Norfolk Safeguarding Children Board

SERIOUS CASE REVIEW

CHILD S

Date of Incident: July 2015

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1. INTRODUCTION

1.1 The circumstances that led to undertaking this Review

1.1.1 In July 2015 Child S, who was 3 years old, was taken by ambulance to the family's local Hospital Accident and Emergency Department with a serious head injury and other bruising on her body. Her mother's partner, who had been caring for Child S at the time was charged with Section 20[1] Grievous Bodily Harm and was subsequently sentenced to 32 months in prison.

1.1.2 There were serious concerns initially about the possibility that Child S might have sustained permanent physical impairment as a result of the head injury. However, Child S made a good recovery with no evidence of permanent injury. Following her admission to hospital both Child S and her younger sibling were placed on Interim Care Orders by the Family Court and were subsequently made subject to Special Guardianship Orders within their extended family.

1.1.3 The case of Child S was referred to the Serious Case Review Sub Group of the Norfolk Safeguarding Children Board on 16th July 2015 by Norfolk Constabulary. The Independent Chair of Norfolk Safeguarding Children Board formally made a decision to undertake a Serious Case Review on 14th September 2015. Child S's case had met the criteria for a Serious Case Review as identified in Working Together to Safeguard Children 2013[2], in that there was information that:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

1.1.4 The initial completion date for the Review was hoped to be the end of May 2016. However, due to the criminal proceedings, the review was unable to be completed until November 2016.

1.2 Family Composition

The family members referred to in this review are as follows:

- Subject – Child S
- Sibling – Sibling S
- Mother
- Father of Child S – Adult A
- Mother's partner, father of Child S's Sibling – Adult B

1.3 Methodology

[1] Section 20 of the Offences Against the Person Act 1861

[2] Working Together: HM Govt 2013

1.3.1. Statutory guidance within Working Together requires Local Safeguarding Children Boards to have in place a framework for learning and improvement, which includes the completion of Serious Case Reviews. The guidance establishes the purpose as follows:

> *Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children. (Working Together, 2013:66)*

1.3.2. The statutory guidance requires reviews to consider: "*what happened in a case, and why, and what action will be taken*". In particular, 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.*

1.3.3. The methodology used for this Review was underpinned by the principles outlined in Working Together, including the need to use a systems approach. The author of this report is familiar with a systems based methodology. In particular this approach recognises the limitations inherent in simply identifying what may have gone wrong and who might be 'to blame'. Instead it is intended to identify which factors in the wider work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely. A central purpose therefore is to move beyond the individual case to a greater understanding of safeguarding practice more widely.

1.3.4. The Review was led and authored by Sian Griffiths who is independent of all the agencies involved. Sian Griffiths has significant experience in undertaking Serious Case Reviews.

1.3.5. The Independent Reviewer worked with a core Review Team from relevant agencies in Norfolk and in Essex, which is where the mother, father and mother's partner had lived prior to moving to Norfolk.

1.3.6. Attendance at the Review team was made up of Senior Safeguarding representatives from the following agencies:

- ❖ Norfolk County Council Early Years Service
- ❖ Norfolk County Council Children's Services
- ❖ North East London NHS Foundation Trust
- ❖ Norfolk NHS Designated Safeguarding Children Team on behalf of 5 Clinical Commissioning Groups.
- ❖ Norfolk Constabulary
- ❖ Norfolk Community Health and Care NHS Trust
- ❖ Essex County Council Children's Social Care

The Norfolk Safeguarding Children Board Manager was also a member of the Review team and the Board provided administrative support.

1.3.7. The review process included

- Consideration of chronologies and Agency Reports produced by the key agencies:
  - Essex County Council Family Operations
  - North East London NHS Foundation Trust (NELFT)
  - GP Practice (chronology produced by Named GP for Safeguarding Children, Norfolk and Waveney.)
  - Basildon and Brentwood Clinical Commissioning Group
  - Norfolk Community Health and Care (Health Visiting and Community Services)
  - Norfolk County Council Early Years Service
  - Norfolk Constabulary
- 4 meetings of the Review team.
- Copy of the statement provided to the Police by Child S's Childminder
- Copy of Norfolk NHS Serious Incident Report and Norfolk GP Practice Safeguarding Report
- Copy of Norfolk Children's Services Record of Strategy meeting relating to the events of July 2015

1.3.8. The Independent Lead Reviewer met with the following professionals who had direct involvement with key members of the family:

- ➢ Family GP (Norfolk)
- ➢ Social Worker from the Norfolk Multi Agency Safeguarding Hub(MASH)
- ➢ Health Visitor (NELFT)
- ➢ Personal Advisor (Essex)
- ➢ Child S's Childminder (Norfolk)

1.3.9. It had been intended to undertake a learning event with the key professionals in order for them to contribute further to the review, however, given the limited numbers of professionals involved and the fact that they worked in different counties, the decision was taken that this would not be a proportionate approach.

