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1. INTRODUCTION

1.1.1 Introduction to the circumstances
In early August 2013 three children from the same family, Sibling 1, Sibling 2 and Sibling 3, aged 7, 6 and 4 were made the subject of Police Protection by Norfolk Constabulary following a visit to the family home by the Social Worker SW4 and they were accommodated under Section 20 of the Children Act 1989. The Police and Social Worker were very concerned at the physical state of the property the children were living in, which was judged to be neglectful, placing the children at risk of significant harm. Prior to this event the three children had been the subject of Child Protection Plans from March 2009 until January 2010 as there were significant concerns about their parents’ ability to meet their needs, maintain appropriate standards of physical care, prioritise the children’s needs over their own and maintain an appropriate emotional environment for the children.

1.1.2 A joint investigation took place by Children’s Social Care and Norfolk Constabulary and the children were placed in foster care. Although a decision was taken to initiate care proceedings the matter was not placed before the Court until 13-11-2013. In the intervening period the parents Father N and Mother N had refused to consent to further Achieving Best Evidence (ABE) interviews of the children and had also refused to allow the children to move schools even though this resulted in the children not attending school until after the initial Court hearing.

1.1.3 The CAFCASS Children’s Guardian was very concerned about the manner in which the children’s situation had been responded to both before the removal under Police Protection and subsequently once in foster care. The Guardian requested that Norfolk Local Safeguarding Children Board undertake a Serious Case Review to consider what lessons could be learnt from the situation. Once in foster care it became clear that the cumulative impact of the neglectful care that the children had suffered was both significant and potentially long lasting in terms of their physical health and emotional wellbeing.

1.1.4 Initially Norfolk Safeguarding Children Board agreed the situation should be looked at via an internal review as there were believed to be some learning opportunities within the case. However, the matter was referred to the National Panel of Independent Experts on Serious Case Reviews who advised that the case did meet the criteria for a Serious Case Review and Norfolk
Safeguarding Children Board agreed to commission a review using the Significant Incident Learning Process (SILP) methodology.

1.2. Introduction to Serious Case Reviews and SILP

1.2.1 SILP is a learning model which engages frontline staff and their managers in reviewing cases, focusing on why those involved acted in a certain way at the time. This way of reviewing is encouraged and supported in the Working Together to Safeguard Children guidance published in March 2013.

1.2.2 The SILP model of review adheres to the principles of:
- Proportionality;
- learning from good practice;
- the active engagement of practitioners;
- engaging with families, and;
- systems methodology.

1.2.3 It has been generally accepted that over recent years the Serious Case Review agenda had become over-bureaucratic and driven by Ofsted ratings. The practitioners in the cases have often been marginalised and their potentially valuable contribution to the learning has often been under-valued and under-utilised.

1.2.4 SILPs are characterised by a large number of practitioners, managers and Safeguarding Leads coming together for a learning event. All agency reports are shared in advance and the perspectives and opinions of all those involved are discussed and valued. The same group then come together again to study and debate the first draft of the Overview Report.

1.2.5 Norfolk Safeguarding Children Board have requested that the SILP model of review be used to consider the circumstances surrounding the three children who were made the subject of Police Protection under Section 46 of the Children Act 1989 in early August 2013, in order to learn lessons about the way that agencies in Norfolk work together to safeguard children.

1.2.6 Working Together 2013 states that SCRs and other case reviews should be conducted in a way which;
recognises the complex circumstances in which professionals work together to safeguard children; seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;

- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

1.2.7 This serious case review has been undertaken in a way that ensures these principles have been followed.

1.3 Introduction to the Lead Reviewer.
Phil Smith is an Independent Consultant Social Worker, Manager and Trainer having worked in both the public and independent sectors. He has 20 years safeguarding experience in safeguarding social work and management (both operational and strategic) including management of allegations against adults who work with children, serious case reviews, procedure writing, managing and dealing with complaints and complex legal work.

1.4 Introduction to the Process
1.4.1 Following the decision of the Independent Chair of Norfolk Safeguarding Children Board to commission a Serious Case Review the process involved an initial Scoping Meeting and the drafting of the Terms of Reference, a Project Plan and an Agency Report Template. These were agreed with the Independent Chair and Serious Case Review Sub Committee of Norfolk Safeguarding Children Board. Agency Reports were requested from Children’s Social Care, Norfolk Constabulary, Norfolk Community Health Care, Health (General Practice), Education, CAFCASS and Early Years. An initial Learning Event for practitioners, authors and managers was held on 15-10-2014 and a Re-Call Day for practitioners, authors and managers to discuss the initial draft report was held 19-11-2014. Both days had around 25 participants.

1.4.2 The specific scope of the Serious Case Review was agreed to include the three children Sibling 1, Sibling 2 and Sibling 3 and their parents Father N and Mother N. The time period was agreed to be 18-02-2009 the date of the Strategy Meeting that led to the Child Protection Conference and 18-11-2013 the date when the children commenced the new school. It was also agreed that any significant safeguarding issues regarding both parents and children prior to 18-02-2009 should be reviewed and any learning points highlighted. In addition there would be
generic analysis highlighting good practice, effective interagency working, identifying any missed opportunities and evaluating how effectively the children’s voices had been heard. It was also agreed that specific focus would be given to:

- How effectively historical information about the father was used,
- Whether the step-down process from Child Protection to Child in Need to case closure was effective,
- How effective were agencies at working with these hostile and resistant parents,
- And why were consent issues allowed to hold up what was in the best interests of the children.

2. FAMILY BACKGROUND AND HISTORY.

Family details;
The children –
   Sibling 1 born summer 2006 male
   Sibling 2 born summer 2007 female
   Sibling 3 born autumn 2008 female.

Father N had had two previous relationships the first with Ex-Partner 1 and a second relationship with Ex-Partner 2. Father N and Ex-Partner 1 had three children together Half-Sister 1, Half-Brother 1 and Half-Sister 2. Due to concerns about parenting their children were removed and Half-Sister 1 and Half-Brother 1 spent time in foster care whilst Half-Sister 2 was adopted. Father N subsequently had a relationship with Ex-Partner 2. Concerns were raised about Father N’s violent behaviour towards her 3 children and the influence of Ex-Partner 1 on their relationship. Mother N is not believed to have had any significant relationships prior to her relationship with Father N. However, there was involvement with her family due to concerns about sexual abuse, although it was not substantiated that Mother N was a victim of sexual abuse. The alleged perpetrator, XX, came into contact with Mother N in June 2010.

A genogram is included below:
3. PARENTAL INVOLVEMENT

As part of the Serious Case Review process both parents were consulted separately by Phil Smith and Abigail McGarry the Norfolk Safeguarding Children Board Manager. The mother was visited on 12-11-2014 and the father was visited on 18-11-2014. The purpose of the interviews was to explain the Serious Case Review process and to obtain their views on the services they and their children received. The interviews were an opportunity for them to express their opinion about how well the agencies worked together and worked with them and the children. Prior to the meetings both parents received information explaining the purpose of the meetings. A summary of their views is contained in Section 6.

4. KEY EVENTS WITH ANALYSIS IN THE PRE-SCOPING PERIOD Before 18-02-2009

4.1 On 24-04-2006 an initial pre-birth Child Protection Conference was convened in relation to the first child, Sibling 1, following a referral from the midwife and the Health Visitor. The full history of both parents is reported to have been available to the conference. This included information about the sexual abuse experienced by Mother N as a child from within her family, the subsequent involvement of Children’s Social Care under child protection procedures and that Mother N was subject to a child protection plan for a period of time. It was also known that Father N had had three children removed from his care due to child protection concerns.

4.2 The decision was reached that a child protection plan was not needed and it was agreed that a family support plan under Section 17 of the Children Act 1989 should be put in place. There
then followed a period between this conference and 13-08-2008 when the main professional involvement with the family was on the part of the Health Visitor. This was characterised by high intervention health visiting (a visit every two weeks) and the limited involvement of Children’s Social Care. It is worthy of note that following Sibling 1’s birth there was felt to be evidence of a warm relationship between Father N, Mother N and their son.

4.3 The Health Visitor attempted to work with the family under the Common Assessment Framework (CAF) process. Children’s Social Care involvement ceased in November 2006 until 12-03-2008 when an initial assessment was undertaken. During this period Sibling 2 was born in summer 2007 and some concerns were noted in relation to Mother N’s ability to relate to her children; it was noted that her eye contact with them was poor, she did not appear to tune into their needs easily, there were few toys in the house and Sibling 2’s weight was “static” meaning that she was not gaining weight appropriately.

Comment

The picture drawn from the involvement of agencies between Sibling 1’s birth and the initial assessment undertaken by Children’s Social Care 13-08-2008 is one of parents struggling to meet the needs of their children. It seems entirely appropriate that an initial child protection conference was held prior to Sibling 1’s birth on the basis of the concerns about the parents’ history and its potential impact on their ability to parent appropriately. The decision of the meeting to work with the parents under Section 17 of the Children Act 1989 does not seem inappropriate. There are comments about Father N’s hostility towards professionals during this period and an accumulation of concerns that suggest Mother N in particular was struggling to cope with the pressure of caring for two children under two years old. This pressure would have been added to further as her pregnancy with Sibling 3 progressed throughout 2008. The ages of both mother and father, he being 39 when Sibling 1 was born and mother being 18, are noted in the agency reports, but no specific conclusions are drawn other than the obvious fact that there was a clear age difference.

4.4 There were two initial assessments in 2008 undertaken by Children’s Social Care, the first in March was in response to a referral from a neighbour alleging “unacceptable parenting”, although there is no clarity what the neighbour specifically meant by this phrase. Prior to the initial assessment the Health Visitor had increasing concerns about the home environment, Mother N’s ability to respond to the children’s needs, Sibling 2’s static weight and Mother N’s
failure to take Sibling 2 to the GP when unwell. The home environment was described as physically cold, with few toys and concerns about Mother N smacking Sibling 1 and always “saying no”.

4.5 Following the initial assessment, the family received support from the Health Visitor and a small voluntary agency which worked with pregnant teenagers and teenage mums. However, the Health Visitor continued to have concerns about the ability of Mother N and Father N to meet the needs of Siblings 1 and 2. In April 2008 it was discovered that Sibling 2 was not being fed weaning foods and Father N is reported to have become very angry at the suggestion of further work under CAF.

4.6 By July 2008 the Health Visitor was concerned that the situation was not improving and that Mother N’s parenting was increasingly concerning. A particular example is the report that Mother N described Sibling 1 to the Health Visitor as “a little shit” and Mother N was seen as deferring to Father N’s views. Additionally Father N’s son by a previous relationship, Half-Brother 1, was staying with the family, in spite of the fact that he was known to pose a risk to children. There were also reports that Mother N was seen smacking Sibling 1 on the head and legs and a report from a neighbour expressing concern about a child crying and a man shouting loudly and aggressively at him. In response to the Health Visitor’s concerns a professionals meeting was arranged and subsequently Children’s Social Care agreed to undertake a further initial assessment.

4.7 The second initial assessment in August 2008 was much broader in focus and reflected the escalation of the concerns about the children’s welfare and the concerns about the care and parenting the children were receiving. The initial assessment was undertaken by SW1 who identified the broad range of issues;
- the hostility of Father N towards professionals;
- Mother N’s inability to maintain an appropriate level of care for both Sibling 1 and Sibling 2;
- Mother N’s apparent poor attachment to Sibling 1 and the level of emotional distress as demonstrated by his tantrums.

