Norfolk Safeguarding Children Board

Learning from Serious Case Reviews

Case Q

Serious Case Review: Case Q

This presentation sets out:

- The case history
- Analysis of practice
- Findings and learning
- Recommendations to the Norfolk Safeguarding Children Board
- Summary & conclusions
- The Board's response
- Thematic Learning from Serious Case Reviews in Norfolk

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Serious Case Review:
Case Q History of the case to 2011

- Two children born in 2007 and 2008
- Significant history of domestic violence, drug and alcohol misuse by parents until they separated in mid 2011
- Parents had both had troubled childhoods: mother was adopted at 7 years old with her 2 sisters, all having been neglected and sexually abused.

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Serious Case Review:
Case Q History of the case 2011 - 2012

- In 2011, mother went to a refuge, was drinking heavily; children became subject to CP Plans and then in care s20 Dec 2011 to March 12.
- March 12 mother and maternal grandmother took children from foster care
- Children returned to mother's care in June 2012.
- Initially appeared to be coping well but school, neighbours had concerns

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Serious Case Review:
Case Q History of the case 2012 - 2014

- School concerns – children to school without breakfast, serious head lice problems, bruises and scratches, holes in shoes, elder child stealing at school
- Elder child disclosing at school and to refuge worker that mother smacking her, mother being under influence of drugs, writing about not wanting to be touched, complained on several occasions of sore genitals
- Several anonymous calls about neglect of the children
- Children stating unknown males in the home, loud parties
- Probation and Police confirming presence of known offenders of drug related crimes in home
- District Council in receipt of many neighbour complaints about noise, Anti-Social Behaviour, drug users in the home.

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Serious Case Review:
Case Q History of the case 2014

- Further deterioration in the home conditions
- Mother misusing drugs and alcohol, partying and males in the household
- Elder child contacted NSPCC Helpline from a neighbour's house – June 14
- Children in care for a week then returned to mother
- Further crisis – Aug 14 - house filthy, children distressed – Police Protection and Interim Care Order. Children now placed for adoption

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Serious Case Review:
Case Q Analysis of Practice

- Several key episodes when more robust action could have been taken to intervene and to protect the children *(see also Norfolk Case O SCR*)
- Delay and drift and lack of consistent planning. Changes of staff involved, neglect not mapped.
- Long history of concerns and mother's vulnerability and risky behaviours insufficiently considered.

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Serious Case Review:
Case Q Analysis of Practice

- Cumulative and pervasive impact on the children of violence, exposure to risky adults and neglect was missed and not fully appreciated.

- Indicators of risk of other types of abuse, including sexual abuse were not explored for a considerable period and the response was not robust.

- Agencies did not always work together effectively or escalate concerns. *(see Norfolk Case O SCR)*

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Serious Case Review:
Case Q Findings and Learning

- **Much good practice and sustained effort to support the children.**

- **Listening to Children** - Case demonstrates the importance and value of giving children opportunities to speak outside of the home and of recording and sharing what they say. Children were sharing considerable worries and examples of neglect and abuse at home. *(See Norfolk Case N SCR)*

- **Over-optimism/over-reliance on accepting small improvements** in the home conditions combined with a general acceptance of mother's accounts.

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Serious Case Review:
Case Q Findings and Learning

- **Joint working and escalation** - not all of the concerns were reported, effective escalation missing when the response was insufficient and all agencies not involved in key decisions. *(Norfolk Cases O & M SCR)*

- **Turnover of Social Workers and starting again** - no consistent overview of the children's experience with changes of SW and team. Lack of opportunities for a strong working relationship to be developed with mother. History not considered. (*Norfolk Case M SCR)*

  Impact of Ofsted inspection in January 2013 disrupted Children's Social Care service and it resulted in a increased turnover of staff and influx of agency Social Workers.

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Serious Case Review:
Case Q Recommendations for Norfolk LSCB

1. Ensure identification of and **response to Neglect** to children is effective.

2. Ensure identification of and **response to Child Sexual Abuse** is well understood and effective so it is included in professional reflection when assessing risk of other types of abuse.

3. **Hearing and responding to children's worries.** Improve the quality of engagement with children and young people who are at risk.

