



Norfolk Safeguarding
Children Board

Norfolk SCR Case R

PUBLICATION DATE: JANUARY 2017

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Acknowledgements

1.1 I would like to acknowledge the cooperation and support of the Norfolk Safeguarding Children Board SCR Panel who have given me generous access to their notes and procedures, and to Abigail McGarry and Andrea James who have coordinated this serious case review (SCR) on behalf of the partnership in Norfolk. I would also like to thank the professionals who have participated in practitioner interviews and the learning event to enable key evidence to be gathered, questioned and represented in this report.

Representation for participating agencies on the Serious Case Review Panel was as follows:

Name	Designation	Agency
Abigail McGarry	Norfolk Local Safeguarding Children Board Manager	Norfolk LSCB
Andrea James	Child Death Overview Panel and Serious Case Review Administrator	Norfolk LSCB
Chris Gray	Practice Lead (Family Intervention and Looked After Children)	Norfolk Children's Services
Jane Black	Designated Nurse for Safeguarding Children	Pan - Norfolk CCGs
Lucy Parsons	Deputy Named Nurse for Safeguarding Children	Norfolk Community Health and Care Trust From April 2016 Cambridgeshire Community Services NHS Trust
Joanne Brooks	Named Nurse for Safeguarding Children	The Queen Elizabeth Hospital NHS Foundation Trust
Jackie Foden	Senior Probation Officer	National Probation Service Norfolk and Suffolk LDU
Mark Hadow	Detective Inspector	Norfolk Constabulary

2 Independent Overview Writer

2.1 The Independent Overview Writer for this case is Briony Ladbury RN, RM, HV cert, FP certificate, BA (Hons) Protecting Children, ENB Specialist Practitioner Award (Child Protection), MSc in Inter-professional Practice (Society, Violence and Practice).

2.2 Briony Ladbury has a background in safeguarding children work in the NHS both in strategic and practice contexts, producing and quality assuring NHS contributions to Serious Case Reviews and leading on developing NHS participation for Serious Case Reviews in London. She completed the taught modules for the Social Care Institute for Excellence Learning Together Systems Training in 2012 and undertook the DfE funded Course for Improving the Quality of Children's Serious Case Reviews in 2013. She is also trained in the NHS Root Cause Analysis Approach.

2.3 Currently Briony Ladbury is working as an Independent Safeguarding Professional. She was appointed by Norfolk Local Safeguarding Children Board as the Independent Overview Writer for this case.

3 Introduction

3.1 Purpose of a Serious Case Review (SCR)

3.1.1 An SCR is commissioned under statutory guidance currently outlined in 'Working Together' (2015) issued by HM Government. Regulation 5 of the Local Safeguarding Children Board Regulations 2006 includes the requirement for a Local Safeguarding Children Board (LSCB) to undertake reviews of serious cases in specified circumstances. One of those circumstances is when children have 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.

3.1.2 The purpose of an SCR is to provide a sound analysis of what happened in a particular case and why, and what needs to happen in order to reduce the risk of recurrence.

3.1.3 Working Together (DfE 2015) stipulates that an SCR 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 that data is collected and analysed;
- Makes use of relevant research and case evidence to inform practice.

3.1.4 This SCR has been undertaken with these principles in mind. It aims to give an understanding of who did what, the reasons why, and the factors that were influencing

decisions and actions within a specified time prior to the incident.

3.1.5 The review includes personal reflections from some of the professionals closely involved with Child R and his family to explain how their organisation operated at the time of the incident and how and why they acted as they did in relation to needs.

3.1.6 This report will outline the lessons learned during the investigation and make recommendations as to how they can be translated into single and multi-agency practice improvements.

3.2 SCR Commissioning Rationale

3.2.1 Child R, aged 10 months sustained serious injuries in May 2015 that were judged to be the result of deliberate harm. Initial investigations showed that several agencies had been working with the family in the preceding months.

3.2.2 On 8th June 2015, Norfolk LSCB Serious Case Review Group considered Child R for an SCR. The Chairman agreed that the case met the criteria for a review according to Chapter 4 paragraph 8 of Working Together to Safeguard Children (2013) and a SCR was commissioned.

3.2.3 The organisations that have participated in this review are as follows:

Organisation	Description of Involvement	Commissioning Arrangement
Norfolk Children's Services	Social Care, Referral and Assessment	Norfolk County Council
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	Pre-sentence Report	National Probation Service

Organisation	Description of Involvement	Commissioning Arrangement
Local Delivery Unit Norfolk and Suffolk Community Rehabilitation Company (NSCRC)	Post-sentence Offender Management	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 Methodology and Report Structure

Norfolk Safeguarding Children Board (NSCB) Learning and Improvement Framework requires that single agency reports are prepared by the participating agencies. Whilst not dictating Terms of Reference, the framework requires the individual single agency and overview authors to consider the following as part of their investigations:

- 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 and domestic abuse/violence

4.1 Background Information

4.1.1 Historical information relevant to Child R and his parents has been supplied by the SCR panel members. It has been summarised to give background and contextual information to the reader of this report.