Whilst both children’s growth and development was recorded as normal, the conclusion was reached that Mother N needed help to understand the children’s medical needs and that the arrival of the third child would complicate an already difficult situation. SW1 also noted that Half-Brother 1 was having contact with the family as was his mother Ex-Partner 1, Father N’s
previous partner. It was whilst Ex-Partner 1 and Father N were in a relationship that they had had their three children removed (including Half-Brother 1) due to child protection concerns. Ex-Partner 1 was reported to be caring for Sibling 1 at times.

Comment

*It is possible to be critical of the first initial assessment for simply focusing on the concerns raised by the referrer and not looking at the situation and the welfare of Siblings 1 and 2 as a whole. It was a missed opportunity for another pair of eyes to look at the whole situation. In light of the full history and the concerns reported in the referral, it should have been used as an opportunity to consider whether more than intervention under Section 17 of the Children Act 1989 was required. This should have been picked up by the managerial process, when the Initial Assessment was reviewed and signed off by a manager. The case was closed on the basis that the Health Visitor would re-refer if necessary. The ongoing involvement of the Health Visitor did provide continuity, but the concerns increased further between March 2008 and August 2008, leading to a further referral. The second initial assessment was broader in scope and led to ongoing involvement from Children’s Social Care until the commencement of the Child Protection process in February 2009.*

4.8 The period between the second initial assessment in August 2008 and the referral by SW1 to the Police on 18-02-2009 was characterised by further concerns being raised about the care and parenting received by Siblings 1 and 2 and the birth of Sibling 3. There were reports of Sibling 1 being slapped by his mother (he was by now just over two years old) and the Health Visitor also found Ex-Partner 1 caring for the children in the absence of Father N and Mother N and further reports of adults shouting and swearing at the children.

4.9 Whilst in January 2009 there were positive reports from home visits by Children’s Social Care Support Workers about the house being warm and clean and Father N cooperating with professionals working with him, however concerns were again raised by the Health Visitor and by Children’s Social Care Support Workers in February 2009. Father N’s relationship with the new Health Visitor deteriorated, concerns about Mother N’s bonding with the baby, Sibling 3, and not taking the baby to the GP when prompted to do so by the Health Visitor. This led to SW1 referring the situation to the Police for a multi-agency discussion.
Comment

At this point the majority of the involvement with the family had been with the Health Visitor and additional family support work by Children’s Social Care under Section 17 Children Act 1989. The case had been open to Children’s Social Care for three periods from the Initial Child Protection Conference in April 2006 till November 2006, for the Initial Assessment in March 2008 and then again for the Initial Assessment in August 2008 until the multi-agency meeting in February 2009. Throughout this period there were concerns about the quality of care provided by Father N and Mother N for their children and the ability of Father N to work with professionals. At times there is evidence of improvement, but the overall impressions is that Father and Mother were struggling to maintain an appropriate standard of care and that this was exacerbated by Father N’s difficulty working with professionals. It is also worthy of note that the family moved house twice during this period. Whilst it was known that Father N had had three children removed from his care during his relationship with Ex-Partner 1, the reasons for their removal were not known by all professionals involved with the family. There is no evidence that the negative impact of Ex-Partner 1’s ongoing involvement with Father N and his new family was evaluated. In the absence of this, it would not be possible to assess holistically whether the factors that had led to the removal of children from their care were still present. This is particularly significant in the light of Ward et al (2012) who state:

“….losing a child to adoption or special guardianship also had a major, ongoing impact on parents’ subsequent functioning, for it had left them with an enduring sense of shame and loss”. (p 60).

5. KEY PRACTICE EPISODES AND EVENTS WITH ANALYSIS IN THE SCOPING PERIOD

5.1 Context

This section now addresses events and episodes within the scoped period from 18-02-2009 (the date of the Strategy Meeting between the Police and Children’s Social Care) to 18-11-2013 (the date the children commenced attending their new school after coming into foster care). At the beginning of this period the family were living in town A and Sibling 1 began attending Primary School 1 in September 2010. He was joined by Sibling 2 in September 2011. The family moved to town B in Norfolk in June 2012 and the children moved to Primary School 2. Sibling 3 began nursery at Primary School 2 in September 2012.
5.2 Key Practice Episode 1 Joint working under Child Protection Procedures from 18-02-2009 to 25-01-2010 (the date of the Review Child Protection Conference when the decision was made to end the children’s Child Protection Plans).

The period covered by work under Child Protection Procedures can be split into two parts. The first period was up until 21-05-2009, during which SW1 was the allocated Social Worker. The second period was from 21-05-2009 until 25-01-2010 (the date of the Review Child Protection Conference), during which the case was initially allocated to the Team Manager TM1 and then allocated to the Social Worker SW2.

5.3 The Initial Child Protection Conference took place 17-03-2009 and was attended by all the relevant professionals. There were representatives from the Police, the Health Visiting Service and Children’s Social Care and the other agencies involved in supporting the family. The Conference decided unanimously that the children should all be made the subject of Child Protection Plans due to the likelihood of neglect. The information and analysis provided for the Conference by SW1 presented a good evaluation of the risks which included neglect of the children’s basic health and emotional needs, poor and distorted attachments between the parents and the children, the history of abuse in Mother N’s childhood and the volatility of Father N and his lack of cooperation with professionals. The differential in age and power between Father and Mother was also highlighted as was the continued involvement of Ex-Partner 1, Father N’s previous partner with the family. It was during Father N’s and Ex-Partner 1’s relationship that Ex-Partner 1’s three children were removed from their care.

5.4 A Child Protection Plan was drawn up that addressed all the areas of concern, set out the expectations of parents and professionals and included the need for a formal parenting assessment and a paediatric assessment of the children. In addition Father and Mother were offered therapeutic support in relation to their own experiences and Father N was offered the continued support of a father’s group. Following the conference there was a period when both Father and Mother appeared to engage with the Child Protection Plan and the support that was being offered to them. The specific support offered by the Health Visitor and Parent – Infant Mental Health Psychologist is worthy of particular note as they provided six sessions of in-depth observation and intervention with parenting. This was potentially a very positive piece of work, but was dependent on the engagement of the Father and Mother. Regrettably it became clear that this support was not going to be taken up.
5.5 However, Father N and Mother N’s cooperation with the Child Protection Plan declined towards the end of April and through May 2009. Father N became angry with the report for the Review Child Protection Conference which highlighted some of the aspects of parenting that they were having difficulty with. Thus by the Review Child Protection Conference in June 2009 he was refusing to have further involvement with the Psychologist. In addition SW1 had left Children’s Social Care and the case had been reallocated to TM1 in the absence of an appropriately experienced social worker.

5.6 At the Review Child Protection Conference on 26-06-2009 some positives were noted, namely that the Paediatric Assessment completed in March 2009 had concluded that the children were reasonably well cared for and in early April an orthoptics examination concluded that there was no evidence of Sibling 2’s squint. (It is important to note that the Paediatric Assessment was based on the physical examination of the children on a specific day, supported by information from birth parents and information contained in medical records). Siblings 1 and 2 were reported to be benefitting from nursery and the Home Based Care Assistant continued to visit the family twice per week and SW1 continued to monitor for signs of neglect. The Review Child Protection Conference also noted that the parenting assessment had not been completed as the case had been allocated to TM1 and that the work with the Parent – Infant Mental Health Psychologist had ceased due to Father N’s aggression and hostility.

5.7 Following the Review Child Protection Conference the case was allocated to TM1, although an agreement was reached that the Parenting Assessment would be undertaken by workers from Family Centre 1. Within a month, Father N had again begun to disengage with the workers from Family Centre 1.

5.8 The second Review Child Protection Conference 17-11-2009 noted that the Parenting Assessment by Family Centre 1 had been abandoned following an incident on 10-11-2009 when Father N had threatened one of the workers. The children had been present during this incident. It is not clear if any supportive action was taken in respect of the workers involved. However, Nursery 1 reported to the Review Conference that all three of the children were settled in Nursery; Siblings 1 and 2 appeared to enjoy it and Sibling 3 was content and smiley. Nursery 1 also reported that Mother and Father appeared to have a positive relationship with the children and there were no concerns about the basic care they provided. It was noted that the children were meeting their developmental milestones. Furthermore it was believed that Mother and
Father had not allowed Ex-Partner 1 to have any contact with the children. The Review Child Protection Conference concluded that the Parenting Assessment should be completed by SW2 as soon as possible and expressed concern about the potential emotional impact on the three children of witnessing aggressive behaviour by AN.

5.9 The third Review Child Protection Conference was held on 26-01-2010. At the conclusion of this Conference the decision was taken that the children no longer needed to be the subject of Child Protection Plans on the basis that the parenting assessment had been completed. This was a unanimous decision of all the professionals, SW1, HV2, the Manager of Nursery 1 and the Family Based Care Assistant. The Review Child Protection Conference heard that there were no concerns about basic care or guidance and boundaries provided by Father and Mother and positive attachments and emotional warmth had been observed between the parents and the children. It was also noted that Ex-Partner 1 was not believed to have visited the family or had any involvement with the children. The children were attending Nursery 1 regularly and consistently. Sibling 3 was described as happy and content, Sibling 2 as bubbly and her language skills were developing well and Sibling 1 was described as a bright, happy and articulate boy who was becoming more independent and confident.

5.10 The Conference also heard that the family would continue to receive support from the Home Based Support Team, but the visits would reduce to once per week. In addition, a play worker had provided information and support to the parents and Mother N was due to start attending a group with Sibling 3. It was stressed to Mother and Father that they needed to accept support from professionals and to give priority to the children’s needs. The Conference concluded that a further period of work under Section 17 of the Children Act 1989 was required and it was agreed that the case should remain open to Children’s Social Care for a further 6 months at least and only be closed with the agreement of all professionals involved.

5.11 Systemic Learning from Key Practice Episode 1
The initial part of the work with the family whilst the case was allocated to SW1 appears to have been effective in identifying the risks in relation to the children and trying to address the risks with a coordinated plan of work with the parents. During the Learning Event one of the clear themes that emerged was the difficulty of working with Father N. The observation was made that non-challenging professionals were accepted by Father N, but challenging professionals became the target of aggression. Thus work with the family by SW1 and by the Health Visitor
and Parent – Infant Mental Health Psychologist particularly the latter was always going to be
difficult. The work undertaken by Family Centre 1 also ran into difficulties due to Father N’s
behaviour. It is unsurprising that the work was not completed by either the Parent - Infant
Mental Health Psychologist or Family Centre 1 and ultimately the parenting assessment was
completed by the allocated Social Worker and with assistance from the Family Based Care
Assistant. Why was Father N behaving like this and what was the appropriate response? Ward
et al (2012) describe the relevance of parent’s history;

“Many of the parents found their own experiences of abuse were difficult to overcome and
impacted, both in terms of poor parenting skills and lack of confidence, on their own
parenting capacity” (p53)

Again observations made during the Learning Event are helpful in this regard as it was
understood that Father N had had very difficult childhood and may himself have suffered
physical abuse as a child. Both Father and Mother were not receptive to feedback, Father N was
controlling as a parent whereas Mother N was often unresponsive and overwhelmed.