1.3.10. The **timeframe** under consideration for this Review was:

January 2013 – July 2015

The starting point was chosen as this was the period when Child S's mother was understood to have met Adult B. The end point is the date at which Child S was taken to hospital and her safety secured.

1.3.11. The Terms of Reference identified four particular issues for consideration by each agency within the Review, however these were not intended to limit any other learning that might emerge:

1. *Given that there were concerns about this family when they were resident in Essex, how effective was cross border working and information sharing*

2. *How well do agencies recognise, support and risk assess vulnerable young parents, particularly when there is evidence that they have been at risk in their own childhoods?*

3. *How well are Early Years providers (childminders) supported in making confident referrals and ensuring they understand when and how to challenge responses?*

4. *How confident are we about the decision making in the Norfolk MASH? Is there a clear and shared understanding of the difference between consultation and referrals?*

1.4 Contribution of family members

1.4.1. The involvement of key family members in a Review can provide particularly helpful insights into the experience of receiving or seeking services. The mother, father (Adult A) and Adult B were all informed at the start that the review would be taking place and then later contacted to see if they would be willing to meet with the Independent Reviewer to provide their views.

1.4.2. Following completion of the criminal proceedings, both Child S's mother and Adult B agreed to meet with the Independent Author and the LSCB Board Manager. Adult A was also contacted to seek his involvement, but he did not respond to that contact. The views of both the mother and Adult B are woven into this report.

1.5 Child S: her personality

1.5.1. Child S's mother and Adult B were able to provide some information about Child S from their experience of her during this time. Her mother described her as a '*bubbly funny kid….gets on with anyone….a bit of a mummy's girl*" . She said

she did not think she liked going to nursery or to school because she would 'scream the house down'. She said that it was still difficult at times to understand what Child S was saying, because of her age. Overall Child S's mother saw her daughter as a happy child.

1.5.2. The limited contact that Child S had with professionals means that there is correspondingly limited information from outside the family that would provide any other insights into her experience of her world. The childminder had most contact with Child S although she missed quite a few of her sessions and had not been at the childminder's long enough to really get into a routine. She described Child S as being shy and quiet and not wanting to leave her mother. Child S took a while to settle and although she did play with other children, she preferred cuddling to playing.

2 SUMMARY OF THE CASE AND AGENCIES' INVOLVEMENT WITH THE FAMILY

The following is a chronological summary of what is now known about the family and their involvement with agencies. The summary, as far as is possible, will identify what was or was not known to the relevant agencies at the time the events were taking place.

2.1. **Historical information:** Child S's parents and Adult B were brought up predominantly in Essex. As a young teenager Child S's Mother had some limited contact with Essex Children's Services, but was not herself subject to any statutory involvement. Essex Children's Services undertook a pre-birth assessment as the Mother was under 16 at the time of her pregnancy and there were concerns about family support. As a result a Child in Need[3] Plan was put in place. Child S was born in July 2012 and the Child in Need Plan was closed a few weeks later. Child S's maternal grandmother was assessed as significantly involved in her care. It was felt that overall Child S's care was of a good enough standard and that Child S's Mother had engaged well with the Child in Need plan, which included the Health Visitor. Child S had routine contact with the Health Visiting service in Essex which offered extra support, for example, Baby Massage classes, although this was not taken up by Child S's mother. Child S's mother told the review that she was happy with the health visitors and social workers she had met and had been told about the various groups she could have gone to. However she felt that she had support from her family and did not need anything extra.

2.2. Child S's mother is white British. No information has been provided regarding any additional needs in relation to her health nor has religion been identified as a significant feature for her.

[3] Child in Need Plan: A Child in Need Plan, or CIN, is a multi-agency plan put in place with the family under Section 17 of the children Act when a child is in need of extra support from different agencies, but is not assessed to be at risk of significant harm.

2.3. **Adult A (Father of Child S)**. It is understood that Adult A separated from the mother of Child S not long after she was born and had limited contact with his daughter subsequently. Adult A is understood to have spoken to a solicitor about contact with Child S but there is no further information as to whether he pursued this further. There is very little other information about Adult A available to the review.

2.4. **Adult B (Mother's partner and father of Child S's sibling)**. Adult B was one of a group of siblings. There were some concerns about their care and a pattern for several of the siblings of leaving the home at an early age to live with other family members. Adult B's mother sought help from Essex Children's Social Care as she found Adult B's behaviour difficult to manage and as a result at 13 years old Adult B was voluntarily accommodated with foster carers. Adult B himself described a high level of physical abuse and punishment and said that he went to the Local Authority and asked to be taken into care as a result. Behavioural problems, including reference to some '*violent behaviour*', led to foster placements breaking down and he eventually moved first into residential care and later into supported, semi-independent accommodation. He was then subsequently supported by the Leaving Care Service.

2.5. Adult B is white British. He is recorded as having some health problems and being delayed in his academic progress. There is no information identifying that religion was a significant feature for Adult B.

