proceduresonline.com/chapters/p_bruising_inj_babies.html*. There is a robust electronic recording system in place which allows for Child Protection flags to be added to the record. The new national pilot system CP-IS has now been launched.*

Recommendation 2: The LSCB and Children's Services need to urgently satisfy themselves that there are appropriate arrangements in place for social workers to receive good quality legal advice which is recorded and actioned.
The LSCB has received ongoing assurance regarding the arrangements in place for social workers to receive good quality legal advice which is recorded and actioned. All Children's Social Work staff have access to quality legal advice this includes the Independent Reviewing Officer (IRO) Service who can also access independent legal advice and all decisions on legal advice are recorded in case files. There is a case tracking manager who is tasked with managing the tracking system and responding to any Legal Planning Meetings that have not taken place within timescales.

Recommendation 3: The LSCB should undertake an audit of decision making regarding undertaking a pre-birth assessment and the quality of existing pre-birth assessment processes.
The LSCB has a robust system of audit and quality assurance for testing out the quality of information and response to unborn babies and has completed a full audit on the response to pre-birth assessment in March 2017 http://www.lcitylscb.org/media/1335/20170310-pre-birth-multiagency-audit-summary-v3.pdf*. There are plans in place to further test the quality of the response to unborn babies and infants in 2019-20. Through the multi-agency case audits there has been evidence of improved management oversight, practice and outcomes for children*

Recommendation 4: The LSCB should review the procedures regarding the assessment of neglect and consider whether the existing, but outdated, tools provided to the multi-agency network are fit for purpose or need updating.
The LSCB has completely reviewed and rewritten its inter-agency procedures for neglect and produced revised Neglect Practice Guidance and a bespoke Neglect Toolkit.
http://llrscb.proceduresonline.com/chapters/g_neglect.html?zoom_highlight=neglect The LSCB conducted an audit of practice in April 2017 and a survey of practitioner knowledge and confidence regarding the Neglect Toolkit in http://www.lcitylscb.org/media/1372/llr-lscb-multiagency-neglect-survey-and-audit-briefingv4-pdf.pdf. *While this has shown some improvement in identification and response to neglect it has also shown that there is further work to do in regarding to embedding the neglect practice guidance and toolkit which continues to be a priority for the LSCB.*

Recommendation 5: The LSCB should review the guidance regarding working with hostile and uncooperative parents and ensure it makes clear the process for working with families who refuse to engage with Child Protection plans and what action can and should be taken to ensure the safety and wellbeing of children.
The LSCB procedure for working with Uncooperative and Hostile Families was updated and re-launched at large scale practitioner events in September 2016. The identification of disguised compliance will continue to be reviewed as part of the quality assurance work undertaken within the LSCB thematic audit and assurance programme.
http://llrscb.proceduresonline.com/chapters/p_rel_host_fam.html?zoom_highlight=hostile

Recommendation 6: The LSCB must be satisfied that the audits of Child Protection Plans carried out by CSC in October 2015 are being embedded in practice, with a particular focus on the quality of those plans, and the actions taken when tasks and goals are not achieved.

Audits have identified where children receive consistent practice by the same social worker, plans are more focused, and outcomes are achieved in a timelier way. Senior managers within LCC CSC regularly review all children on Children Protection Plans to ensure that plans are being progressed appropriately and that progress is being made to achieve their stated outcomes in a timely way.

Recommendation 7: The LSCB must ensure that the quality improvement plan drawn up as a result of the review of the safeguarding unit is implemented in 2016 and there should be a process for reviewing whether this has improved the oversight and actions by the Independent Chairs of the quality of Child Protection Plans.
The LSCB has through its participation in the Leicester City Children's Improvement Board (LCCIB) throughout 2016-2017 challenged and sought assurance regarding the oversight and actions taken by the Independent Chairs to improve the quality of Child Protection Plans. The LSCB Performance, Analysis and Assurance Group (PAAG) have received regular assurance regarding the multi-agency aspects of the Child Protection process and the process for monitoring and escalating any concerns about the Child Protection Conference or core group process. This has shown evidence of the quality of oversight, actions and escalations within the Child Protection Conference Service.

Recommendation 8: The LSCB and CSC should put in place a process of review at a senior level when children have been subject to Child Protection Plans for more than two years.
The LSCB has as a key performance measure the outcomes for children who have been subject to a Child Protection plan for over two years this has also been monitored through the LCCIB Performance Book. The LCC CSC have implemented a process where senior managers review all cases prior to the two-year point which can include a Signs of Safety mapping approach to test for any drift or delay in achieving the stated outcomes for children.

Recommendation 9: The LSCB should ensure that all agencies review their recording arrangements in the context of Child Protection processes. This is particularly important for Housing Association which evidenced poor recording practices.
All agencies have provided assurance and evidence to the LSCB that they have reviewed their own agencies recording practices and the standard of recording is compliant with the LLR Multi-agency safeguarding procedures. The housing provider has provided assurance that all information on safeguarding practice including recording standards is up to date and that staff and managers are briefed on this and compliant with the expectations.

In conclusion, there has been much scrutiny and challenge over the last four years and recognition from Ofsted and other external partners that a lot of progress has been made in improving the multi-agency safeguarding system for children including the identification of neglect, physical abuse, the quality of Child Protection plans and escalation protocol. Consistency of approach and response going forwards is important and the implementation of the Signs of Safety model by the Local Authority and sign up to this by the LSCB partners is one of the ways the system is evolving and improving in Leicester City.

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Leicester City, Leicestershire and Rutland Local Safeguarding Children Boards Procedures Manual (undated) http://llrscb.proceduresonline.com/

Glossary of Abbreviations

CiN - Child in Need

CPC - Child Protection Conference

CPP - Child Protection Plan

GP - General Practitioner

IMR - Individual Management Review

LSCB - Leicester Safeguarding Children Board