5.12 Whilst understanding what may cause Father N to respond with aggression and explain
Mother N’s behaviour, it is important to understand how to continue to work in such situations.
Ofsted (2014) suggests a range of practical measures to support effective engagement including
working alongside adult workers, using (clear and robust) written agreements to make it clear
what was expected of parents, arranging transport to meetings and arranging meetings at times
convenient for the parents. Ultimately in cases of non-compliance Ofsted (2014) suggest use of
the Public Law Outline (advising the family that the Local Authority would resort to legal action)
to form an agreement with parents. However, it could be argued that without understanding
Father N’s history and working with him to address his history, any change was unlikely to
happen. Featherstone et al (2014) support this view;

“...although parents and parenting capacity are seen as critical in terms of impacting on
children’s welfare, an irony of the current policy and practice climate is how little attempt is
made to understand parents as people, men and women, mothers and fathers, and what
they want from each other and how we can support more hopeful relationships between
them”. (p114)

5.13 There are several themes to be reflected upon during the period May 2009 to 26-01-2010
the date of the Review Child Protection Conference when the children’s plans were ended. The
first is the appropriateness of allocating the case to TM1. The Agency Report from Children
Social Care suggests that this was due to understaffing. Furthermore SW2 suggested when interviewed that TM1 believed that Mother N could parent given the appropriate support. During the Learning Event it was suggested that the context for this social work team at the time (mid 2009) was very challenging. There were insufficient number of appropriately experienced staff to whom complex child protection cases could be allocated. That being said, it is not appropriate for a child protection case to be allocated to a Team Manager and whilst the actions of the individual manager could be explained in the given context, this should be viewed as a strategic organisational problem and an appropriate frontline managerial response should be identified and supported at the highest strategic level within Children’s Social Care. A further consequence of a Team Manager having a case allocated is this undermines the role of supervision unless the Team Manager is benefitting from direct casework supervision from another manager. Reflective analysis of social work case work through supervision requires critical distance from the situation by the supervisor. That critical distance is lost by allocation to a Team Manager in the absence of supervision.

5.14 It would appear that whilst the case was allocated to TM1 there was some drift. The Review Child Protection Conference should have taken place on 01-06-2009, but was re-scheduled due to lack of information from Children’s Social Care and the one of the Core Groups was cancelled as TM1 was not available. Although the case was allocated to SW2 in mid-September 2009, TM1 continued to work the case. SW2 suggested to the Agency Report author that TM1 had built up a positive relationship with the family who believed that Mother N could parent well given the right support. It is possible now with the benefit of hindsight to view this as overly optimistic, although the reasons for this are not clear and TM1 is no longer with the Local Authority.

5.15 It is also pertinent to ask why the Child Protection Plans were ended at the Review Child Protection Conference on 26-01-2010 and to question the appropriateness of this decision. At the Practitioner Recall Day 18-11-2014 it was confirmed that the parenting assessment was based on visits and observations by SW2 and the Family Based Care Assistant. No concerns were raised about basic care, guidance or boundaries. Positive attachment, stable routines and emotional warmth had been observed. In addition the Conference Chair’s Report demonstrates that information from the Family Based Care Assistant, information from Nursery 1 and from Health Visitor 2 about the parenting capacity of Mother and Father was discussed. It was the collective multi-agency view that there was no longer a need for Child Protection Plans. In other
words the members of the Conference made a decision about the need for Child Protection Plans on the basis of evidence. To criticise this decision does not seem appropriate. It is a decision that was made in good faith by a multi-agency group on the basis of the evidence they had before them. The need for Mother and Father to continue to cooperate with professionals in the interests of their children was clearly stated in the Conference, evidence that their ongoing cooperation remained a matter of concern to those present. It was recommended that the case remain open to Children’s Social Care under Section 17 Children Act 1989 for a further 6 months as a contingency plan and that Father and Mother should continue to prioritise their children’s needs and accept advice and support from professionals. The decision of the Conference could have been enhanced further by setting out steps to be taken in the event that Mother and Father did not do this.

5.16 Key Practice Episode 2 Children’s Social Care involvement under Section 17 of the Children Act 1989 until 01-09-2010.

During this period the involvement of Health Visitor 2 continued, the children continued to attend Nursery 1 and SW2 undertook home visits. Two particular matters stand out during this period, the involvement with the family of extended family members and a specific incident that was not dealt with and responded to appropriately. This latter incident was a report from Nursery 1 to Children’s Social Care on 15-02-2010 that Sibling 1 had told a Nursery Worker that daddy wee’d on him in bed but is not naughty. This was part of broader conversation about how the children were getting on at Nursery 1. There was considerable discussion at the Learning Event about this comment, particularly in the light of the subsequent allegations of sexual abuse made by Sibling 1. SW2 has no memory of this comment, but the collective view from the Learning Event was that this was potentially very concerning, had been missed and should have prompted a Strategy Discussion with the Police and a visit to speak to Sibling 1 on his own as part of a Joint Investigation. The comment was only shared with Children’s Social Care and had remained in a set of case notes detailing the feedback from Nursery 1. The consensus from the Learning Event was that this should have been investigated at the time.

5.17 The second matter from this period was the involvement of two members of the extended family and the impact of contact with them on the emotional environment and dynamics within the household. The first of these, Half-Sister 1, was Father N’s daughter with Ex-Partner 1. She moved into the family home at the end of February 2010. Half-Sister 1 was one of the children who had been removed from Father N and Ex-Partner 1’s care. Half-Sister 1’s stay in the family
home lasted until mid-April 2010 when she moved out following an argument. The second extended family member was XX. He was a male member of Mother N’s family and had been allegedly involved in sexual abuse within her family most notably against Mother N’s sister. Mother N reported in mid-June that XX had been following her. XX’s involvement with Mother and Father lasted only a few days and ended with an allegation of assault by XX on Father N.

5.18 Systemic Learning from Key Practice Episode 2
As highlighted above the Practitioners attending the Learning Event were concerned that the comment made by Sibling 1 and reported to Children’s Social Care on 15-02-2010 by Nursery 1 was in effect a missed opportunity. It was suggested that the situation in the family at the time appeared to be positive and that the potential significance of this statement was therefore overlooked. Clearly Nursery 1 believed correctly that this should have been passed onto Children’s Social Care. What is not clear is why at the time this was shared Children’s Social Care, the comment’s potential significance was overlooked.

5.19 The involvement of extended family members with Mother and Father simply raises the question of the external pressures from family connections that impact on the three children’s home life and the ability of their parents to focus on meeting their needs. At the Practitioner Recall Day it was noted that Half-Sister 1’s presence in the household had at times a positive impact and that she had a good relationship with the three children. Her departure following an argument underlines that point that her presence could also have a negative impact adding to the pressure that Mother and Father were experiencing. Half-Sister 1 and XX were not two extended family members who arrived to provide support, but were two family members bringing additional stresses to the household.

5.20 Key Practice Episode 3 Information Sharing and Assessment (from Case Closed 01-09-2010 to the referral to Children’s Social Care on 06-03-2013).
This next period from September 2010 to March 2013 included the time when Siblings 1 and 2 attended Primary School 1, moved to Primary School 2 and Children’s Social Care continued to support the family with Nursery placements for Siblings 2 and 3. There were three referrals to Children’s Social Care. Information sharing between agencies is a key element of this period as well as the interpretation of the information.
5.21 During the Learning Event there was a lengthy discussion about Sibling 1’s attendance at Primary School 1 and the school’s relationship with Father N. The School shared that Sibling 1 presented as a lovely boy who made friends easily. Sibling 1 had attended the intake process prior to the summer holidays and presented at school as receptive to learning and well behaved. Primary School 1 were completely unaware of Sibling 1’s history and the history of his family’s involvement with Children’s Social Care. By the time that Sibling 1 began attending school Children’s Service had closed the case, although they were still paying for the nursery placements for Siblings 2 and 3. Had the children still been subject to Child Protection Plans, information would automatically have been shared with school, since 26-01-2010 the case had been a “Child in Need Section 17 of the Children Act 1989 case”. Consequently there was no automatic sharing of information without the consent of Father and Mother.

5.22 During the period that Siblings 1 and 2 attended Primary School 1 there were a number of incidents when Father N behaved aggressively towards members of staff. (Sibling 2 began attending in September 2011). The incidents involving Father N culminated in the Local Authority writing to him in March 2012 and advising him that he was not allowed onto school premises for one school term. Clearly Father N’s behaviour towards professionals had not changed in any way. The children left Primary School 1 in June 2012 when the family moved from town A to another town in Norfolk.

5.23 There were also two recorded incidents at Primary School 1 when the children were very hungry at school. The first incident in November 2010 involved Sibling 1 and the second involved both Sibling 1 and Sibling 2 in December 2011. Following the second incident the children were offered free places at the school breakfast club. On neither occasion were these incidents referred to Children’s Social Care and in the Education Agency Report it states that both were regarded as low level concerns. Had Primary School 1 been aware of the previous history, then these two incidents, coupled with their concern about the inappropriate and aggressive behaviour of Father N towards staff, a referral to Children’s Social Care may have been made.

5.24 Of the three referrals received by Children’s Social Care the first was a form completed by the Police following their attendance at a domestic incident to a household with children. (The form is known by Norfolk Constabulary as a C39d Child at Risk form). The incident was on 30-01-2011 and Children’s Social Care received the form 02-02-2011. The incident was a verbal
argument between Mother and Father. It advised that Father N had lost his job and the situation in the household was strained. The children had been asleep upstairs when the Police attended. In response Children’s Social Care decided to write to Father and Mother advising them of the potentially damaging emotional effect on children of domestic arguments. There is no record that Children’s Service considered the potential impact on the family of Father N losing his job, although it is now possible to see the potential significance of this information albeit with the benefit of hindsight.

5.25 The second referral was also a C39d dated 23-03-2011 and followed the Police responding to a report that the children at the family’s address were shouting “help, help” from the letterbox. In addition it was reported that there were raised voices and shouting from the address and the mother had been seen and heard in public shouting and swearing at the children and dragging them violently by their arms. The Police did not attend the address, but made enquiries at Primary School 1 and were informed that Sibling 1 lived at the address and about the school’s concerns regarding whether Sibling 1 was being fed appropriately. Mother N had reported to Primary School 1 that Sibling 1 took food from the cupboards at home. Children’s Social Care responded to this incident by undertaking an Initial Assessment completed 03-05-2011. The length of delay is accounted for by the family not being at home when the social worker first visited. Sibling 1 was asked about shouting through the letterbox but stated he could not remember it. Sibling 1 also spoke about eating breakfast, other meals and spoke positively about his parents and the household routines. The house including the bedrooms was described as clean and tidy and there was plenty of food. Checks were undertaken with Primary School 1 and Health, and Children’s Social Care then closed the case believing that the improvements had been sustained since the previous involvement. The only concern noted was that Sibling 3 had not had her two year developmental check by the Health Visitor. The family had been sent a standard reminder letter about this.

5.26 The third referral to Children’s Social Care took place 09-05-2011 when Sibling 2 was asked at Nursery 1 about the red marks on her ankle, she responded that “daddy did it”. Sibling 2 went on to say that “he did it with his teeth, he bit me on the leg, back and arm and he smacked me”. A Strategy Discussion was held the following day 10-05-2011 between the Police and Children’s Social Care and a Joint Investigation initiated. The Police and Social Worker saw Sibling 2 at the family home as she was not at Nursery 10-05-2011. Sibling 2 was described as being very relaxed in the company of her parents and the home was described as clean and
appropriately furnished. Father and Mother readily showed the Police Officer (DC4) and Social Worker (SW3) Sibling 2’s legs, back and tummy. The Norfolk Constabulary Agency Report gives the following detail;

“DC4 recorded that they saw numerous marks that were very clearly insect bite marks and that they was no evidence of any other injuries.”

Similarly the Children’s Social Care Agency Report states that Sibling 2 had bites to her lower legs/ankles and some on her torso both front and back. The Report goes on to give the following detail;

“All were small round red raised areas, some of which looked quite angry and itchy.....They were clearly insect bites.....”