2.6. **Child S's early care in Essex: January 2013 to September 2014** In January 2013 Child S was living with her Mother and maternal grandmother, with apparently limited contact with her father (Adult A). In January 2013 the GP assessed that the Mother was suffering from post-natal depression and she was also again found to be positive for pregnancy. She had been prescribed medication for post-natal depression shortly after Child S was born, but there is no information from the GP as to whether this had been continued. Some months later, Child S's Mother again presented at the GP with symptoms of post-natal depression and was prescribed medication. The GP noted that a referral to CAMHS for counselling would be made, but there is no evidence as to the outcome. It does not appear that the GP made contact with the Health Visitor at this point.

2.7. In October 2013 Child S's Mother referred herself to Childrens Social Care as homeless following an argument with her mother. The police had been called by Child S's Mother to her own mother's home following a report of a domestic incident. Child S's grandmother would not agree to Child S being taken by the Mother as she said she was worried about her ability to care for her child, particularly as she was now pregnant again. There were conflicting descriptions of what had happened and no criminal charges were made. Police sent a referral to the Hospital safeguarding team who subsequently referred to Children's Social Care.

2.8. After a few days living with Adult A's parents, Child S and her Mother returned to live with the maternal grandmother and the case was closed in January 2014 by Essex Children's Social Care (CSC) after further checks had been made.

The hospital safeguarding team noted that a new referral to CSC should be made if there were any further concerns, but none were identified. Child S continued to have routine contact with the health visitor who was aware both of these events and of Childrens Social Care's involvement.

2.9. In November 2013 Child S's Mother was booked for antenatal care at the hospital and the midwife also discussed the family with the Hospital Safeguarding team. Child S gave no cause for concern when she was seen. Child S's mother named Adult B as the father.

2.10. In March 2014 Child S and her Mother moved to a specialist housing unit for young mothers to which she was referred by the Housing Department. The Health Visitor was still identifying that Child S's mother had post-natal depression but was unable to get her agreement either to medication, due to her pregnancy, or to counselling. She did however agree to be referred to a specialist health visitor from the Perinatal Mental Health service and a number of 'listening visits'[4] with her health visitor. Arrangements were also made for a Community Nursery Nurse to visit in relation to problems Child S had in sleeping. At this point the Mother said that she was no longer in a relationship with the unborn baby's father (Adult B) who she had been with for the last two years. Although there were still some problems with Child S's sleeping, there were no fundamental concerns about the parenting she was receiving.

2.11. In June 2014 Child S was taken by her mother to A&E at 9.00 in the evening with a small cut to her tongue which was said to have been caused by an accident in a playground. Staff at A&E made checks with Children's Services and informed the Health Visitor of the accident.

2.12. Later that month Child S's sibling was born and received routine midwifery and Health Visiting services. The Health Visiting service recorded four minor incidents regarding Child S during the following few weeks:

- The Health Visitor noted that Child S's Mother was slow to comfort her child during one visit when Child S was upset at having hurt herself.
- A worker at a Children's Centre contacted the Health Visitor to inform her that Child S had a bruise to her face. The Mother had explained this was an accident and that she had taken Child S to the GP, although no evidence has been found of this in the GP's records. The Health Visitor discussed this with the Mother but was unable to see Child S who she was told was with her father. The Health Visitor again offered listening visits as Mother was feeling lonely and tearful and this was accepted.
- Child S's mother told the health visitor that Child S had taken her new sibling out of the baby bouncer and thrown her to the floor – but she was not injured.
- Child S was taken to A&E by Adult A after falling in the garden and injuring her wrist.

[4] Listening visits: extra visits made by health visitors to support women suffering from mild-to-moderate depression and anxiety in the postnatal period.

2.13. **September 2014: The move to Norfolk**. In September 2014 the Health Visitor was informed by the Specialist Housing Unit that Child S and her Mother had moved to Norfolk to live with her maternal grandfather. The Health Visitor made a number of unsuccessful attempts to contact the Mother by phone in order to gain her new address. At around the same time Adult B's Personal Advisor, from the Leaving Care Service, was informed by Adult B's mother that he had moved to Norfolk. Other than responding to his requests for help with housing, the Personal Advisor had not been able to engage Adult B in any work for some time. She was not aware of his relationship with Child S's Mother.

2.14. Child S was registered with a new GP practice in Norfolk on arrival and she and her siblings records were transferred to the local health visiting service. The accompanying note referred to the last A&E attendance only, not the other minor injuries, and stated "*no other current health needs*". The Norfolk Health Visitor undertook a home visit in December 2014 and completed the 2 year review which had been outstanding for 6 months due to missed appointments and the move between counties. Child S's Mother did not want extra help, such as a children's centre referral and confirmed that the family were not involved with any other agencies. The Health Visitor noted a warm relationship between Child S and Adult B and there were no evident concerns about the children. The last visit from the Health Visitor was in December 2014.