4.1.2 On reviewing the historical information for this case, some important learning considered to be highly relevant to current day practice was identified. A decision was made that although the learning fell outside of the selected scope for this review, it should be included. It is therefore outlined in the background and context section under the heading of background learning.

4.2 Chronology

4.2.1 A tabular multi-agency integrated chronology was compiled by NSCB that consisted of all agency contacts with the family over a five year period between 14th May 2010 and 15th May 2015. The information to populate the table was gathered by the SCR panel members leading on the SCR for their agency using a combination of records review and staff interviews.

4.3 Scope and timeline for the investigation

4.3.1 The SCR panel studied the events in the chronology and selected a timeline that incorporated three distinct episodes of care which were considered to be most significant in relation to the outcome for Child R.

4.3.2 The first episode starts when Child R's mother booked for antenatal care at the hospital on 29th January 2014 and focusses on the services the family received until Child R came to the attention of the police on October 10th 2014 at the age of 10 weeks having been involved in an incident of domestic violence.

4.3.3 The second episode considers the multi-agency activity immediately after the domestic violence incident on 10th October 2014 that led to a child protection referral to Norfolk Children's Services. This episode of care concludes on the 18th December 2014 when the case was closed by Norfolk Children's Services.

4.3.4 The third and final episode reflects on the single and multi-agency practice immediately after Norfolk Children's Services had closed the case on 18th December 2014 until the morning of 14th May 2015, when Child R sustained life threatening injuries when he was ten months old.

4.3.5 The investigation takes into account single and multi-agency safeguarding practice that occurred within the time-lines outlined above, a period of seventeen months in total. The episode of care following Child R's admission with multiple injuries in May 2015 has not been included in this report as the SCR panel looked at the information and agreed that there would be little comment to make as the practice appeared to be of a consistently high standard.

4.4 Documentation

4.4.1 Single agency reports formed a large part of the data for this SCR. Where the reports failed to explain the reasoning behind the analysis or the evidence was not clear, written clarification requests were sent directly to the authors to provide more information. Where supplementary evidence was considered useful, original records protocols, procedures, and inspection reports were also provided.

4.5 Practitioner Interviews

4.5.1 The authors of the single agency reports interviewed key staff in their own agencies prior to completing their single agency reports. They followed a systems approach by using systems interview guidance developed by NSCB. Most of the practitioners involved participated willingly in the interview process, although one key professional working for Norfolk Children's Services was unable to be interviewed as they were no longer working for the organisation. This has limited the analysis and findings of the final SCR to some extent.

4.6 Practitioner Involvement and Support

4.6.1 NSCB provided information about the SCR process to all SCR panel members and practitioners involved. The SCR panel members took the primary responsibility for ensuring that participating staff in their own agencies were engaged, supported and kept informed of progress.

4.6.2 Towards the end of the process, relevant practitioners were invited to a one-day practitioner event to formulate and discuss early findings. PowerPoint presentations to illustrate systems methodology and outline Child R's story were used to enable panel members and practitioners to identify the practice points which impacted positively or negatively on the ability of the partnership to protect Child R from harm. Learning was drawn from the subsequent discussions and reflections about the reasons why actions were taken or not taken, triggering useful debate about what changes could or should be made to improve outcomes for children in Norfolk.

4.6.3 Every effort has been made by the SCR panel to ensure practitioners are aware of the analysis and findings in the final SCR report, to give them a right of reply and an opportunity to clarify or put right any inaccuracies before publication.

4.7 Narrative Summary

4.7.1 As a means of describing the family's journey through the system, the narrative summary gives a shorter and more readable account of the interventions that Child R and his family experienced, based on the data in the integrated chronology. It does not describe every agency contact in detail, but concentrates on the most relevant facts and interactions that occurred during a seventeen month period leading up to the incident which caused his injuries.

4.8 Analysis and Findings

4.8.1 Data has been analysed and triangulated using a systems approach where

possible, taking into account the organisational and practice landscape at the time. Events leading up to the incident have been considered in terms of what happened and when, what should have happened, and wherever possible, why staff took the actions that they did.

4.8.2 Evidence for the analysis has included documentation and views from front line practitioners, managers and the parents. Any practice issues that have emerged during the SCR have been further examined and researched to see if the organisational systems and processes in place at the time were sufficiently robust to support the professionals in their work.