DC4 and SW3 both concluded from looking at the red marks that they were insect bites and it was decided that no further action would be taken. No medical assessment of the marks was undertaken. The Social Worker (SW3) stated that this was a very difficult period following a re-organization when the amount of time allowed for each assessment was very limited due to the pressure of work. SW3 stated that she believed the assessments undertaken at that time were mere snapshots and did not allow for comprehensive consideration of situations and a child’s history. This was the last contact between Children’s Social Care and the children until 06-03-2013.

5.27 During the next almost two years the children received routine Health support and in June 2012 move from town A to town B and Primary School 1 to Primary School 2. In September 2012 Sibling 1 attended the GP Surgery with his mother who complained about Sibling 1’s behaviour tantrums. There is a further visit in November 2012 which resulted in a joint visit to the family by the Health Visitor and the Child and Adolescent Mental Health Service (CAMHS) Worker. The family had begun to suggest that Sibling 1’s behaviour was obsessive. Primary School 2 learnt about this and contacted the GP and Father N to confirm that the behaviours reported were not present in school. Mother N attended the GP surgery again in February to complain that nothing further had happened following the visit in November. The Surgery then wrote to CAMHS requesting follow up. It is possible to speculate that the behaviour allegedly displayed by Sibling 1 at home was an indicator of the level of emotional distress he was feeling about the home situation.
5.28 Systemic Learning from Key Practice Episode 3
Information sharing was a key theme during the Learning Event particularly in relation to the period when the work including Children’s Social Care came to an end and the family continued to receive support from the Health Visitor and Nursery 1. There was a view that Primary School 1 should have been informed about the family history in order to be able to support Sibling 1 appropriately and respond to any issues should they arise. Information about the family history would have helped Primary School 1 to see their experience of Sibling 1 and the family in the context of what had already happened. It was clear from the Learning Event and from Agency Reports that it was not a deliberate decision by any professional not to share information with Primary School 1, but rather a consequence of the process or system. A Child Protection case should have been subject to information sharing, whereas a family support or child in need case would not and would generally require seeking the consent of parents. Therefore it is legitimate to ask on what grounds information could have been shared.

5.29 During the Learning Event Government guidance on information sharing was referred to. This was first issued by the Department for Children, Schools and Families in 2008, Information Sharing: Guidance for Practitioners and Managers (2008). The guidance is referenced on the Norfolk Safeguarding Children Board Procedures website in section 1.7 Information Sharing and Confidentiality. The guidance is also referenced in Working Together 2013. The starting point for sharing information would be seeking the consent of those involved, in this situation Father and Mother, unless it was believed at the time that a person or persons were at risk of significant harm, in which case consent would not be needed. There are very helpful flowcharts and a straightforward checklist in the guidance providing practitioners with seven golden rules on information sharing and a succinct summary to inform their decision making. However, ultimately this comes down to a matter of professional judgement. Could the Health Visitor or Nursery 1 have legitimately shared with Primary School 1 Sibling 1’s history and that of his family? Inevitably there may be considerable debate about this, pitting the constraints placed on professionals by the Data Protection Act 1998 versus the need to share information from the perspective of safeguarding and promoting children’s welfare. Clearly the information that Sibling 1 was the subject of a Child Protection Plan until 26-01-2010 was confidential information. Thus any professional would need to be able to justify sharing this with Primary School 1 against the criteria set out in the guidance. It is this author’s view that it is not possible to make a definitive judgement about this which can then be applied to other cases. The starting point in these circumstances would have been for Nursery 1 or the Health Visitor to...
have asked for the consent to share information from Father and Mother. With the benefit of hindsight it is possible to justify using “public interest” that there was no need for consent. Ultimately in similar circumstances professionals should exercise professional judgement, using the guidance provided and then record their decisions and the evidence they have drawn on to support their decisions.

5.30 It may be helpful to consider how Norfolk Constabulary use the form C39d to inform other agencies about their attendance at an incident when a child is believed by the Police Officer to be at risk. Clearly the decision to complete a C39d is made by the individual officer on the basis of the Norfolk Constabulary Force Policy Document on Child Protection and the Norfolk LSCB Protocol 1, the latter of which sets out specific criteria in Appendix 2. Two of the criteria may assist in this particular case;

- Where a child's circumstances raise concern for that child's welfare,
- A child is present or known to live in a household where domestic violence has been reported.

Thus an individual Police Officer is expected to make a judgement with regard to a specific incident and the Constabulary Policy and LSCB Protocol give further clarity about the relevant circumstances. They do not rely on whether the child is involved in Child Protection processes as opposed to a Family Support or Child in Need situation to reach their decision. Nevertheless this is still a matter for the individual Police Officer and therefore a question of professional judgement. During the Learning Event the point was made that Police Officers should normally inform parents that they are completing a C39d. The exercising of professional judgement is promoted through a learning culture as opposed to a compliance culture and as suggested by Munro (2011);

“...will require practitioners and leaders in particular, to learn to expect the possibility of error, always seeking and adapting in response to, feedback and making sure that what is learned makes a difference to practice and therefore outcomes for children and young people”. (p129).

In addition it is also worth remembering that information sharing practice will not remain static, but will be influenced by case law and continue to develop. With this in mind it is important that Norfolk Safeguarding Children Board promotes continuous reflection about and review of information sharing by multi-agency partners.
5.31 The referral on 09-05-2011 and the account of what happened was the focus of some discussion at the Learning Event and Practitioner Recall Day, which included whether it was appropriate to conclude this investigation without a medical opinion. In addition there was some discussion as to whether Sibling 2 had talked about a different incident not connected to the red marks/insect bites, namely that she had been referring to an incident when Father N did bite and smack her. Whilst it is possible to accept that seeking a paediatric medical simply to confirm that these were insect bites was not justifiable, an assessment would have allowed further exploration of whether Sibling 2 was talking about a different incident. This was not explored and should be seen as a missed opportunity. The proposal mentioned during the Recall Day to include Health participation in the MASH process would ensure in future that a Health perspective contributes to any strategy discussion or meeting. Furthermore, it was not appropriate to have a conversation with Sibling 2 in the presence of her father if, as Sibling 2 had stated, he was responsible for biting and smacking her. As stated in the Norfolk Constabulary Agency Report;

“It would have been difficult for Sibling 2’s true voice to have been heard in these circumstances. Although she was spoken with, this was not in circumstances that would have allowed her to freely express herself.”

Both the Police Officer and Social Worker drew similar conclusions about Sibling 2’s relationship with her father on the basis of the interaction they witnessed between Sibling 2 and Father N. They were reassured by what they saw, namely Sibling 2 was relaxed and playful in the company of her father. These conclusions do not address the question of professional curiosity in relation to why Sibling 2 actually said that her father had bitten and smacked her.

5.32 A further point from this incident also raised at the Learning Event and Practitioner Recall Day was the timing of referrals. Referrals received later in the day from educational establishments may not be responded to until after the child in question has left for the day. Thus it would no longer be possible to speak to the child in the neutral (safe) environment of the school or nursery. In this particular situation the Police Officer and Social Worker were not able to speak to Sibling 2 until the following day when she was at home as she did not attend nursery every day. In the absence of grounds to insist on speaking to Sibling 2 in another environment away from her father, the Police Officer and Social Worker relied on other evidence to judge the situation. They would have been assisted by being able to speak to Sibling 2 at the Nursery. That being said, the timing of referrals is also affected by the time of the disclosure from the child
and, in the case of nurseries, whether the child attends the whole day or only attends in the afternoon.

5.33 The process of undertaking a Serious Case Review enables us to step back and reflect on what happened during this period;

- There was the matter of Father N’s aggressive behaviour towards professionals,
- There was the domestic incident in January 2011 from which the Police, Children’s Social Care and Health learnt that Father N had lost his job,
- There was the letterbox incident as a result of which Primary School 1’s concerns that Siblings 1 and 2 were not being fed properly were shared with the Police, Children’s Social Care and Health,
- There was the referral in relation to the red marks on Sibling 2’s ankles and her statement to the Nursery Officer about daddy biting and smacking her.

Whilst we are now able to consider these four elements/events together, what is not apparent is whether professionals involved with the family at that time would have been able to do this. It is also not clear today, that seeing the context in this way would have produced a different response by the agencies involved at the time. A further point made at the Learning Event related to the nature of Police involvement, different officers dealing with specific incidents which does not enable an overview. Furthermore, during the same period March to May 2011, Children’s Social Care had been undergoing organisational restructure according to participants in the Learning Event. This could also have undermined the possibility of an overview by Children’s Social Care due to the movement of staff within the Service, the departure of some staff and the change in team and organisational structure. Consequently this left Health and Education as the professionals with a level of continuous involvement with Siblings 1, 2 and 3, albeit that the family moved house and schools in June 2012.

5.34 Key Practice Episode 4 Core Assessment in March and April 2013

It is noteworthy that there were no further referrals to the Police or Children’s Social Care for almost two years. The next period begins with a referral from Primary School 2 to Children’s Social Care. Sibling 3 had been attending Primary School 2 since September 2012 joining Siblings 1 and 2. In January 2013, just prior to the referral, the Health Visitor received information from the Police that Sibling 3 had been in the household of Ex-Partner 1 when the Police attended a domestic dispute. The referral from Primary School 2 on 06-03-2013 prompted a Strategy Meeting between Children’s Social Care and the Police and the agreement that the Police would
undertake a welfare visit by uniform officers that day and Children’s Social Care would initiate a Core Assessment. The information from Primary School 2 was that Sibling 1 had stated that he is locked in his room at night by string tied to the door handle. In addition, Sibling 1 stated that his dad hit him hard and left a red mark, although Primary School 2 confirmed that there was no evidence of this. Sibling 1 was described as fluctuating between happy and sad. It is also reported that Father N had been hostile to a class teacher on one occasion.

5.35 Uniformed Police Officers attended the family home and fed back to Children’s Social Care that the door handles had been tied as Father and Mother were worried about Sibling 1 getting up at night and taking knives from the kitchen. The parents stated that they had asked their GP for support with Sibling 1’s behaviour but had received no help or medication. They believed he had ADHD or autism. The house was described as clean, as were the bedrooms, although the girls’ room was described as untidy. The parents also advised that the girls’ door handle was tied at night to keep them safe.

5.36 The Core Assessment was allocated to a Student Social Worker and an unannounced home visit was undertaken on 26-03-2013. During the home visit Sibling 1 was spoken to and admitted getting knives from the kitchen during the night, but was not able to explain why. The Core Assessment included consultation with other professionals and considered the previous history. It was acknowledged that Father and Mother accepted insecure attachment was the probable cause of Sibling 1’s behaviour and that tying up the bedroom doors represented a fire risk. The children were found to be generally happy, clean and the accommodation decent. The Core Assessment also stated that school have no significant underlying concerns. Half-Sister 1 was staying semi-permanently with the family and the children were believed to get on well with her. The hook and string arrangements for tying the bedroom doors at night were removed. The Core Assessment was completed 18-04-2013 and the case was closed after a referral letter had been sent to CAMHS requesting short term family therapy.