2.15. On Christmas Eve 2014 Child S was taken by her Mother to see the GP. She had a bruise around her left ear, which Child S's mother said she thought was due to her rubbing at her ear. She had no other bruises and the GP had no other information accessible during the consultation that would suggest that there was reason for concern. The mother was given medication for an ear infection for Child S and advice about calling 111 if there were any further concerns over the Christmas period.

2.16. In February 2015 Child S was registered with a local childminder three days a week. The Mother had wanted to enrol her with the local school nursery, but at this point in the year no places were available. Other than being registered with the GP, who had no further contact with Child S, there were no other professionals involved with the family at this time. Between February and July the childminder began to have some concerns about Child S. She noted that Child S appeared less willing to be brought to and from her home by Adult B than she was by her Mother. She also recorded four incidents when Child S had bruises or told her that she was hurt and then said that Adult B had caused it.

2.17. In April 2015 the Childminder telephoned the Norfolk Multi Agency Safeguarding Hub (MASH) for a consultation and spoke to an experienced social worker. As this was a call for a consultation, not a formal referral, the childminder did not give Child S's name. The conclusion was that no action was understood to be necessary by the social worker who gave advice, and the childminder understood that she was to record any further incidents. The Social Worker and the Childminder have very different understandings of what was said during this consultation and this will be considered further in the analysis section.

2.18. In early July 2015 Adult B phoned for an ambulance and Child S was taken to the A&E department at the local hospital with a significant head injury and other bruising on her body. Adult B explained that the injuries were the result of an accident. Both the attending paramedics and the hospital staff were concerned about her presentation and about Adult B's explanation. The paramedics made an internal safeguarding referral and the hospital subsequently contacted the police and Children's Social Care. Adult B was interviewed by police and charged with assault.

3 APPRAISAL OF PRACTICE AND ANALYSIS

3.1 Introduction

3.1.1. This Section will appraise the key aspects of multi-agency practice that have been identified. It will identify what multi-agency learning there may be for future practice and consider in particular the Terms of Reference outlined by the Safeguarding Board at the outset of this review.

3.1.2. Where individual agencies have already established appropriate learning and taken action within their agency, this will not result in further recommendations within this Review.

3.2 Cross Border working and Information sharing

3.2.1. Both information sharing and working across Local Authority borders are well recognised challenges in safeguarding practice. Information sharing, which is central to effective safeguarding practice has been a routine feature of Serious Case Reviews for many years and cross border working also emerges within the research as a recurring difficulty.[5] In this case routine information sharing generally did take place to expected standards, but on one occasion whilst information was shared, the way in which it was communicated and recorded could have enabled some key information to be better understood.

3.2.2. The Health Visitor in Essex forwarded the children's records to the Health Visitor in Norfolk as is expected. She also left a telephone message for a Norfolk colleague to speak to her about the family. This conversation never happened, although it is unclear why not. The Essex Health Visitor's summary of Child S's case referred to the last attendance at A&E, but not that there had been a cluster of 4 (minor) concerns over a 3 month period, or that there had been a Child in Need plan in the past. It should of course be recognised also that this was in the context of there being plausible explanations for any injuries. All this information was in the transferred records and therefore accessible to the receiving Health Visitor and GP surgery, but ideally, and particularly as it was being sent into another county, it should have been included in the summary. Equally had the information been drawn out of the records and highlighted by the receiving health professionals when Child S

[5] Sidebotham, P et al: Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 (2016:163&187)

was subsequently brought to the surgery this again might have identified the possibility of a pattern of concerns.

3.3 **Child S's presentation to the GP**.

3.3.1. The GP's response to the presentation of Child S at the Surgery with an ear infection and a mark near the ear on Christmas Eve 2014 has been subject to a full investigation commissioned by the Clinical Commissioning Group (CCG). The SCR Independent Reviewer also met separately with the GP concerned to discuss the events in detail. The investigation commissioned by the CCG clearly identified that marks or bruising around the ear are strongly indicative of a non-accidental injury. With the benefit of hindsight, the GP concerned has fully accepted that he had not recognised this at the time and that he should have done so.

3.3.2. The GP was presented with a concerned parent who had sought advice; a child who showed no other evidence for concern; and an explanation combined with other symptoms as to why she might have been rubbing her ear causing a mark. He had seen a full list of patients that morning (approximately 16 patients, each with an allocated 12 minutes), he did not know the family concerned and in the time available to him to scan the records would not have been able to identify either that there had been previous injuries, or that Child S had been subject to a Child in Need Plan as a new baby. Whilst the GP did not minimise his own sense of responsibility, it was also apparent that had this information been highlighted on the system it would have provided an alert to the possibility of a different explanation to the one that he had been given.

