Norfolk Safeguarding Children Board

Norfolk SCR
Case R
Executive Summary

PUBLICATION DATE: JANUARY 2017

Contents

1 Reason for commissioning the SCR

1.1 Working Together (2015) stipulates that a SCR should be initiated when a child has been seriously harmed and there is cause for concern as to the way in which the Authority, Board partners or other relevant persons have worked together to safeguard the child.

1.2 Norfolk Safeguarding Children Board (NSCB) commissioned a statutory Serious Case Review (SCR) investigation for Child R, aged 10 months after being notified that he had sustained serious and life threatening injuries on 8th May 2015. The injuries were judged to have been the result of deliberate harm.

1.3 This report is an executive summary of a SCR investigation report that was written in relation to the case, and which provides a comprehensive systems analysis of single and multi-agency practice that occurred over a total period of seventeen months. The report identifies lessons learned about how agencies worked individually and collectively to safeguard Child R and promote his welfare.

2 Background and context

2.1 Child R's parents are of white UK origin and have known each other since school days. They were in their mid-twenties when Child R was born. Child R was well at birth, following a normal and uneventful pregnancy. The couple initially lived in shared accommodation with extended family members.

2.2 Child R Background checks revealed that Child R's father had been brought to the attention local police for minor offences as a young adult. Child R's mother was also known to the police in relation to earlier domestic violence incidents with a previous partner.

3 Brief summary of the case

3.1 Child R's mother received normal ante and post-natal services from the primary healthcare team and maternity department at the local hospital.

3.2 The health visitor, based within the local children's centre, introduced herself during the antenatal period and continued to support the family afterwards in line with the national Healthy Child Programme. It was decided that the family required targeted support under a Universal-Plus category.

3.3 A Family Support Worker also based in the Children's Centre accepted a referral to deliver a 'Parent as First Teacher' (PAFT) programme, a bespoke activity-based programme designed to support Child R's health and development.

3.4 Child R was directly involved in a domestic abuse incident in October 2014 when he was ten weeks old. He was unharmed in the altercation although his mother did require hospital treatment for minor injuries. The incident resulted in a criminal justice prosecution for which Child R's father was convicted and sentenced to receive probation supervision from the local Community Rehabilitation Company (CRC).

3.5 A child protection referral was sent to the Norfolk Multi-agency Safeguarding Hub (MASH) in relation to the domestic abuse incident. Norfolk's Children's Services decided that the case required a level 3 Child in Need response following a strategy discussion. The case was allocated to a social worker to undertake an Initial Assessment.

3.6 The social work assessment was completed in December 2014 having been open for a period of eight weeks. The case was discussed at a management meeting with the team manager and a decision was made to close the case. The social worker was directed to send a warning letter to each parent at the point of closure, pointing out the adverse effects on children of witnessing domestic violence. At this juncture Child R's parents were not living together.

3.7 A second child protection referral was sent to social care by the probation service early in February 2015 when Child R's father talked openly about reconciling with his partner. The referral was made on the basis that a pre-sentence report prepared by the probation service had warned that Child R's father would pose a potential risk to partners and children.

3.8 A Section 17 Child in Need response was deemed appropriate and a second Initial Assessment was commenced. Child R's father was not spoken to as part of the assessment. The case was closed less than two weeks later after a management decision that there was no role for children's services. A further warning letter about the effects on children of witnessing domestic violence was posted to each parent.

3.9 Child R's parents continued to openly express their intention to reconcile during February and March 2015 and by April 1st 2015 the couple were living in their own house in a new geographical location with the full intention of starting a new life.

3.10 The change in geographical location triggered a transfer to another health visiting team. The family received a visit from the newly allocated health visitor who assessed the family as no longer needing targeted support. The Universal Plus service was therefore withdrawn.

3.11 Child R's mother returned to work in April 2015, leaving Child R in the sole care of his father. On 14th May 2015, whilst in the care of his father, Child R sustained serious injuries, deemed to have been inflicted deliberately.