5.37 There is a further referral from Primary School 2, 26-04-2013, which reiterates much of the information from the referral dated 06-03-2013, Sibling 1 being locked in his room, always being in trouble and the difficulties in Sibling 1’s relationship with Mother N. Children’s Social Care discussed the referral to CAMHS with Primary School 2 and advised the School to speak to Mother N. CAMHS contacted Children’s Social Care 02-05-2013 requesting background information.
5.38 Systemic Learning from Key Practice Episode 4

There was some discussion at the Learning Event about the timing of the referral on 06-03-2013. It was agreed that the written referral was not received until 4.00pm by which time the children had gone home. It was confirmed that a verbal referral had been made earlier in the day and that this should have allowed a response before the children had left school. Clearly it was appropriate to have ensured that the children were seen that day, albeit by uniformed Police Officers, to confirm that the children were safe. However, in so doing the assessment of Uniformed Officers is relied upon and only the voices of the parents are heard. The Norfolk Constabulary Agency Report reflects robustly on how this referral was responded to and recognises that the Police response did not enable Sibling 1’s voice to be heard and significantly did not allow Sibling 1 to talk about his statement, that his father hit him hard enough to leave a red mark, to a trained child abuse Officer or Social Worker.

5.39 The other element of this situation that is very concerning is the parent’s explanation as to why they tied the children’s bedroom door handles with string, namely due to Sibling 1 getting up in the night to take a knife from the kitchen to hide under his pillow. The focus of the Police visit and the Core Assessment of Children’s Social Care was the tying of the door handles. The question of why Sibling 1 was getting up to get knives was not addressed. At this point Sibling 1 was six years 10 months old. It seems very unusual that a child of this age would even consider taking a knife and hiding it under his pillow and raises the question of what had he been exposed to or seen that caused him to do this. At the Practitioner Recall Day it was reported that Sibling 1 was asked why he did this, but he did not respond and the question was not asked again. Whilst the involvement of CAMHS to assist and support Father and Mother in managing and responding to behaviour is appropriate, the reason for the behaviour was not looked into. This reported behaviour combined with the statement by Sibling 1 that his father had smacked him hard enough to leave a red mark surely must indicate that Sibling 1 was at risk of significant harm. Thus the appropriate response was not a Core Assessment and visit by uniformed Police, but rather a Section 47 Enquiry focussing on these two elements. In addition, it should have been established whether Sibling 1’s reported behaviour was indeed true. In the light of the previous history of this case, this episode in March 2013 has to be seen as a missed opportunity. There was a failure to conduct a s47 Enquiry into the allegation of physical abuse on Sibling 1 by Father N and a failure to investigate why Sibling 1 was getting up in the night to get knives from the kitchen to hide under his pillow.
5.40 The suggestion that the underlying cause of Sibling 1’s behaviour was due to relationship and attachment difficulties requiring a family therapy response could be viewed as supporting the position that he and his siblings were at risk of significant harm. Davies and Ward (2012) state that;

“Neglectful parenting can also affect the essential processes of children’s early attachment and subsequent development. Children who receive care which is unpredictable, rejecting or insensitive are more likely to develop attachments that are less secure……Neglected children tend to be more aggressive than children who are not neglected, also more uncooperative and noncompliant.” (p 31).

Furthermore the view that Sibling 1’s behaviour was appropriate at school, but problematic at home (according to his parents) could be seen to add further weight to the view that the home situation needed an assessment of his and his siblings need for protection.

5.41 The Children’s Social Care Agency Report identifies appropriately that the decision to allocate the case to a Student Social Worker was inappropriate in the light of the significant history and complexity of the case. The Agency Report also suggested that this was due to staffing difficulties. Ofsted (2013) would seem to support the view about staffing difficulties, in that the Inspection Report identified substantial variation in workloads which significantly impacted on functioning, effectiveness and outcomes for children.

“Whilst the action plan following the last Ofsted inspection resulted in a review of workloads and secured additional resources in the areas of highest demand, the current situation is one of great differentials in social work caseloads. In some other areas, unallocated work is a concern, as is casework being undertaken on occasion by unqualified workers or by managers, and the varying means of coping with variable workloads are contributing to the failure of the service to protect children at the front line.” (p 13).

5.42 Criticism of the Student Social Worker’s findings does not seem reasonable in the light of the view that the decision to allocate this Core Assessment to a Student Social Worker was inappropriate. The findings were reviewed by a Manager or Supervisor and do, as identified in the Children’s Social Care Agency Report, indicate a lack of professional scepticism and a focus on supporting the Parents. This should have been queried by the Manager or Supervisor as part of their role in supporting a Student Social Worker. It is also worthy of note that the Core
Assessment noted Half-Sister 1 was a semi-permanent member of the household, but there is no exploration of what this meant in terms of contact between the children and their parents and Ex-Partner 1, whose involvement with the family had always been a cause of concern.

5.43 The further referral on 26-04-2013 from Primary School 2 has to be seen as another missed opportunity to assess Sibling 1’s needs appropriately (and the needs of his siblings) including his need for protection. At the very least the Core Assessment and conclusions could have been reviewed in response.

5.44 Key Practice Episode 5 Multi-Agency Response to the contact with the family in the period June to 5th August 2013

From the point at which Children’s Social Care closed the case and referred the family to CAMHS in late April 2013 there was no further contact with Police and Children’s Social Care until 06-06-2013. The family continued to have contact with Health and the children continued to attend Primary School 2. On 06-06-2013 uniformed Police Officers attended the family home in response to a reported domestic incident. A C39d was completed and forwarded to Children’s Social Care and Health. The domestic incident was an argument between Father and Mother, reported to be about Father N’s belief that mother N was “having an affair” and Police Officers stated that the argument had been witnessed by Sibling 1.

5.45 On Friday 14-06-2013 Children’s Social Care received two referrals one anonymous and the other from Primary School 2. The anonymous referral alleged that the children were being left at home alone and were being locked in their bedrooms. The referral from Primary School 2 outlined a disclosure by Sibling 1 that his father hit him very hard when he is angry. In addition, Sibling 1 had stated that his parents were splitting up and there had been an argument and the Police had been called. (This is presumably a reference by Sibling 1 to the incident on 06-06-2013).

5.46 Later on 14-06-2013 Father N came into Primary 2 and was verbally abusive to the School Secretary. He demanded that the children should not be allowed to go home with Mother N at the end of the day. Primary School 2 contacted the Police informed them about the situation and the concern that Father N was hitting the children. The Police attended the School, escorted Mother N home and spoke to Father and Mother and advised them to seek legal advice about their situation. The Police Officers completed a C39d which summarised what had happened.
and included that the children seem healthy and that Primary School 2 believed Father N was hitting Sibling 1. The Police described the house as untidy but not unsanitary.

5.47 Children’s Social Care received the written referral from Primary School 2 on Monday 17-06-2013 as well as the C39d from the Police. The written referral from Primary School 2 detailed that Sibling 1 had stated his Dad hit him on the bottom really hard, whereas his Mummy slapped softer. It also detailed that Sibling 1 reported his parents had split up and that his Dad had asked Sibling 1 to go with him and never see Mummy again.

5.48 Children’s Social Care allocated the case to a Social Worker, SW4, the following day 18-06-2013. The same day Primary School 2 contacted the Police again as Father N had gone into School again and been verbally abusive. School also reported that both parents had stated to School that the other parent was not allowed to collect the children. Primary School 2 added that as there were no court orders or restrictions they could not comply with the requests.

5.49 A further referral was sent to the Multi- Agency Safeguarding Hub 20-06-2013 by Primary School 2 in relation to Sibling 3 who had come to School with an injury to her lip. Father N had stated that she had fallen in the garden and sustained the injury. Police had visited Primary School 2 again due to Father N attending and being verbally aggressive. Later in the school day Sibling 3 stated to staff that her Dad had hit her and twisted her head. A Strategy Discussion took place between the Police and the Emergency Duty Service (Out of Hour Social Work Service) due to lateness of the referral. It was agreed that the Police and Social Worker SW4 would visit the school the following day 21-06-2013 to assess the situation.

5.50 21-06-2013 SW4 and a Detective Constable DC1 from the Child Abuse Investigation Unit visited Primary School 2 and spoke to both Siblings 1 and 2. Sibling 1 confirmed that his parents were splitting up and that he got sent to his room for being naughty and sometimes the door handle got tied by his parents with a belt. He also confirmed that Sibling 3 got locked in sometimes too and that he was smacked on his bottom by his Mum and Dad sometimes. Sibling 1 did not know how C Sibling 3 had got the injury to her lip. Sibling 2 confirmed that she had seen Dad smack Siblings 1 and 3 on their bottoms and that their bedroom doors were tied up, but not hers. She also said that it makes her sad when Dad shouts at Mum. She too did not know how Sibling 3 had sustained the injury to her lip. Sibling 3 was also spoken to but would not engage with SW4 or DC1. Mother N had brought Sibling 3 to Primary School 2 and was
spoken to by SW4 and DC1. Mother N confirmed that there were ongoing arguments between herself and Father N but asserted that he would not hurt his children. She stated that Father N smacked Sibling 1 on the bottom as he had hit his sister. She also confirmed that they used to lock the children in their rooms but had stopped doing this following advice from Children’s Social Care. Mother N stated that she thought the injury to Sibling 3’s lip was a cold sore that Sibling 3 had been picking. SW4 and DC1 then visited Father N at the family address. They spoke to Father N and explained the reason for the visit and for speaking to the children at school. They also expressed concern about the affect the domestic situation was having on the children. The house was described as tidy downstairs but messy upstairs although not to the extent that it was concerning. There was no sign of locks or string on the bedroom doors.

5.51 The following day 22-06-2013 uniformed Police were called to another incident and attended the family address. Father N stated to the Police that Mother N was still tying or locking the children in the bedrooms. There was a potty full of faeces in Sibling 1 and Sibling 2’s bedrooms. All the children’s bedrooms had beds with duvets but no bed sheets. The Police completed a C39d which was sent to Children’s Social Care and Health.

5.52 The receipt of the C39d relating to 22-06-2013 prompted SW4 to request the Police to visit the family address. On the evening of 25-06-2013, this task was completed by two Detective Constables, DC2 and DC3, from the Child Abuse Investigation Unit. Father N had also contacted SW4 and stated that Mother N was still locking the children in their bedrooms, another reason for requesting the Police visit. The Police found that the children were asleep in bed upstairs and the bedroom doors were not tied up or locked.

5.53 There is a further incident 27-06-2013 when uniformed Police Officers attended the family address following a telephone call from Father N. He stated that he had gone out earlier in the evening following an argument and returned at 11.00pm to find that Mother N had gone out leaving the children at home. Officers were sceptical about Father N’s story. They did check the bedrooms and found no locks on the doors. The uniformed officers described the children’s bedrooms as bare, in contrast to the living room and also commented that the bedrooms were smelly. A C39d was completed and forwarded to Children’s Social Care and to Health.

5.54 On 03-07-2013 and 04-07-2013 uniformed Police Officers attended the family address in response to a call from Father N stating that the children had been left at home alone by Mother
On 03-07-2013 Father N was outside the property, stating he had been locked out. However, a key was under the mat. The children were all asleep in separate rooms and had locks/chains on the outside of each door. The officers completed a C39d. PC1 attended the following day to speak to Mother N. In the Norfolk Constabulary Agency Report PC1 is reported to have described the house as dirty and that one of the bedrooms had a stained mattress and a full potty in the corner that had been there for some time. Mother N was reported to be hostile, whereas Father N was reported to try to present as the “good guy”. It was also made clear to Father N that he was equally responsible for the children’s welfare and could not simply blame Mother N for the conditions and use of locks. Whilst the situation was not acceptable PC1 did not feel that the conditions warranted removal of the children and Father N began to clean up when asked to do so. SW4 subsequently visited the property 05-07-2013 and found the home conditions to be generally good although the children’s beds had no bedding and there were full potties.