3.3.3. The GP evidently understood and took seriously his responsibilities for safeguarding and there is no reason to doubt that he would have made a referral to children's services if he had identified a possible non-accidental injury. Whilst this event presented an opportunity to learn more about what might be happening in Child S's life, it would be too simplistic to conclude that a different diagnosis by the GP at this point would have resulted in a different outcome for Child S in the longer term. It cannot be assumed that further investigation would inevitably have led to an unequivocal conclusion that Child S had in fact been harmed; that a full Child Protection assessment would have taken place; or that any resulting intervention would have prevented the events that took place 6 months later.

3.3.4. Since these events both the GP and the entire GP surgery has taken part in a joint training event organised by the CCG to refresh their knowledge on the symptoms of physical abuse in children and consider how to improve their systems for identifying significant information. It is not the conclusion of this Serious Case Review that this one event represents a fundamental concern about the practice and knowledge of the GP concerned, or of GPs more widely. Rather it reflects the reality that however competent an individual GP, in circumstances such as those outlined here, with very limited time for assessment and inaccessible historical information, the possibility of a mistaken diagnosis can never entirely be ruled out. Information provided by the review team member for the CCG is that this GP and the surgery has taken

the learning from this one event very seriously and there is no reason to consider that there are wider concerns about either the GP's awareness of physical abuse or the safeguarding responsibilities. As a result no recommendation has been considered necessary.

3.4 Recognition, support and risk assessment of vulnerable young parents

3.4.1. The Mother and Adult B, were young parents who themselves had experienced some difficulties in their early lives, including stresses within their birth families and, in Adult B's case, a period of his life spent in care. Adult A was not known to services during the relevant time period and it is not possible for this review to assess whether he had unmet needs. It is well recognised that there are additional stresses which can make young parents, and therefore their children, more vulnerable. Teenage mothers are, for example, three times more likely to experience post-natal depression[6] and teenage parents experience higher levels of poverty and poor housing. A range of services are in place across Norfolk and Essex to support young parents. However, it is also the case that being a young parent does not mean that poor outcomes for them or their children are inevitable.

3.4.2. The Mother of Child S was recognised as being vulnerable during her pregnancy with Child S, given her age and family circumstances. A pre-birth assessment took place resulting in a Child in Need Plan, which was closed within a comparatively short timescale. There was never any information that would suggest that the Mother of Child S represented a risk to her child or that Child S was otherwise at risk of significant harm. Whilst the fact of the mother becoming pregnant with her second child would create an opportunity to offer more support, it would however be unreasonable to suggest that a pre-birth assessment would have been justified.

3.4.3. Pre-birth assessments are not routine and usually reflect a high degree of concern about the risk of significant harm to a child. Such assessments are recognised to be quite intrusive, stressful processes for the expectant parent. Essex, in line with recognised good practice, has a Policy which helps identify when this would be justified. The Mother did not demonstrate the indicators of parental vulnerability which would suggest a Pre-birth assessment eg: substance abuse; serious domestic abuse; concealment of pregnancy; or mental ill health likely to impact significantly on the baby. The Mother did continue to experience some difficulties, including post-natal depression, but did respond, if not always very consistently, to Health Visitor appointments and did agree to access other help. It may have been an option to consider an offer of Early Help for the mother and child at this point. Early Help is a means to provide planned, co-ordinated support to families where children have additional needs, but do not meet the thresholds for statutory intervention by Children's Services. However, the mother was already being linked into other relevant services and this may not have achieved a great deal more. The mother herself does not feel that she needed other services than those that were offered.

[6] Public Health England: May 2016

3.4.4. Adult B was aged 19 when he moved to Norfolk with Child S and her mother. He had himself been in Care as a young teenager, although he maintained contact with his family. Leaving care services were provided to Adult B, and he was allocated a Personal Advisor (PA) whose role was to offer support and advice as he moved into independence. However, Adult B generally only engaged with his PA in relation to practical problems such as obtaining housing and by the time he was 19 years old he had effectively withdrawn from any contact as he was entitled to do. Essex Children's Social Care had no knowledge that had taken on a parenting role and there is no reason that this information would have become known to them.

3.4.5. During his time as a child in care, it was identified that Adult B should be supported to '*access a local counselling resource when he is ready'*. If he did not take up this offer, he should be referred to a Leaving Care Mental Health Worker. This was not pursued with him later in his involvement with the leaving care service which would have been good practice. Whilst it is quite possible that he would not have taken up such services, the opportunity should have been offered to him. This has been identified by Essex CSC as a key learning point in that it should have been pursued with a greater level of persistence given the impact on his emotional wellbeing of his early life experiences.

3.4.6. There are some references within the information available to Essex CSC to episodes of aggression by Adult B but these were of a comparatively low level nature. Adult B's Personal Advisor did not have any information that led her to believe he could be a risk of serious harm to others. She was aware that he did have some history of violence with his peers during his time in residential care. This was not of an unusual or particularly disturbing nature given the '*hothouse*' atmosphere of residential care and there was nothing that she was aware of that would suggest he was an instigator of violence. She described him as not being difficult to get on with and '*not generally aggressive or inclined to seek out trouble.*' The Personal Advisor had no knowledge that he was in a relationship with Child S's mother and therefore no specific reason to attempt to engage him in discussions about parenting.