4.8.3 The findings have been considered in the context of whether they directly or indirectly contributed to the outcome for Child R. Attention has also been paid as to whether any of the contributory factors should be considered as root causes. Some of the findings are attributed to a single agency, while some are more generalised to several organisations and thematic in nature.

4.9 Recommendations

4.9.1 The findings have been translated into recommendations designed to improve the overall safeguarding systems and practice for children and young people in Norfolk. All are relevant to Child R's story.

4.9.2 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 stipulates that a Serious Case Review should investigate how the Local Authority, Board partners and other relevant persons worked together to safeguard a child. Inevitably, during the process of an investigation, findings will emerge that pertain to the internal safeguarding arrangements of some of the participating agencies.

4.9.3 The responsibility for implementing any single agency systems changes, service re-design or development arising from this SCR lies with the agency concerned. However, NSCB will seek regular assurance from partner agencies as to the progress and implementation of any single agency actions. Agencies in Norfolk should also inform NSCB as to how agency specific learning from this SCR will be translated and embedded into practice.

4.9.4 NSCB will take responsibility for recommendations that are more thematic and generalised to one or more agencies in the partnership. It will need to consider how the recommendations apply to the Board's current priorities and whether they relate to thematic actions arising from previous SCRs. NSCB will also need to disseminate the multi-agency learning from this SCR to all of the partners in Norfolk.

4.9.5 In addition to the single agency recommendations articulated in this report, agency leads have identified system issues peculiar to their own service which did not contribute either directly or indirectly to Child R's story. This unconnected or incidental learning discovered when reviewing case files or talking to practitioners, if ignored, could create a weakness in the agency's capacity to respond to a safeguarding issue in the future. Where any flaws in internal arrangements that have been noticed, a programme of work to improve them must follow. Routine assurance should be offered to NSCB in relation to any improvements made.

5 Serious Case Review Investigation and Report for Child R

5.1 Background and Context

5.1.1 The GP notes for Child R's father allude to emotional ill health and school difficulties from the time he started school. He continued to be troubled by mental health issues throughout his childhood, adolescence and early adulthood and often required treatment and support.

5.1.2 Past searches have revealed that Child R's mother had come to the attention of Norfolk Children's Services in 2007 when she was thirteen years old. A police 'child at risk' form is filed on the social care record but the reason and outcome is not recorded. A further contact with the police occurred in 2010, when another police 'child at risk' form was sent to Children's Services for information, in line with local procedure. The issue was minor and no follow up action was necessary.

5.1.3 In July 2010 and September 2010 Child R's mother was assaulted by an ex-partner as she tried to retrieve belongings from his home. The incidents were serious and resulted in criminal charges. The police did not inform Norfolk Children's Services about either incident, which both occurred prior to her eighteenth birthday.

5.1.4 Child R's father was also known to the police as an adult, in the context of being drunk and disorderly and for causing criminal damage to public property. There is no record of Child R's father in any Children's Services files.

5.1.5 Child R first came to the attention of Norfolk Children's Services at the age of ten weeks when he was directly involved in a violent altercation that involved his parents in the street. Child R's mother and father, who were both 21 years old at the time, had been in a relationship for about two years but were not married. They were living in shared accommodation with extended family on the mother's side.

5.1.6 Child R's father was arrested following the violent incident and charged with actual bodily harm, receiving a suspended sentence, although the child neglect charges brought on the day of the incident were left to lie on file. Many professionals from several agencies had contact with the family prior to this incident.

5.1.7 On May 14th 2015, Child R, aged 9 months and two weeks, attended the Accident and Emergency Department (A&E) after having sustained serious injuries including fractures to his skull and arm, trauma to his nose and ears and bruising to his face. The injuries occurred whilst in the sole care of his father earlier that day. The medical opinion concluded that the injuries were not consistent with the explanation given and were therefore judged to have been as a result of deliberate harm. Child R's father was subsequently charged with Grievous Bodily Harm and remanded in custody. After a short spell of hospitalisation and intensive care Child R has made a full recovery.

5.2 Background Learning

5.2.1 A significant practice issue linked to the background information for this SCR is still pertinent today and as it is connected to a recent change in the national domestic

abuse definition, the SCR panel thought it was worthy of comment in this SCR report.

5.2.2 The two criminal assaults on Child R's mother that occurred in July and September 2010 resulted in her ex-partner being charged with Battery. Child R's mother was 17 and, as such was a minor according to the law. However on neither occasion was a police 'child at risk' form completed by the attending officers for the attention of social services. This meant that historical information about her being involved in domestic violence and her apparent unwise decision on two separate occasions to put herself in harm's way were invisible on social care systems.