5.55 There were four further Police attendances before the children were removed under Police Protection on 05-08-2013. They were 10-07-2013, 12-07-2013, 14-07-2013 and 01-08-2013. These were all responses to domestic incidents or allegations being made by Father against Mother. The first two were during the day and the second two were late in the evening. C39ds were sent to Children’s Social Care and Health. According to the Norfolk Constabulary agency report by 14-07-2013 uniformed Officers were expressing concern about the emotional impact of the continuing disputes on the children. Observations about the home conditions were only reported on in the C39d from 01-08-2013 when the children’s bedrooms were said to smell heavily of faeces and urine and Sibling 1’s room was found to be tied shut. Mother N offered the same explanation for this namely that Sibling 1 would take knives from the kitchen and also cause damage.

5.56 During this same period SW4 was completing a Core Assessment with a view to transferring the case to the Safeguarding Team. On 16-07-2013 SW4 completed the Core Assessment and summarised the risk factors which included the children witnessing domestic violence and sleeping in locked rooms with no access to the toilet at night. The Core Assessment also summarised the events of the preceding weeks, the aggressive behaviour by Father N at Primary School 2, the allegations and domestic incidents and mentioned the disclosures made by Sibling 1 about being hit by his father. Mother N is reported to have stated that their relationship is over, but that Father N has nowhere to go. The Core Assessment concluded with the
recommendation of further assessment on the basis that there was insufficient information to initiate child protection procedures. The view was that further assessment by a long term team was required to address the concerns and work with the family.

5.57 The case is allocated to a Social Worker SW5 from the Safeguarding Team as a Section 17 Child In Need case and on 01-08-2013 a referral was received from the NSPCC. An anonymous person had stated that the children were being left alone at night. On 05-08-2013 SW5 visited the family with a Family Support Worker FSW1. As a result of the conditions that SW5 and FSW1 found the children living in, they asked for Police assistance and the children were taken into Police Protection under Section 46 of the Children Act 1989. PC1 is one of the Police Officers who attended. She had attended the family home on two earlier occasions and the Norfolk Constabulary Agency Report states that she believed the conditions on 05-08-2013 were significantly worse than on the two previous occasions. The parents were arrested, the children taken into foster care and photographs were taken of the family home as evidence.

5.58 Systemic Learning from Key Practice Episode 5
The Police attendance at the family home on 06-06-2013 provided some reassurance that the condition of the household downstairs was acceptable on that date. The children were described as safe, well and happy. Unfortunately due to the structure of Police work the attending officers would not have been aware of the family history or the potential significance of the information about Mother N having an affair and the implication for the emotional atmosphere in the household. It is worthy of note that the Police Officer (PC1) who dealt with this incident also attended the family address on 03-07-2013 and on 05-08-2013 when the children were taken into Police Protection. PC1 was very clear in the discussions during the Recall Day that the condition of the home was significantly worse on 05-08-2013 than it had been either on 06-06-2013 or on 03-07-2013 and that the home situation had deteriorated rapidly between the visit at the beginning of July and the call out on 05-08-2013.

5.59 The referral to Children’s Social Care on 14-06-2013 represents a missed opportunity. It is difficult to understand why Children’s Social Care did not open a Section 47 Enquiry and deal with the situation under child protection procedures, in light of;

- the known history of the family;
- the breakdown of the parents’ relationship and its impact on the situation;
• Sibling 1 stated to staff at Primary School 2 that he was being hit by his father and slapped by his mother.

The referral in relation to Sibling 3’s lip injury 20-06-2013 adds further evidence of the need to assess the situation from the perspective of the children’s need for protection. The decision to hold a Strategy Meeting was appropriate, however, the decision not to conduct the assessment as a Section 47 Enquiry (Child Protection Assessment) was not appropriate, a view that the discussion at the Learning Event concurred with. Furthermore in the absence of a medical opinion about the injury to Sibling 3’s lip, doubt remains about the cause of the injury. It could have been caused, as Sibling 3 herself stated, by Daddy hitting her and twisting her head.

5.60 The period from the beginning of June to the removal of the children under Police Protection presents a picture of a situation where the dominant element is the breakdown of the parents’ relationship. Their behaviour draws the focus of professionals away from the children and the children’s need for protection. The Children’s Social Care Agency Report describes “the chaos of repeated allegations by Father N” which seems an apt description. Furthermore in terms of the understanding the potential impact of father and Mother’s behaviour on the children Ward et al (2012) consider studies that have considered situations where abuse and neglect has occurred to determine when it is likely to re-occur. They note;

“The most consistently identified factors for recurring abuse were parental conflict and parental mental Health difficulties.” (p52).

Each referral during this period can be seen as an opportunity when S47 Enquiries should have been opened in the context of what was already known about the family. This would have given a more robust formal process in which to assess the children’s need for protection and to evaluate whether there was sufficient cumulative evidence to take legal action to remove the children earlier.

5.61 Key Practice Episode 6 The period in foster care.

The final period within the scope of the Serious Case Review 05-08-2013 to 18-11-2013 was when the children were in foster care, initially under Police Protection (Section 46 Children Act 1989) and subsequently by agreement with Mother and Father under Section 20 Children Act 1989. The most significant matter during this period pertinent to the Serious Case Review was the failure of the Local Authority to apply for an Interim Care Order. This would have enabled the children to change schools, thereby maintaining the normality of school attendance, and
also would have enabled the children to have been interviewed by the Police in connection with further allegations of abuse and neglect. As the children were accommodated under Section 20 Children Act 1989, the consent of their parents was required for both further ABE interviews and for a change of school. Parental consent had been obtained for the initial ABE interview, but when asked for further consent in early September 2013 they refused to give it and refused to consent to a change of schools.

5.62 The children had been ABE interviewed 13-08-2013 and had disclosed physical abuse and neglect. During August the children’s behaviour in the foster placement raised concerns about possible sexual abuse and subsequently the children made disclosures to the foster carers and to a Police Officer and Social Worker about alleged sexual abuse. The decision was taken that it was not possible to conduct ABE interviews without parents’ consent, consequently parental consent was sought and refused. One option open to Children’s Social Care at this point would have been to have applied for an Emergency Protection Order, a point that was raised during the Practitioner Recall Day and in the CAFCASS Agency Report. There is no evidence that this was even considered. Had it been considered, it is not clear how supportive the legal advice would have been with regard to such a proposal.

5.63 There was no decision to apply for an Emergency Protection Order and the initiation of Care Proceedings took a further 2 months. The Core Assessment required as part of the process was signed off 08-10-2013 and the actual initial hearing took place 13-11-2013. An Interim Care Order was granted that day allowing ABE interviews to take place. In addition the Court agreed that the children did not need to see their parents and the Local Authority was able to change the children’s school.

5.64 During the period up until 18-11-2013 the question of contact between the children and their parents was problematic. The children clearly stated on a number of occasions that they did not want to see their parents. The parents continued to request contact. Due to the ongoing criminal investigation contact did not take place until 25-10-2013. Only Sibling 3 attended contact on this date as both Siblings 1 and 2 refused to attend. There was a further contact 01-11-2013 when all three children attended. They were reported to be very distressed afterwards.
5.65 Systemic Learning from Key Practice Episode 6

It is unacceptable for an application to the Court to take so long. The circumstances around the children needed to be placed before Court far sooner than the three and a half months that elapsed between the Police Protection and the initial Court hearing 13-11-2013. As already stated, the refusal of the parents to consent to further ABE interviews could have prompted an application for an Emergency Protection Order, but did not. This combined with the refusal to consent to a change of schools should have led to an application to Court for an Interim Care Order. There was some discussion about this at the Learning Event and the Practitioner Recall Day. It is particularly concerning that rigid adherence to the Public Law Outline, e.g. reliance on the production of a Core Assessment, may have delayed the application. It was also stated that inappropriate Legal Advice was given, namely that it was not necessary to get the matter before the Court speedily as parents had consented to accommodation under Section 20 of the Children Act 1989. This was clearly not appropriate advice as the failure to get the matter before the Court in September delayed the criminal investigation and resulted in the children not attending school for two and a half months.

5.66 In a situation where Children’s Social Care staff and managers are given legal advice with which they do not agree, there should be a mechanism for them to challenge such advice or seek a second legal opinion. This is not simply a structural matter, but also a matter of the organisational culture, namely a culture that encourages reflection and challenge on the basis of evidence. Ultimately it is also important for Children’s Social Care staff and managers to remember that they are the instructing Department. Frontline managers should be supported by Children’s Social Care to instruct the Legal Department when Children’s Social Care believes rapid legal action is necessary.

6. PARENTAL VIEWS

6.1 The discussion with Mother N took place on 12-11-2014. During the conversation with Phil Smith the Lead Reviewer and Abigail McGarry the Norfolk Safeguarding Board Manager, Mother N had two professionals to support her. The conversation focussed on the involvement of the different agencies with the family and Mother N expressed her views about which agencies and professionals she thought had been helpful and those that she thought had not. Mother N was particularly positive about professionals who provided practical support and advice, e.g. around finances, potty training and behaviour. Mother N felt less positive about professionals that she
felt were monitoring her parenting. She described feeling that they were waiting for her to make a mistake. She also stated that she was unclear about the reasons why some professionals were involved with the children and that she was unclear about some of the tasks she was asked to undertake. She also stated that she did not understand the reasons why she was asked questions about her childhood by professionals.

6.2 The conversation with Father N took place on 18-11-2014 with Phil Smith and Abigail McGarry. Father N did not have anyone supporting him and the meeting was very short as Father N did not wish to have a lengthy conversation. Father N described his view that professionals twisted his words and promised things that did not happen. He gave several examples in support of his view. Father N did however feel that one professional had been nice, polite and had been straight with him.

7. CONCLUSIONS
7.1 Generic Analysis
7.1.1 From the referral to Children’s Social Care in March 2013 there were a number of opportunities to assess the children’s need for protection under Section 47 Children Act 1989. Each incident can be viewed as a missed opportunity. During the Learning Event and Recall Day held as part of the Serious Case Review, there was considerable discussion between the practitioners and managers present about the accumulating concerns and the action taken. There was a clear consensus that action should have been taken earlier under Section 47 Children Act 1989, a view shared by the author. Examining the children’s need for protection under formal procedures would have ensured structured multi-agency assessment of their situation. This would have prompted discussion about whether their home situation and the parenting they were receiving was good enough. The Learning Event and Recall Day enabled thorough debate about whether the children should have been removed earlier. Whilst the evidence suggests that Section 47 Enquiries should have been opened, the Police Officer who visited in June, July and August assured the Review that the conditions were much worse in August 2013, prompting the Police Protection. This view was accepted by the practitioners and managers present. The question of consensus about what is good enough from a child’s perspective is a matter for multi-agency reflection and should be facilitated by the Safeguarding Children Board’s learning and improvement agenda.
7.1.2 Throughout the period under review there is evidence that some appropriate judgments were made and appropriate actions taken. There are also examples when the children’s voices are clearly heard by professionals and other occasions when the children’s voices become drowned by the noise of hostility from Father and Mother. There is also evidence of challenge by professionals and the Learning Event and Practitioner Recall Day demonstrated how for some practitioners this had been a particularly demanding piece of work. They personally experienced considerable hostility whilst working with the family.