3.4.7. During their time in Norfolk, other than the childminder, the only contact that Adult B and the Mother had with relevant professionals were one meeting with the Health Visitor for Child S's 2 year developmental review; one consultation with the GP as previously considered; and for Adult B a low level contact with the police that did not lead to any further action. Whilst simply the fact of their age could be said to identify them as vulnerable, there was no other reason for them to come to the attention of safeguarding agencies in Norfolk.

3.4.8. Both the adults describe their relationship to some degree as difficult and unhappy. Adult B described feeling trapped in a relationship he would not have chosen to continue had it not been for the mother's pregnancy and acknowledges he was frustrated and at times behaved in unacceptable ways towards the Mother falling short of direct violence. The Mother however describes a small number of occasions when Adult B was abusive towards her, although not leading to injury. She did not at the time consider that this was unusual in a relationship and did not consider she should seek help.

3.4.9. Both parents were frustrated and unhappy with the contribution of the other to the care of the children and appear to have been ill prepared to cope with the stresses of parenthood. They also described growing up and witnessing a degree of violence from parents to their children both personally and within their communities which meant that, for example, punishment such as 'occasional slaps', were understood a normal part of parenting. It appears likely that their acceptance of physical chastisement of the children will have contributed to a situation where there was a risk of escalation when combined with other frustrations. Neither felt at the time they would have sought help or welcomed any attempts by outside agencies to challenge them or help them think differently. It was Adult B's strongly expressed view that it was the problems in the adult relationship that ultimately resulted in the circumstances leading to Child S's injuries. *"it was never the kids fault….it's the parents having the conflict…nothing could have helped except both of us being mature enough to say this isn't working".*

3.4.10. Both the Mother and Adult B were provided with help and support by universal services and also offered other avenues of support. That they did not always take advantage of those offers raises a question as to how effective agencies are able to be in fully engaging young people in these circumstances. There were some occasions when a more proactive approach to both the Mother and Adult B was justified. Examples included:

- the mother being referred to CAMHS by the GP, but no evidence of this being followed up
- Pathway Planning for Adult B as a care leaver included further referral to emotional support and counselling as he became older, but this was not pursued.

It is not however the view of the author that a specific recommendation in this regard would be proportionate, rather it would be expected that the wider lessons from this review are shared across the agencies within normal learning and development processes.

3.4.11. Whilst there is no apparent link with the outcome for Child S, it is also worthy of note, that there was a lack of clarity at times about who was her father and what role the birth father should or could be playing in his child's life. There were times when the father or partner's name was not recorded and sometimes the confusion about who the father was.

3.5 The concerns of the Early Years Provider (childminder) and the role of the Multi-Agency Safeguarding Hub (MASH)

3.5.1. The concerns identified by the childminder during early 2015 and how this was responded to by the MASH, was one of the most significant episodes in relation to Child S. This section of the report will in effect consider two of the specific issues raised within the terms of reference:

- *How well are Early Years providers (childminders) supported in making confident referrals and ensuring they understand when and how to challenge responses?*

- *How confident are we about the decision making in the Norfolk MASH? Is there a clear and shared understanding of the difference between consultation and referrals?*

3.5.2. Child S began to attend part time at the childminder's in February 2015. From a very early point the childminder noticed that Child S's relationship with her Mother was more relaxed than with Adult B who she appeared to be less keen to go with. At the time the childminder thought this was probably because Adult B was not the birth father and Child S was just more strongly attached to her Mother. However, she described having a gut instinct that something was wrong and following an incident in which Child S had a mark on her cheek and initially said that Adult B had hurt her, but subsequently said it was the cat, she decided to call the MASH for a consultation.

3.5.3. The childminder clearly understood that she was seeking advice by means of a professional consultation, not making a child protection referral. 'Consultations' consist of advice given to professionals without identifying the specific child and generally without that professional having spoken to the parents.

3.5.4. The childminder was concerned to separate facts from her own opinions, so had been careful only to write down and therefore relay what she had actually seen. She had also understood from a previous period of employment in a nursery setting that it was better not to discuss the concerns with the mother as this might make the situation worse. This was unhelpful generic advice for her to be given as it would only apply in very particular circumstances when by doing so it would directly increase the risk of significant harm to the child before steps could be taken to protect that child. She described being told by the Social Worker at the MASH that she '*needed to speak to mum and unless she clearly stated that Child S was being abused, Children's Services could not do anything.*' She also stated that she had been told to keep recording any comments or concerns and to contact the MASH again if the Mother reacted oddly. It was apparent that the childminder was not entirely reassured by what she understood the advice to be, but followed it.