4 Arrangements for carrying out the SCR

Organisations contributing to the SCR were as follows:

Organisation	Description of Involvement	Commissioning Arrangement
Norfolk Children's Services	Social Care, Referral and Assessment	Norfolk County Council

Organisation	Description of Involvement	Commissioning Arrangement
Norfolk Community Health and Care Trust (From April 2016 Cambridgeshire Community Services NHS Trust)	Health visiting and Community Health Support for children	Norfolk CCGs
The Queen Elizabeth Hospital NHS Foundation Trust, Kings Lynn	Maternity, Accident and Emergency NHS Acute Care and Safeguarding Service	Norfolk CCGs
National Probation Service Norfolk and Suffolk Local Delivery Unit Norfolk and Suffolk Community Rehabilitation Company (NSCRC)	Pre-sentence Report Post-sentence Offender Management	National Probation Service National Offender Management Service
Norfolk Constabulary	Police Police Custody Investigation Unit Police Domestic Abuse Safeguarding Team Police Child Abuse Investigation Unit Multi Agency Risk Assessment Conference Multi-agency Safeguarding Hub	
NHS Primary Care	GP and primary care nursing services	NHS England (Midlands and East Region)
Norfolk and Suffolk NHS Foundation Trust as joint provider for the Norfolk Recovery Partnership	Advice and treatment for adults with drug and alcohol problems	Norfolk County Council Community Services (Partnership Board)

4.1 Involvement of Norfolk Serious Case Review (NSCB) Panel

4.1.1 Senior managers and practitioners with safeguarding children responsibilities within the participating agencies formed the membership of the NSCB SCR panel. They coordinated the single agency SCR activity, including providing sources of written evidence and conducting practitioner interviews with staff.

4.1.2 The NSCB SCR panel opted not to set terms of reference ahead of the investigation, but asked that all agencies involved in the SCR considered the following points in relation to the case:

- Needs assessment and planning
- Opportunities for assessment
- Application of thresholds
- Services provided
- Inter-agency collaboration and participation
- Supervision and oversight
- Family engagement
- Policies and procedures
- Alcohol, domestic abuse and mental health

4.2 Practitioner Involvement and Support

4.2.1 Practitioners involved in this case were encouraged to participate in the SCR from the outset. Key individuals were interviewed on a one-to-one basis and a wider group of practitioners and managers were invited to attend a practitioner event later in the process to discuss the early findings and enable relevant experiences to be factored into the analysis.

4.3 Family Involvement

4.3.1 Child R's parents both gave consent for information to be reviewed and also agreed to be interviewed as part of the SCR process. Their views have been both welcomed and appreciated and have been taken fully into account in the full report.

4.4 Organising the investigation

4.4.1 On reviewing the chronological data the NSCB SCR Panel decided to closely examine three distinct Care Episodes likely to provide learning for the partnership. The rationale for focussing the SCR in this way is explained as follows.

4.4.2 The first Care Episode involved the antenatal and post-natal care delivered to the family. Evidence provided by the participating agencies indicated that information was known and held on record by several key agencies prior to R's mother becoming pregnant. Information alluded to known paternal mental ill health, alcohol and substance abuse and petty crime. Child R's mother was known to have been a victim of previous domestic abuse.

4.4.3 Care Episode 2 concentrates on the responses of agencies after Child R was involved (but not injured) in the domestic abuse incident when he was 10 weeks old. The episode includes activity following the initial child protection referral and the subsequent Section 17 'child in need' assessment until the case was closed for the first time.

4.4.4 The third and final Care Episode, spanning a period of 5 months,

examines professional interactions from when Social Care closed the case after the initial child protection referral until Child R presented with life threatening injuries on 16th May 2015 aged 10 months. It was during Care Episode 3 that a second child protection referral was made. The case was assessed by social care for a second time and subsequently closed as requiring no further action.

5 Key issues arising from the case

The main SCR report has examined in detail both the single and multi-agency systems and practices in place during the three identified care episodes for this review. This was to analyse how the child care sector was working individually and as a whole to support Child R and his family.

Specific attention was paid to the identification of risks associated with Child R's history and lived experience as a pre-verbal infant entirely dependent on his parents.