7.1.3 There are some clear examples of good practice, e.g. the work of SW1 for the Child Protection Conference in March 2009 and the combined efforts of SW2 and the Family Based Care Assistant who jointly completed the parenting assessment discussed at the Review Child Protection Conference in January 2010. Other work to complete the parenting assessment had been totally undermined by the hostility and resistance from Father N. It was particularly striking at the Learning Event and Practitioner Recall day that some professionals had been subject to very concerning levels of hostility from Father N. Needless to say this in turn begs the question about how the children experienced his behaviour. Whilst there is evidence that professionals were conscious of this point, as already stated it was also the case that the children’s voices were at times not heard due to the level of distraction and noise created by this hostility.

7.1.4 Overall interagency processes and communication were acceptable with the notable exceptions that have been discussed already. There is, however, a clear need for all agencies to reflect on how effectively historical information is used and shared, a subject which is discussed further below.

7.2 Case Specific Analysis from the Terms of Reference.

7.2.1 How effective was the gathering, analysing and sharing of historic information on the children’s father?

It is clear that historic information about Father N was known to Children’s Social Care and the Police and most of the other agencies. Discussions during the Learning Event and the Practitioner Recall Day revealed that there was varying understanding of the full history amongst agencies and some agencies did not have any information about the family prior to beginning their involvement. Whilst the majority of agencies were aware that Father N had had children removed from his care, they were not necessarily aware of the reasons for the removal. In the
case of Primary School 1 they had no information about the family. This matter has already been explored in 5.21 and 5.28 above. What is clear is the relevance of historical information cannot be understated. It is vital that all agencies have a clear understanding of why a parent or parents had their children removed. Such information must then be used to evaluate whether the parent has changed, the capacity of the parents to change and to inform the appropriate approach that should be taken with regards to meeting the needs of their children. As discussed in 5.29 professionals should be conversant with the Government guidance “Information Sharing Guidance for Practitioners and Managers” (DCSF 2008). Ensuring this document is understood and used by all agencies in Norfolk is a matter for the Norfolk Safeguarding Children Board.

7.2.2 How effective was the step-down process from Child Protection to Children in Need and from Children in Need to closure of the case?
As discussed at 5.15 above the decision to end the Child Protection Plans at the Review Child Protection Conference 26-01-2010 was a multi-agency decision based on the evidence of the agencies and discussed at the meeting. Criticism of the decision is therefore not appropriate. During the following period until the case was closed 01-09-2010 the review process has highlighted 2 specific concerns that should have prompted a different response from the agencies involved. These are explored at 5.16 to 5.19 above, namely a referral from Nursery 1 to Children’s Social Care on 15-02-2010 and the involvement of two members of the extended family in February 2010 and June 2010. The former was a missed opportunity in terms of assessing the children’s need for protection. The latter was not seen in terms of the extra stress that the two extended family members would have brought to the household.

7.2.3 The final observation in relation to the effectiveness of the step down process relates to the sharing of information with Primary School 1. The case was closed by Children’s Social Care 01-09-2010 and Sibling 1 began to attend Primary School 1 06-09-2010. As explored at 5.29 above Primary School 1 was unaware of the background information and that Sibling 1 and his sisters had been the subject of Child Protection Plans until 26-01-2010. The Learning Event and Practitioner Recall Day discussed at some length information sharing, specifically in the Child in Need context. As mentioned above at 7.1.1 ensuring that the Government guidance on information sharing is understood and used is a matter for all agencies working with children in Norfolk and the Norfolk Safeguarding Children Board.
7.2.4 How effective were agencies at working with these hostile and resistant parents?

This was the focus of considerable discussion at both the Learning Event and Practitioner Recall Day. It is also a matter that has concerned a number of other Serious Case Reviews at a national level going back a significant number of years. In this particular case there was an attempt to engage with the family and continue working with them in spite of Father N’s difficult and hostile behaviour. As articulated by practitioners at the Learning Event, it is clear that professionals who were seen as a challenge or threat were the subject of greater hostility than those who were perceived as supportive. It was also noted that Father and Mother’s behaviour towards the Police was always mitigated by the possibility of arrest should the hostility or resistance become too great. One professional was literally backed into a corner on a particular occasion and consequently ceased to work with the family. The fact that Father N was banned from Primary School 1 is evidence of the extreme nature of this hostility. What the hostility did not do is cause the withdrawal of all services. In particular during the period of the Child Protection Plan, although some agencies and professionals ceased to work with the family, others continued and the Child Protection Plan was completed. At other times the family continued to receive support from Nursery 1 and the Health Visitors. It is clear that the Review has demonstrated the need to share information about parents who are hostile, aggressive and threatening as a staff safety issue. Section 7.5 of the Norfolk Safeguarding Children Board Interagency Procedures has very clear advice and guidance about working with hostile and reluctant families which all agencies should review to ensure that they are following. The procedures stress the importance of supervision to identify cases where the failure of parents to engage is impacting on the safety of the children. The procedures also have practical suggestions such as visiting with a colleague from another agency to help identify particular difficulties in communication and gain another view of the circumstances.

7.2.5 The Learning Event and Practitioner Recall Day did reveal the significant impact that Father N’s behaviour had on some professionals. This raises two further points for reflection. Firstly that dealing with Father N’s hostility must have drawn the attention of professionals away from exclusively focussing on the needs of the children. Secondly it is very concerning that if professionals found Father N to be challenging, hostile and difficult, the children must have experienced his behaviour similarly. As discussed at the Practitioner Recall Day it is difficult to imagine what it must have felt like to experience a parent behaving in such a hostile manner.
7.2.6 Why were consent issues allowed to hold up what was in the best interests of the children (e.g. the second ABE interview and the change of schools)?

This has already been explored at 5.61 and 5.62 above. In summary it is not acceptable to allow the Public Law Outline to delay an application for an Interim Care Order when circumstances require an urgent application. It is also important that frontline staff and managers are encouraged to challenge legal advice when they believe the legal advice is inappropriate in the particular situation. In this case consent issues held up what was in the best interests of the children because it took two and a half months to place the matter before the Court.

7.3 Overview

7.3.1 Throughout the Agency Reports, Learning Event and Practitioner Recall Day there were descriptions of the children and how they interacted with each other, their parents and the professionals. From the considerable number of descriptions a picture is created of the children at the centre of this case and their resilience in the face of very difficult experiences. A phrase often used in Serious Case Reviews is “the child’s voice” and this was indeed used a number of times during this process. At the Practitioner Recall Day the phrase “the child’s world” was also used, which allowed professionals to reflect on the information about the household and its impact on the children and more specifically gain some insight into what it was like as a child to live in the household. Sibling 1 was described by Nursery 1 as a bright bubbly boy and by Primary 1 as a lovely boy. Mother N also described during her interview how helpful Sibling 1 was at home. In contrast to this are the observations that were shared about Sibling 1’s response to moving to foster care, namely how happy he was about being clean and having clean clothes to wear and about being able to use the toilet instead of a potty.

7.3.2 There were also observations about the other children, how Sibling 2 loved nursery and that Sibling 3 was a very content baby. The account of Sibling 2’s behaviour in May 2011 during the joint investigation regarding insect bites provides another picture of her when she was observed at home and described as being relaxed in the company of her father and how she went to sit on his lap during the conversation between the Police Officer, Social Worker and her parents. Again this is contrasted by the information that Sibling 2 had a number of health needs that were not appropriately followed up until she came into foster care and that both Sibling 2 and 3’s dental care was neglected to a significant extent and caused them some distress. The picture created by the Police records of the visits to the household is very concerning, detailing
how the children had to sleep in inappropriate conditions, use potties as a toilet and how their bedroom doors were tied shut.

7.3.3 Holding this picture of the children in mind, it is profoundly regrettable that they were left in these circumstances till 05-08-2013. What is not clear is when the situation at home deteriorated to the state observed on that day. As already mentioned at 5.39 the referral to Children’s Social Care 06-03-2013 has to be regarded as a missed opportunity for involvement with the family under Child Protection Procedures. However, it is not possible on the basis of the evidence examined to judge whether this would have made a difference to the overall outcome. Ultimately the people responsible for the children’s abuse and neglect were their parents.
8. Recommendations

8.1 A number of measures introduced since 2013 are relevant to Case N. The Lead Reviewer is happy to note these.

- Joint initial assessments for children under 5 are now undertaken with health visitors.
- Child Seen visit forms have been introduced by Children’s Social Care which encourage workers to see the child alone and check the child’s wellbeing, views, wishes and feelings. The new paperwork discourages a tick box approach to recording such visits. It is believed that the introduction of the Signs of Safety methodology will also support this approach.
- Child in Need Plans are now required on all children active to Children’s Social Care for more than 15 working days that do not have another plan (i.e. LAC plan, CP Plan, Pathway Plan).
- Child in Need Plans are reviewed at least every 6 weeks by the multi-agency team around the child.
- The Children’s Social Care policy around student social workers has been amended to prevent them from conducting statutory tasks, such as child seen visits, and assessments. While student social workers may have input into assessments and conduct visits to children in between statutory visits, they should always be the co-worker, with the child/children and their family being seen and assessed by a qualified worker as well.
- NCHC have revised their Did Not Attend (DNA) policy and raised awareness of the need to be compliant with its process at internal meetings, and in supervision.

8.2 Single agency recommendations

The Board agrees with the recommendations put forward by individual agencies and will scrutinise their implementation.

8.2.1 Children’s Social Care

- Chronologies should be added to the electronic record of all children active to Children’s Social Care to ensure they are accessible following case closure or transfer and that the history isn’t lost. ICT have suggested that this will be a possibility with the introduction of DNA. By having chronologies embedded within a Care Assess form, it would be possible to report on any active children who do not have a chronology. Due to there being some delay in the roll out of DNA, it would be expected that this recommendation might be achieved by next spring 2015.
- Policy should be updated to ensure that cases are never allocated to a Team Manager. The electronic system already flags all cases that are allocated to a Team Manager or Assistant Team Manager as ‘unallocated’. However, Managers at all levels need to review the data in light of the
lessons learnt from this case and ensure that it is regarded as unacceptable practice and stopped.

- Supervision with workers should always reflect on the lived experience of the child within their home environment. The template and supervision policy should be amended to reflect this, and ensure workers are asked the question “What is it like for this child in their home environment?”. Ongoing supervision audit can check this and challenge where reflection on the child’s experience is not covered. Report progress by Spring/Summer 2015.

8.2.2 Norfolk Constabulary

- It is recommended that Norfolk Constabulary and Children’s Services seek to develop a process for the obtaining of signed consent to interview children that is a continuous consent throughout the course of the investigation unless withdrawn. This would allow for further ABE interviews when new disclosures are made without the need for returning to the parents to seek further consent. This process should be developed and implemented within three months.

8.2.3 Norfolk Community Health and Care NHS Trust

- NCH&C safeguarding and children’s operational leads to review guidance on expected response to police information.
- NCH&C to make plans to further promote communication between GPs and HVs in child protection cases.
- NCH&C to ensure implementation of DNA policy in such a way that children not brought to first appointments are followed up where there have been previous child protection concerns.

8.2.4 Health

- NHS England, the Designated team for Safeguarding Children and community health services should work together to facilitate regular communication between GPs and community health staff regarding cases where there are concerns.
- NHS England, the Designated team for Safeguarding Children and Children’s Services should work to improve contact with primary care during Child Protection or Child in Need processes.

8.2.5 Education

- All schools should be reminded of the procedures for escalating concerns about decision-making in the best interests of the child in line with the NSCB Resolving Professional Disagreements.
Protocol. The Protocol should be re-issued to schools via a Management Information Sheet and continue to be discussed in Senior Designated Professional training.