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Serious Case Review:
Case Q Recommendations for Norfolk LSCB

4. Ensure that staff are aware of their **duty to escalate** concerns when they consider that a child is not appropriately protected and/or is suffering from neglect or other forms of abuse.

5. Develop **improved multi-agency assessment, planning and working** to ensure there is robust interagency involvement.

Procedures should:

- Ensure that there is direct multi-agency involvement when assessments are being undertaken and when significant decisions are being made.
- Be reviewed in relation to the management of the **interface between child protection and looked after children systems.**

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Serious Case Review:
Case Q Summary & Conclusions

- **Many occasions in this case when immediate harm could have been demonstrated.** This required a systematic application of assessment, observation, seeking the children's views and effective coordination of the sharing and eliciting of information from all of the professionals and agencies who were involved with the family.

- **The frequent change of social worker** and an **over-reliance on mother's expla**nations meant that a comprehensive and coherent picture of the episodes of harm and of the impact on the children was not brought together through an appropriate reflective process.

- **The statements by the children were not taken sufficiently seriously** and tended too easily to be discounted despite much evidence of poor parenting and neglect.

Serious Case Review:
Case Q Summary & Conclusions

- Although it is challenging to take successful legal action in cases of neglect because of the high threshold operated by the Court that there must be risk of immediate harm, there were many occasions in this case when immediate harm could have been demonstrated. This required a systematic application of assessment, observation, seeking the children's views and effective coordination of the sharing and eliciting of information from all of the professionals and agencies who were involved with the family.

- The frequent change of social worker and an over-reliance on mother's explanations meant that a comprehensive and coherent picture of the episodes of harm and of the impact on the children was not brought together through an appropriate reflective process.

Serious Case Review:
Case Q Summary & Conclusions

- The statements by the children were not taken sufficiently seriously and tended too easily to be discounted despite much evidence of poor parenting and neglect.

- Ofsted published a study in 2010 about lessons from SCRs. The key points made in that publication can all be applied to this case:
  - inconsistency in the application of thresholds for neglect;
  - poor professional understanding of neglect;
  - difficulties in engaging with hostile or avoiding families; and
  - professionals failing to provide sufficient challenge to parents in cases of neglect.

Serious Case Review: Case Q - The Board's Response

Neglect is a Board priority. Since 2014, we have:

- Implemented a strategy to **identify and tackle neglect**
- Established a pool of **Neglect champions** across the partnership
- Developed a **Neglect Identification Tool**
- Introduced the **Graded Care Profile** assessment tool and training to Norfolk professionals
- Delivered a number of **awareness raising and best practice events** on neglect

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Serious Case Review:
Case Q - The Board's Response, cont.

We have progressed the recommendation in relation to **notifications of domestic abuse to schools.**

- During the Autumn Term 2016, joint work has been taking place with Norfolk Constabulary and Children's Services Colleagues in the Multi-Agency Safeguarding Hub (MASH) to pilot Operation Encompass in 18 schools and 1 FE college in the Gorleston and Great Yarmouth area.
- The aim in of the Operation is to notify all schools of all reported domestic violence incidents that have occurred within the last 24 hours; these notifications are made via telephone to a nominated Key Adult at the school before 9am the following day.
- Following this successful pilot, the scheme will be rolled out across the County from January 2017 – staff from approximately 200 schools have signed up to attend one of the briefings this term in order to be part of the scheme in January 2017.

Serious Case Review:
Case Q - The Board's Response, cont

- Introduced and embedded the **Signs of Safety Framework** supporting consistent practice across the child's journey
- Revised and launched the **Norfolk Threshold Guide** to align with Signs of Safety
- Developed a **Thematic Learning Framework** to include learning from this and other Norfolk SCRs to better address the recommendations at a strategic level, supported by whole system leadership

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Serious Case Review:
Thematic Learning Framework

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Norfolk Safeguarding Children Board: Challenges

Professional Curiosity – how can the NSCB encourage and support appropriate curiosity with families, and between professionals?

Fora for Discussion & Information Sharing – how can the NSCB ensure that we use opportunities for discussion effectively, include all relevant parties, act promptly and clearly; and share information well?

Decision Making & Planning – how can the NSCB improve timely and collaborative planning and get strong and shared decisions?

Leadership – how does the NSCB give effective leadership and champion better safeguarding, locating clear accountability?

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