Focussing on professional interventions has enabled an understanding of how practitioners were exercising their safeguarding responsibilities within their operational context at the time.

This summary is organised under the headings that the SCR panel were asked to consider. A great deal of good practice was identified within the evidence gathered for this SCR; however this summary concentrates on the lessons which suggest that a systems improvement is needed.

5.1 Needs assessment and planning

5.1.1 Neither of the social care initial assessments done in response to the two child protection referrals was fully informed by the partnership. Agencies were contacted but information was not sought in sufficient enough detail to be helpful. Brief notes were based on a single visit and conversation with Child R's parents, without question or clarification of what was being said, the content taken very much on face value.

5.1.2 The first initial assessment took eight weeks to complete, after which it was closed. The second was closed within two weeks. Neither of the assessments indicated a robust systematic approach for analysing past and present information and neither calculated actual or likely risk in a child centred way. Assumptions of safety remained unchallenged and the rationale for decisions and actions, including closure remained vague.

5.1.3 Closing the case two weeks following the second child protection referral was considered by the SCR panel to be premature. The SCR heard from practitioners who suggested managers were being pressurised to close cases to relieve the demand on the service and front-line workers.

5.1.4 The social care service in Norfolk has recently adopted the Signs of Safety model as a means of assessment. The model balances stressors and strengths in a more systematic way. Assessment and care planning in the County will most likely improve having adopted this model.

5.1.5 Evidence in the case files of other partner agencies also indicated that a 'rule of hopeful optimism' guided their conclusions, with the overall tenor of the

assessments and care plans being adult focussed.

5.1.6 Well informed holistic and child-centred risk assessment models should be adopted across the sector in Norfolk to ensure risks and needs are identified in a systematic and consistent manner. Several models are available to guide practice, not least an adapted form of the Signs of Safety model mentioned earlier.

5.1.7 Finally, evidence suggested a generalised misunderstanding about increased risk associated with significant changes in circumstances. For example, there is evidence that when the family reconciled and moved into their own home away from their extended family support, professionals did not consider fully what those changes might mean. As a result the risk assessment and level of support stayed the same, or in the case of the health visiting service was considerably reduced.

5.2 Opportunities for assessment

5.2.1 There was considerable engagement with the family throughout the seventeen months' timescale for this SCR. However, the numerous assessments undertaken were primarily single agency in nature, entirely service specific and mainly task oriented and there was very little cross communication between the partner agencies about what they were doing.

5.2.2 There was evidence of systematic failures for NHS partners that reduced the opportunities for assessing or reassessing the family. Lack of consent, time and capacity to interrogate the system-one electronic recording system caused health information stored by various health disciplines to remain hidden and unknown. This, together with operational systems that neither encouraged nor provided key NHS professionals such as midwives GPs and health visitors to talk about cases of concern, failed to promote the conditions and information sharing that might have triggered a further assessment of the family.

5.3 Application of thresholds

5.3.1 The two child protection referrals made in relation to Child R both resulted in a Section 17 child in need response. The rationale for the application of a child in need threshold for both referrals was driven by the fact that there was no evidence of injury to Child R when the referrals were made and professionals were assured by Child R's mother and her extended family that they would cooperate and provide Child R with adequate protection.

5.3.2 The SCR panel learned that at the time of the first referral, front-line police officers and hospital staff immediately noticed that the family were justifying and minimising the level of violence that had occurred, including denying that it was harmful. There was also historical information held on file that cast doubt on mother's ability to protect herself, let alone her baby.

5.3.3 This information was not shared in the strategy discussion, not least because the referral occurred at a weekend and working patterns meant that key practitioners were off duty and unavailable for comment. Information recording

systems were similarly unavailable. This unavailability was also responsible for the limited strategy discussion that involved only two agencies.

5.3.4 Evidence suggested that the threshold decision placed too much emphasis on the absence of injury in what was a serious assault on child R's mother whilst she was holding him. There also appeared to be insufficient weighting given to the emotional impact that the child R would have experienced during the assault. With the benefit of hindsight, practitioners reflecting on the child-in-need threshold decision thought that a Section 47 child protection response would have been a more appropriate and robust approach.