3.5.5. The Social Worker involved was not able to recollect the call in detail, due to the sheer volume of calls taken in one day. He also stated that without the parent's consent they could not discuss an individual child, but he was however adamant that if at any point he had been told about specific concerns for example that a child had made a disclosure or there were unexplained bruises, he would have said immediately this needed to be a referral not a consultation and he would need to know the child's name. The Social Worker was also absolutely clear that it is completely contrary to his practice to advise someone to keep a list or diary, something which he has taken a very clear and explicit view about with his colleagues.

3.5.6. The outcome was that the childminder continued to record some of her concerns where she felt they were factually based, but did not refer to MASH again although her worries continued.

3.5.7. The recollections of the childminder and the Social Worker about their conversation are quite different. It is apparent speaking to both of them however that their views are genuinely held. It is the author's view that the most important issue for learning is not in simplistic terms who is '*telling the truth*' or which of their perceptions provides the more accurate picture, but what can be learned from their different understanding of this brief, but significant conversation.

3.5.8. With hindsight what it appears may have happened is a degree of miscommunication between the two professionals arising out of their different experience and the inherent limitations of a consultation. Subtle shifts in language and the way in which things were expressed or heard could quite possibly explain the different perceptions of what was said. The childminder was clearly trying hard to be factual in what she relayed, but her gut instinct and the clues she was seeing were telling her something more serious was happening than she could state in factual terms.

3.5.9. Childminders do not generally have routine experience of child protection. They receive basic safeguarding training, and are inspected and registered by OFSTED, but for many childminders their experience of safeguarding is likely to be a rare one. Often they work in their own home, which raises particular vulnerabilities, and for those who work alone, the options for talking through a concern are limited. The childminder for Child S had never had direct experience of child protection or of making a referral to Children's Social Care, and although her instincts and focus on the child were sound, it appears she may not have been able to articulate those instincts in a way which ensured that her concerns were fully understood. For her as an individual this has been a lesson hard learnt. There is every reason to assume that other childminders could respond in the same way in similar circumstances.

3.5.10. The individual Social Worker is experienced and valued by his manager for his skill and the contribution he has made to the team. The Social Worker for his part described how difficult it can be to get to the bottom of what is happening when having a consultation with another professional. In taking such calls the social worker is completely reliant on the detail of what they are being told. "*I don't have the luxury of talking to the child*". In anonymous consultations there is always the potential that key information which might indicate a safeguarding concern, may not come across clearly, particularly with a professional who is not familiar with the process. It is also the case that history, which is a crucial feature of assessment, is not available in an anonymous referral.

3.5.11. Ultimately the complexity of what the childminder wanted to get across, combined with the difficulty that the Social Worker had in getting to the core of the issue with an unknown professional, meant that the consultation was not effective.

3.5.12. No evidence has been provided to this review that Child S's experience is representative of a fundamental problem with the quality of decision making in the MASH. The Social Worker was able to refer to audit evidence that illustrated the MASH team are, if anything, over cautious when responding to

referrals from other professionals. In a recent audit of 30 referrals accepted and forwarded by the MASH for assessment, 29 did not in fact result in a full S47[7] assessment.

3.5.13. What however Child S's experience does reveal is that there are inherent risks in any system for '*consultation*' in which the child is not identified and in the Social Worker's words "*achieving a 100% safety net with consultations is not realistic".* It is reasonable to suppose there will be a proportion of other situations where key information is either not provided or not understood and which may therefore affect both the advice given by the call taker and the action taken, or not taken by the caller. Information from the MASH team is that a very high number of consultations, compared with referrals are dealt with by the team, and the perception that the team is carrying a high level of risk is a strong one. The demand for 'consultations' demonstrates professionals feel the need for some form of advice, but also raises the question as to whether this is best met by a discussion about an unidentified child in a time constrained phone call.

3.5.14. Norfolk Safeguarding Board and its partners are seeking to develop greater professional confidence and understanding of the part everyone plays in ensuring a child is kept safe from harm.[8] In order to achieve this there is a crucial role for the key statutory authorities including Children's Services and the police. But it is also critical that all professionals who work with children have access to appropriate support and also the confidence to raise any concerns they may have with families directly in the first instance unless it is not safe to do so. Achieving this across the county given the wide range of professionals who have contact with children is a very significant task. The Review has been provided with evidence that there is work ongoing, for example the Local Authority's Early Years Service is developing specific training for Early Years providers, which includes the 600 Childminders working in Norfolk. Nevertheless this would appear to be an area that needs continued attention.

3.5.15. Two recommendations are therefore made by this Review in relation to i) the effectiveness of the 'consultation' process provided by Children's Services and ii) the role of Norfolk Early Years' Service in supporting childminders and other early years professionals.