8.2.6 Early Years

• All training for Safeguarding Lead Practitioners (SLPs) to include more detailed guidance on keeping records in relation to safeguarding concerns, following information sharing and data protection protocols. Alongside this, NCC ‘Safeguarding Guidance for Early Years and Childcare Settings’ to include enhanced written guidance for early years practitioners on good record keeping practice. Updates to be in use by end of February 2015.

• Further develop existing guidance for early years settings on transition to include transferring of safeguarding records to other settings and schools. Available from end February 2015.

• Provide information through Family Information Service regarding early education funding to all professionals involved in supporting families. Information to be sent out early January 2015.

8.3 Additionally the Lead Reviewer makes the following recommendations for Norfolk Safeguarding Children Board.

8.3.1 Norfolk Safeguarding Children Board must ensure that all agencies working with children in Norfolk use the Government guidance “Information Sharing Guidance for Practitioners and Managers” (DCSF 2008). This should be completed using a briefing note or other appropriate means of communication within three months of the completion of the Serious Case Review. The briefing note should include the recommendation that agencies discuss the seven golden rules of information sharing in staff meetings.

8.3.2 Norfolk Safeguarding Children Board should highlight the significance of historical information when working with children and their families. What has happened previously, what needs to change and the likelihood of change are essential elements of effective working with children and their families. Again this should be shared using a briefing note or other appropriate means of communication.

8.3.3 Norfolk Safeguarding Children Board should review the production and sharing of C39ds by the Norfolk Constabulary, Children’s Social Care and Health agencies. C39ds are clearly an extremely useful source of information concerning the welfare of children. There is however a danger that in the absence of an overview mechanism each C39d is treated as a single event and not seen in the
broader context. The opportunity offered by the MASH arrangements to retain an overview of C39ds in relation to families or households should be pursued and the Safeguarding Board should ask for feedback in 6 months (June 2015) as to the effectiveness of this approach.

**8.3.4** Norfolk Safeguarding Children Board should highlight to all agencies the importance of speaking to children in a safe environment when responding to a concern or allegation. Children are unlikely to share their concerns if spoken to at home or in the presence of the alleged perpetrator. This should be shared using a briefing note or other appropriate means of communication.

**8.3.5** Norfolk Safeguarding Children Board should ask Norfolk Constabulary and Children’s Social Care to develop an approach to seeking consent from birth parents to ABE interviews that does not allow refusal of consent to delay joint investigation of Child Protection concerns. Once developed Norfolk Safeguarding Children Board should review the effectiveness of the process in after 12 months.

**8.3.6** Norfolk Safeguarding Children Board should ask Children’s Social Care to review the effectiveness of arrangements for initiating both emergency legal action and Care Proceedings by Children’s Social Care to ensure that applications are timely and in the interests of children. The Safeguarding Children’s Board should expect Children’s Social Care to report the findings of the review within 3 months. The review should include the effectiveness of legal advice provided and provide detail of how disagreements about legal advice are resolved.

**8.3.7** Norfolk Safeguarding Children Board should review the question of consensus about what are good enough home conditions and good enough parenting from a child’s perspective. The Safeguarding Board should commission the Workforce Development Group to review how implementation of Signs of Safety will address the question of consensus about what is good enough from a child’s perspective. The Workforce Development Group should report back to the Safeguarding Board within 6 months.

**8.3.8** Norfolk Safeguarding Children Board should ask all member agencies to review and report back on their compliance with Section 7.5 of the Interagency Procedures with regard to working with reluctant and hostile families. This should be completed within 6 months and any practice concerns raised should be addressed through Safeguarding Board improvement processes.
8.3.9 Norfolk Safeguarding Children Board should review the arrangements within the MASH to confirm that the inclusion of Health as an agency is secure and that it has enabled Health practitioners to contribute to strategy discussions and meetings on safeguarding referrals. This review should take place within 3 months.
REFERENCES AND APPENDICES

(i) References

(ii) TERMS OF REFERENCE

NORFOLK SAFEGUARDING CHILDREN BOARD

TERMS OF REFERENCE & PROJECT PLAN

SUBJECTS:

Sibling 1 – Summer 2006
Sibling 2 – Summer 2007
Sibling 3 – Autumn 2008
Mother N – 1988
Father N – 1967
1. **Introduction**

The three children were subject of Child Protection Plans from March 2009 to January 2010. Subsequently the case was closed to Children’s Social Care on 23.8.10. Further concerns were raised and referrals made up to 6.3.13 when a Section 47 investigation was commenced. On 5.8.13 the children were made the subjects of Police Protection and they were then accommodated (Section 20).

Although they were initially ABE interviewed, parents refused consent for a second interview. They also refused consent for the children to move to a school near the foster home and thus the children were out of schooling for 2-3 months.

The Chair of the Norfolk Safeguarding Children Board endorsed the view of the Serious Case Subgroup that this case did not require a Serious Case Review and that another form of learning opportunity would be initiated. However, the National Panel advised that the case did meet the criteria for a Serious Case Review; and therefore the Chair agreed to commission this Serious Case Review using SILP methodology.

2. **Purpose**

The purpose of a SILP remains the same as that for a Serious Case Review, namely:

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

*(Working Together to Safeguard Children, March 2010)*
3. **Framework**

Serious Case Reviews and other case reviews should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings

(Working Together, para. 10, March 2013)

4. **Specific Scope**

- The subject children:
  
  Sibling 1 – Summer 2006  
  Sibling 2 – Summer 2007  
  Sibling 3 – Autumn 2008

- The two parents
  
  Mother N – 1988  
  Father N – 1967

The time period from:

18.2.09 (The Strategy Meeting between the Police and Children’s Social Care which led to the Child Protection Conference)

to 18.11.13 (when the children commenced attending their new school)
5. **In addition**

Agencies are asked to review and report on significant events and safeguarding issues on both parents and children prior to February 2009. This material will be used primarily to provide a background context and therefore should be concise and summarised, highlighting any particular learning points.

6. **Agency Reports**

Agency reports within the scoping period will be commissioned from:

- Children’s Social Care
- Police
- Education
- CAFCASS
- Early Years
- Community Trust (Health Visiting, School Nursing, Community Paediatrics)
- CCG (GP)
- Legal Services

- CAMHS
- Adult Mental Health
- Acute Trust
- Housing

- To be checked
Generic Analysis

7.1. Critically analyse and evaluate the events that occurred, the decisions made and the actions taken or not. Were there missed opportunities or episodes when there was sufficient information to have taken a different course? Were assessments conducted effectively and appropriate conclusions drawn?

7.2. Where judgements were made or actions taken which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why.

7.3. Demonstrate whether your agency/service heard and responded to the child’s voice.

7.4. Identify and explain if your agency/service believes that other agencies/services should have been sought and/or provided.

7.5. Identify good practice.

7.6. Were professionals proactive in escalating concerns and effecting challenge where appropriate?

7.7. From an inter-agency perspective, were processes and communication effective? Did services operate in silos rather than being “joined up” with each other?

7. Case-specific Analysis

i. How effective were we at gathering, analysing and sharing historic information on the children’s father?

ii. How effective was the step-down process from Child Protection to Child in Need and from Child in Need to closure of the case?

iii. How effective were we at working with these hostile and resistant parents?

iv. Why were consent issues allowed to hold up what was in the best interests of the children (eg. the second ABE interview, change of schools)?

8. Engagement with the family

The Board Manager will write to both parents informing them of this Serious Case Review and its purpose. It is hoped that at some time in the future they will be offered the opportunity to participate in the form of an interview; but this will have to await the end of the current Criminal proceedings.
9. **Documentation**

The “bundle” for the Learning Event will comprise:

- Integrated Chronology
- Agency reports

Additionally, for the Lead Reviewer:

- Child Protection Conference minutes, Core Group minutes, LAC Review minutes, Core Assessments, etc.

10. **Timetable**

Terms of Reference and Project Plan and Agency Author Format distributed to authors/SCR Panel – Friday 18 July

Chronologies – back by 19 September

Agency reports - back by 26 September

Quality assurance of the reports by AM and MR – week beginning 29 September

Distribution of agency reports – Monday 6 October

Learning Event – Wednesday 15 October

Recall Day – Wednesday 19 November

Presentation to the Board – Friday 5 December
NORFOLK SAFEGUARDING CHILDREN BOARD

AGENCY REPORT

(Name of the agency)

SIGNIFICANT INCIDENT LEARNING PROCESS

SUBJECTS:

Sibling 1 – Summer 2006
Sibling 2 – Summer 2007
Sibling 3 – Autumn 2008
Mother N – 1988
Father N – 1967
11. **Please see Terms of Reference and Project Plan document for:**

   - Introduction
   - Purpose
   - Framework

12. **Specific Scope**

   - The subject children:
     - Sibling 1 – Summer 2006
     - Sibling 2 – Summer 2007
     - Sibling 3 – Autumn 2008

   - The two parents
     - Mother N – 1988
     - Father N – 1967

   The time period from:

   18.2.09 (The Strategy Meeting between the Police and Children’s Social Care which led to the Child Protection Conference)

   to 18.11.13 (when the children commenced attending their new school)

13. **In addition**

   Agencies are asked to review and report on significant events and safeguarding issues on both parents and children prior to February 2009. This material will be used primarily to provide a background context and therefore should be concise and summarised, highlighting any particular learning points.
14. **Within the Scoping period (18.2.09 – 18.11.13)**

7.1. Summarise in narrative form the key information on the child and parents from your agency/service.

7.2. Summarise the services offered and/or provided to the child and parents; and the decisions reached.

15. **Generic Analysis**

5.1. Critically analyse and evaluate the events that occurred, the decisions made and the actions taken or not. Were there missed opportunities or episodes when there was sufficient information to have taken a different course? Were assessments conducted effectively and appropriate conclusions drawn?

5.2. Where judgements were made or actions taken which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why.

5.3. Demonstrate whether your agency/service heard and responded to the child’s voice.

5.4. Identify and explain if your agency/service believes that other agencies/services should have been sought and/or provided.

5.5. Identify good practice.

5.6. Were professionals proactive in escalating concerns and effecting challenge where appropriate?

5.7. From an inter-agency perspective, were processes and communication effective? Did services operate in silos rather than being “joined up” with each other?
16. **Case-specific Analysis**

v. How effective were we at gathering, analysing and sharing historic information on the children’s father?

vi. How effective was the step-down process from Child Protection to Child in Need and from Child in Need to closure of the case?

vii. How effective were we at working with these hostile and resistant parents?

viii. Why were consent issues allowed to hold up what was in the best interests of the children (e.g. the second ABE interview, change of schools)?

17. **Key Learning Points**

7.1. What did we do well which we need to keep doing?

7.2. What didn’t we do so well that needs to stop?

7.3. What things need to be done differently to lead to improvements and how should this be done?

7.4. What is to be learnt about improving multi-agency working?

18. **Recommendations**

You may make in-house/single agency recommendations (but are not obliged to do so). If you are making recommendations please make them SMART, i.e.

- Specific
- Measurable
- Achievable
- Realistic
- Timely
19. **Sign-Off**

_(Neither the reviewer nor senior sign-off person has had any direct involvement with this case prior to the death of the child._)

Agency Reviewer: 

Date: 

The reports of all reviews must be signed by the relevant senior officer, indicating that the review has been:

- carried out to the required standard 
  
  *and*
  
- the learning points are accepted by the organisation
- the recommendations/action plan will be implemented

The Senior Officer accepts that:

- The review has been carried out to the required standard.
- The learning points reached in the review are accurate.
- The recommendations/action plan will be implemented.

Senior Officer: 

Job Title: 

Date: 

On completion, please send or deliver the completed report by **26th September 2014** at the latest.