5.3.5 At the time of the second referral, there were notable changes in family circumstances that suggested an increased likelihood of risk of significant harm, i.e. the pre-sentence probation report was clear that Child R's father could pose a risk to partners and children should the family reconcile. In addition the increased stressors of moving to a new home further away from sources of family support together with financial and employment difficulties were concerning.

5.3.6 In general terms, evidence submitted to the SCR suggested there was widespread confusion within the partnership about the language, rationale and application of the NSCB thresholds and their relationship to other assessment processes and thresholds. For example, the police DASH risk assessment and the thresholds defined in the 'Healthy Child Programme' (DH 2009) for universal and targeted services.

5.3.7 Evidence also suggested a poor understanding generally of how social care applied their step-up or step-down processes for children already in the system, or of how 'no action or closure' decisions were made.

5.3.8 A new NSCB threshold guidance document that was in development during this review has recently been published and distributed to the multi-agency partnership in Norfolk.

5.4 Services provided

5.4.1 A range of services engaged with the family and were delivered by qualified practitioners from maternity, health visiting, primary healthcare, social care, early years, police, probation and mental health disciplines. The family was seen regularly and no major issues arose with regards to non-access visits or non-compliance. However many of the service providers involved in this SCR were experiencing organisational changes which seemed to impact on the care that was delivered.

5.4.2 Strain was reported in the social care system which at the time was organised into three teams covering the whole of the county. The workforce was not particularly short of staff and consisted of a combination of Local Authority employed social workers and agency staff. An agency worker was allocated the task of assessing Child R.

5.4.3 Social workers reported that they were spending lengthy periods of time

travelling to and from their cases, at a time when they were being instructed to be vigilant about meeting performance targets. The impact of balancing time between case work activities and meeting performance targets was considered to have had a direct effect on threshold decisions and the thoroughness and quality of the casework undertaken. The acute focus on completing tasks within a given timescale was born out of a critical Ofsted inspection.

5.4.4 A new operational structure is in place at time of publication of this SCR which has improved this situation. The service now consists of six local social care teams covering much smaller geographical areas and there has been a shift in emphasis to the quality of services delivered rather than the hitherto narrow focus on performance.

5.4.5 The NHS health visiting input at the children's centre was also in a state of flux as the provider of the service was about to change to a new provider organisation. Negotiations were in the final stages of working out the systems and processes that would apply under the new contract. As the service prepared to change hands, health visitors were noticing an increase of families requiring additional help whilst trying to cover staff shortages.

5.4.6 An early health visiting assessment undertaken by a relatively inexperienced practitioner concluded that the family required a Universal Plus service due to relationship difficulties, alcohol abuse and paternal anxiety. The decision to arrange for additional support was sound. However, the response was to request the provision of a 'Parents As First Teachers' (PAFT) programme, despite there being no indications of attachment difficulties or emerging developmental issues that the programme is designed to support.

5.4.7 Whilst the PAFT programme provided an opportunity to observe the family, it was not designed to pick up the complex behaviours and needs of Child R's father. The SCR panel considered that practitioner inexperience was key to the decision, highlighting the importance of supervision and service review which are mentioned elsewhere in this summary.

5.4.8 Lastly, the offender manager service directed to provide supervision to Chid R's father was also in state of transition due to the implementation of a new national model whereby low to medium risk offenders were outsourced to a local private community rehabilitation company (CRC). During this transitional phase, the CRC service was not expected to provide a home visiting service, so a chance for the offender manager to observe and consider the risk his client posed to Child R in his home and family environment did not take place. Since completing this review standards regarding home visiting have been introduced.

5.4.9 How the organisational stresses and transitional risks associated with change collectively challenged the ability of partner agencies to work together could not be fully measured. It is likely that a period of transition without adequate processes and controls would trigger a culture of organisational inward thinking where structures and processes become the priority. The evidence submitted to this review strongly suggests that many of the services operating at the time, albeit delivered by well-intentioned practitioners, were being delivered from a very

narrow professional perspective, utilising a single agency and silo'd approach.