4 CONCLUDING COMMENTS

4.1. The purpose of a Serious Case Review is to learn from the case in order that improvements to practice can be put in place to help families in the future. The outcome for Child S was that she was seriously injured and her family life

[7] S47 – **Section 47** of the Children Act 1989 places a duty on LAs to investigate and make inquiries into the circumstances of children considered to be at risk of 'significant harm' and, to decide what action, if any, it may need to take to safeguard and promote the child's welfare. This is also often referred to as a Core Assessment.

[8] The Norfolk Threshold Guide: https://drive.google.com/file/d/0B0dx9NWXeMnDZ0tWdXF0ZjFWd2M/view

fundamentally changed. Whilst her physical injuries have not proved to be life changing, the impact for her and her siblings' emotional development should not be underestimated. The limited involvement of agencies inevitably meant that there were correspondingly limited opportunities to understand or respond to Child S's needs, or indeed her family's needs. Whilst some flaws in practice have been identified it is not the assessment of this Review that professionals were anything other than focussed on providing a good quality service to Child S.

5 RECOMMENDATIONS FOR THE BOARDS

It is important that a proportionate response should be taken when considering what action is required as a result of this SCR and as such the following two recommendations are made:

Recommendation for Norfolk Safeguarding Children Board: That a review is undertaken to consider the effectiveness of professional consultations provided by Children's Services in which the child concerned is not named. The Review to include:

- monitoring and analysis of the current nature of consultations
- planning to ensure that all reasonable safeguards are in place in the interim.
- planning to further develop a shared understanding of roles and practice principles across the agencies and the MASH

Recommendation for Norfolk Safeguarding Children Board: The Board to seek assurance that proper mechanisms and support systems are in place in order to ensure that Early Years practitioners are aware of the Board's safeguarding priorities; understand the way in which multi-agency systems for protecting children work in Norfolk and know how to seek professional support when concerned about safeguarding children.

Recommendation for Essex and Norfolk Safeguarding Children Board: That the learning from this review regarding engaging with young parents and care leavers is disseminated to relevant partners.

APPENDIX A: Individual Learning Points and Action Plans

Basildon and Brentwood Clinical Commissioning Group

- GPs to record name of adult and their relationship to the child when they bring children and young people to GP appointments.
- The voice of the child must be recorded at all GP consultations
- GPs to share information with health Visitors and other agencies when concerns for parenting capacity and maternal emotional wellbeing are identified
- GP Practice staff must make enquiries when a child is not brought to appointments, and must inform other relevant colleagues and agencies.

Essex County Council Family Operations

- The Leaving Care service Mental Health Worker should be consulted where there is a recommendation made in the young person's Pathway Plan concerning a young person's emotional needs, especially where a service provision is recommended.

- The Pathway Plan should be specific about what services are recommended to meet an identified need. Pathway Plans should avoid making a general reference to eg 'maintain positive emotional health' without making specific recommendations about how this should be achieved.

- Reviews of the Pathway Plan should consider, if the recommendation has not been fulfilled whether any other approach is needed, or whether the recommendation is still necessary.

- Leaving Care Team managers should review in supervision whether the recommendations made in Pathway Plans are being fulfilled, and what else should be tried if they are not.

- Leaving Care Personal Advisors should receive sufficient support, through training and supervision, to be able to progress recommendations about a young person's emotional needs, especially where it is likely that it will be difficult to get these needs met.

Norfolk County Council Early Years

- All childminders need to be encouraged to keep proper records to inform future events. All records, including incident forms need to be signed and dated by the childminder and the child's file should be kept ordered to ensure easy access to information.

- Childminders should keep a written record of any referral made to MASH and send written confirmation of the referral to MASH within 24

hours. These actions are being addressed through the review of the Safeguarding Toolkit, which is available in the NCC website.

- Regular opportunities for contact with childminders need to be available to ensure there is an opportunity for dialogue between the LA and childminders. The provision of the early years helpline also needs to be emphasised so that requests for support, where appropriate, can be made.

GP Practice (from Root Cause Analysis investigation Report)

- As part of the appraisal process all doctors are required to be up-to-date with level 3 safeguarding training. Specific training on identifying which bruises are significant. The recommendation would be that all clinicians responsible for dealing with children attend training.
- All clinicians to be aware of the safeguarding protocol and contact details of the local team
- The case should be discussed in a significant event meeting at the practice and learning outcomes circulated to all

North East London Foundation Trust

- The recording templates on SystmOne lend themselves to a focus on the mother hence the practitioners are not so readily prompted to record father's information. SystmOne, a task and finish group with membership from operational services, the safeguarding children team and SystmOne administrators will identify the changes required and agree the implementation plan.
- All staff using SystmOne to be made aware that if a practitioner other than the allocated practitioner for a child or family is required to carry out a task, the allocated practitioner must also be copied into the task.
- A supervisors Network meeting to be held on the theme of *Encouraging Professional Curiosity during Supervision*
- Emerging learning to be shared at Safeguarding Meetings, Operational Meetings and a formal learning event highlighting the key points from this case to be arranged on completion of the review.