5.5 Inter-agency collaboration and participation

5.5.1 There was very little interagency, inter-professional or multi-agency communication or information sharing by any agency before, during or after contacts with Child R's family. Decisions remained uninformed, unchallenged and sometimes not communicated at all.

5.5.2 Evidence showed a general tendency within the partnership to either defer to social care colleagues; make broad assumptions that partners and colleagues would do all that was needed to be done, or employ a 'fait-accompli' attitude that any decisions once made, could not be challenged.

5.5.3 Language, terminology and interpretation was also a major source of professional confusion across the partnership. The different perceptions and translations of what was deemed to be high risk or low risk influenced the actions and expectations of professionals as to how agencies should or would respond.

5.5.4 Similarly, the importance of multi-agency working was not given enough credence at critical stages of the case, for example undertaking a strategy discussion with only two agencies present and failing to organise a joint health/ social care visit to complete the Initial Assessment (an agreed multiagency procedure).

5.6 Supervision and oversight

5.6.1 The supervision and management sessions across the wider children's sector workforce did not appear to work well or adhere to a robust framework that facilitated systematic professional reflection, scrutiny and challenge.

5.6.2 The established social care and health visiting supervision systems in particular did not demonstrate an effective reflective restorative approach designed to challenge and inform practice. Actions arising from supervision including the rationale for decisions and plans were generally poorly recorded.

5.6.3 For health visitors specifically the SCR panel concluded that safeguarding supervision would best be delivered by a skilled supervisor from a similar clinical professional background who understands the professional requirements and limitations of the health visiting service.

5.6.4 Management oversight was similarly poorly executed and recorded. A review and evaluation of the social work undertaken in terms of improved child centred outcomes and risk reduction was not clearly articulated. The discussion and management direction was primarily focussed on case closure. The reason for this may well link to the organisational pressures and performance driven culture mentioned earlier in this summary.

5.6.5 On two occasions, social care management direction was to close the case following the posting of a letter to each parent warning them about the adverse impact on children of witnessing domestic abuse and the child protection

consequences. Using domestic abuse warning letters as a 'no further action pathway' or as a means to close a case is not recommended. An NSPCC study in 2010 concluded that the practice was generally ineffective and increases rather than reduces the risk.

5.6.6 Managerial oversight for health visiting actions was similarly problematic. The service specification for reviewing complex outreach cases subject to integrated care was to discuss the effectiveness of the intervention in a formal review meeting at six to eight weekly intervals. However, the specified review meeting process was suspended. This was due to pressure on the team's ability to meet demand caused by caused by staff sickness and maternity leave. As a result Child R's case and the PAFT intervention was not subject to a managerial or monitoring review from mid-2014.

5.6.7 Discussion about this issue revealed that there was no escalation of this risk as staff were unclear how the risk should be reported, when and to whom. The risk associated with suspending the meetings therefore remained unreported, and the necessary contingencies for maintaining professional oversight and preventing 'casework drift' were never discussed or implemented.

5.7 Family engagement

5.7.1 The family cooperated with service providers and did not appear to avoid or evade contact with the professional network during the timescale of this investigation. Both parents have participated willingly in this SCR to give us the benefit of their perspective.

5.7.2 Meaningful engagement with Child R's father about his parenting role and capacity to parent safely was negligible despite a number of professionals knowing about his troubled past and concerning behaviours. Recorded information about Child R's father's difficulties remained unexplored, unshared and untested in the context of how they might impact on Child R's health, safety and welfare. The interview with Child R's father supports this finding.

5.7.3 The concentration on mothers at the expense of assessing and supporting fathers has been raised nationally in relation to health visiting practice. However evidence for this case suggests that all agencies in Norfolk need to review the level and quality of work they undertake with fathers to ensure consistent holistic assessment is embedded across the partnership.

5.8 Policies and procedures

5.8.1 No evidence has been found that suggests that the safeguarding resources available to staff were inadequate although recommended national and local guidance was not always followed, for example excluding the NHS from the strategy discussion. It does appear however that the procedures were designed to work primarily during office hours and were less effective at weekends and at night.

5.8.2 Single agency operational procedures and safeguarding guidance were

also available but were sometimes not adhered to in practice; for example, the maternity policy for routine domestic abuse enquiry at antenatal booking was inconsistently applied.

5.9 Alcohol /domestic abuse and mental health

5.9.1 The historical and situational information held within the system about Child R's family alluded to a combination of parental alcohol abuse, domestic abuse and mental health issues. Recent research suggests that where a combination of the above factors is present, the potential risk of significant harm to a child is increased. The combination of these risk factors was not given sufficient weighting in risk and needs assessments.

5.9.2 The complex dynamics of violence and abuse in a relationship and their impact on pre-verbal infants was not completely understood by practitioners. Assumptions were made that Child R would be adequately protected by extended family members and by his mother in particular. However there was no hard evidence to suggest this was the case, indeed information on record rather suggested the opposite was true.

5.9.3 It appears then, that the risks associated with domestic abuse were not fully realised and safety planning assumed a low priority in care plans. Given that domestic abuse is both common and harmful, the workforce must be better trained to recognise and respond to information that indicates domestic abuse may be a problem.

5.9.4 Since this review was commissioned Child R's mother has received services from a local domestic abuse support service. She explained to a SCR panel member that had she been supported in this way following the assault in October 2014, she would have had a better insight into her relationship and how to keep herself and Child R safe.

6 Recommendations

The following recommendations were agreed by the NSCB SCR panel. NSCB will consider the recommendations and formulate an implementation plan according to the NSCB Learning and Improvement Thematic Framework.

The following tables represent the findings and areas for improvement in a multi-agency whole sector context. A full description of the practice and rationale for the recommendations can be found in the full report of the investigation.

6.1 Multiple Agency Recommendations

MULTI-AGENCY RECOMMENDATIONS
Norfolk Local Safeguarding Children Board
Norfolk LSCB should audit and receive regular assurance that agencies have organisational escalation and operational risk management systems in place

(including contingency planning arrangements) which can be robustly applied when service delivery is compromised or under stress.
Norfolk LSCB should work with the Domestic Abuse and Sexual Violence Board (DASVB) to provide clarity about the MARAC assessment and risk threshold, the role of IDVAS and the alternative referral pathways for managing low to medium risk cases.
Norfolk LSCB in conjunction with the DASVB should measure how established risk assessment tools can improve the overall response to babies, children and young people experiencing domestic abuse in the county including within multi-agency forums and MARAC.
Norfolk LSCB must audit the membership of strategy meetings/discussions to ensure compliance with the statutory minimum requirements for participation.
Norfolk LSCB must undertake a whole partnership review of safeguarding arrangements in place outside of working hours, and for any time when key safeguarding professionals are not available, to ensure robust and effective safeguarding responses happen at any time on any day of the year.
Norfolk LSCB must ensure that the agreed NHS and Local Authority Children's Services joint visiting standard for undertaking assessments is regularly audited and reviewed to ensure compliance with and the effectiveness of the system.
Agencies providing services in integrated Children's Centres in Norfolk must undertake a full service review, to include an audit of systems and practice to improve the standard of assessment, risk assessment, general safeguarding competencies and inter-professional working.
Norfolk LSCB SCR sub-group must assess how generalised the themes from this SCR are across the partnership and the level of priority they should assume in the LSCB work-plan. • The engagement of fathers • Child-centred risk assessment • Inter-professional practice, communication and joint working • Working in isolation, silo-working and professional deference • The understanding of and practical application of the Norfolk threshold document • The skills base for practitioners working with families experiencing domestic abuse • The quality of safeguarding supervision and management oversight • The assessment and care planning for troubled families experiencing significant life changes
Norfolk LSCB should receive: • Assurance that all single-agency recommendations for this SCR are implemented • Assurance that agencies have disseminated the learning throughout their organisation.

6.2 Single Agency Recommendations

The value of achieving marginal gains through making small systems changes in single agency procedures and practice can impact positively on the overall safeguarding response of the sector as a whole. They should not be underestimated.

Single agency learning and improvements in relation to Child R have been identified as part of this SCR process. Their implementation and follow up is the responsibility of the relevant organisation. Assurance for their implementation will be sought by Norfolk Safeguarding Children Board.

SINGLE AGENCY RECOMMENDATIONS
Norfolk Constabulary
Norfolk Constabulary should reinforce its safeguarding operating procedures across the workforce to ensure that officers inform social care of all children 0 – 18 years of age coming to the attention of the police when they are involved in a domestic abuse incident, to enable an assessment of the child's risk and vulnerability.
Queen Elizabeth Hospital
Assurance must be given to NSCB that the systems review of domestic abuse routine enquiry in the Maternity Department will extend beyond the booking appointment, will provide clarity about supporting mothers following disclosure, and will be subject to practice audit.
The Maternity unit at QEH should develop and apply strategies and systems to promote the inclusion of all fathers in maternity care.
Queen Elizabeth Hospital should review the safeguarding children systems and processes (including at weekends, holidays and at night) in the hospital including the capacity and support for the statutory Named Professionals for Safeguarding Children.
Cambridgeshire Community Services NHS Trust
The Community Health Service in Norfolk must review the systems in place to further improve communication and information sharing between health visitors and GPs particularly face to face meetings and electronic information exchange.
The Community Health Service in Norfolk must review its safeguarding supervision model to ensure health visitors receive individual safeguarding supervision from a suitably qualified community clinician, in addition to any sessions delivered by professionals from another professional background.
The professional team leadership structure for Health Visitors in Norfolk should be reviewed to ensure that all health visitors responsible for Healthy Child Programme activity can access day to day management, support and professional clinical advice from an accountable Senior Health Visitor.
All health visiting assessments and care plans for families receiving a targeted Universal-Plus service in Norfolk must include clear care aims, rationale and success criteria based on the three domains for child development; parenting capacity

(including fathers) and family and environmental factors (Framework for the Assessment of Children in Need and their Families DH 2000).
A robust system to regularly and routinely review care plans for families receiving a targeted Universal-Plus service must be implemented to avoid 'drift' and to ensure early help interventions are safe and effective.
Norfolk Local Authority Children's Services
The current Local Authority out of hour's child protection referral process should include a system that will facilitate prompt communication with all relevant professionals who only work between 09.00 and 17.00 Monday to Friday.
Children's Services in Norfolk must apply and further promote a system that ensures the participation in strategy meetings of the most relevant professionals with the best knowledge and information. This should be subject to regular performance monitoring.
Norfolk Children's Services should review their system of sending warning letters to families following an incident of domestic abuse in the absence of any further intervention, in line with the NSPCC study and recommendations of 2010.
All social work assessment records must incorporate a section based on an established risk assessment instrument designed to analyse and balance the likelihood and impact of harm and which articulates clearly any risks or vulnerability factors for the child and the evidence to support them.
Norfolk Children's Services should apply and promote a robust system for management oversight and supervision for social workers that introduces checks and balances and a systematic process for casework reflection and challenge that clearly records the discussion and rationale for decisions. This should be monitored via regular QA audits.
Norfolk and Suffolk Community Rehabilitation Company
Norfolk and Suffolk CRC must review the safeguarding training, supervision, operational systems and processes that support the safeguarding practice of NSCRC Offender Managers, and provide assurance to Norfolk LSCB that these are in place, effective and compliant with the 'Practice Framework National Standards for the Management of Offenders for England and Wales' (2015)
NHS England Primary Care Commissioners (Midlands and East Region) and Norfolk GP Practices
The Primary Care GP Services in Norfolk must review the systems in place to further improve communication and information sharing between health visitors and GPs particularly face to face meetings and electronic information exchange.
NHS England (Midlands and East Region) should seek regular assurance from GPs in the Norfolk Area to ensure that Lead Clinicians in General Practice have reviewed their safeguarding children systems and processes and implemented improvement plans.

7 Next steps

Work is already underway to improve the safeguarding children systems and processes in the County based on learning from previous SCRs undertaken in recent months. NSCB will respond to the findings of this SCR and formulate a written response explain how the above recommendations will be translated into the NSCB work-plan, and how the learning will be distributed to the partnership for embedding into practice.