5.2.3 The SCR panel member for the police confirmed that in 2010, a police 'child at risk' form should have been completed due to the circumstances, age and vulnerability of Child R's mother, although the reason for the omission has not been ascertained or actively pursued.

5.2.4 Whilst discussing this issue many of the SCR panel members agreed that managing information pertaining to young people aged 16 and 17 can be confusing to practitioners from across the partnership. People in this age group are frequently treated as adults, particularly as it is lawful to consent to marriage, sexual activity and medical treatment from the age of 16 years onwards. This can result in vulnerable young people of 16 and 17 being treated as adults rather than young people entitled to protection until their eighteenth birthday.

5.2.5 Recently, there has been a change in the definition of domestic violence to include young people of sixteen and seventeen, in recognition that they are the most likely group to suffer abuse from a partner (Office of the Children's Commissioner 2012). This could create further confusion about the entitlement of a young person involved in a domestic violence incident to receive a child protection response. It is important therefore that police officers particularly are clear about their child protection responsibilities to this age group.

5.2.6 Numerous research studies have consistently proven that witnessing or experiencing domestic abuse impacts negatively on the physical and emotional development of children and young people, leading frequently to emotional and/or relationship problems in later life. Notifying social care of all minors coming to police attention is therefore extremely important. The issue of failing to complete a police 'child at risk' form for social care when a minor has been exposed to domestic abuse has been a finding in previous SCRs in Norfolk and is currently a recognised area for practice improvement.

5.2.7 To avoid any confusion regarding the rights of young people to be protected, it is important that any new police procedure both acknowledges the new definition for domestic abuse and incorporates clear guidance for front line officers to ensure 16 and 17 year old victims continue to be notified to social care for consideration of their vulnerability and need for protection.

1. Single Agency Recommendation (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.

5.3 Narrative Summary (Child R's journey through the system)

5.3.1 On 29th January 2014, Child R's mother booked for antenatal care at the Hospital and attended all subsequent antenatal appointments.

5.3.2 Towards the end of the pregnancy Child R's father came to the attention of his GP in relation to a mental health problem for which he was already being treated.

5.3.3 A health visitor undertook an antenatal home visit on 27th July 2014 which was three days prior to Child R's birth. The delivery was straightforward and after initial feeding difficulties the midwifery service discharged Child R and his mother into the community. The post-natal period was relatively uneventful and the midwifery service discharged mother and baby on 22nd August 2014.

5.3.4 On 12th August 2014, the health visitor completed a standard new-birth assessment. A plan to offer targeted support via a Universal Plus Pathway was made. A referral was sent to the outreach team based in the Children's Centre for Child R's mother to receive additional help in the form of a Parents As First Teachers (PAFT) programme.

5.3.5 The PAFT parenting programme, delivered by a Family Support Worker (FSW), started one week after the health visitor had completed an eight week developmental assessment which was normal.

5.3.6 On Friday 10th October 2014, police attended an address following a report of a fight in the street. The incident had involved Child R's parents after they had returned home from a family party. Child R's mother had challenged her partner about drinking excessively and what started as a verbal altercation resulted in a serious physical assault upon Child R's mother when she decided to leave the house with Child R in her arms. Child R's mother was pulled to the ground with Child R cradled in arms. During the assault and whilst on the ground, she laid the infant on the road for safety. Child R's father picked up the infant and took him back into the house, setting him down on broken glass from a bottle he had smashed earlier in the altercation. Child R's mother followed her partner into the house, retrieved Child R and left the premises again. Concerned neighbours who witnessed the assault decided to take Child R and his mother into their home for protection. As they escorted them, Child R's father assaulted the neighbour as well. Child R's father was arrested, charged and refused bail for what was judged by the custody suite officer to be to be a high risk domestic violence incident. A police child at risk form was forwarded to social care.

5.3.7 An ambulance was called to take Child R and his mother from the scene of the

incident to Queen Elizabeth Hospital (QEH) Accident and Emergency (A&E) Department for medical assessments. Child R's mother was treated for injuries but Child R was found to be physically unharmed. The Norfolk social care Emergency Duty Team (EDT) was informed of the admission and a child protection referral form was completed and sent. A message was left for the Named Nurse for Safeguarding Children on the hospital safeguarding team's answerphone and a copy of the referral form was sent to the hospital safeguarding team for their attention.

5.3.8 On 11th October 2014 (Saturday) at 01.03hrs, in response to the referral, EDT entered into discussions with the police and hospital staff to enable a safe and proportionate response. It was decided that Child R and his mother could safely be discharged into the care of extended family.

5.3.9 Meanwhile, a detective sergeant assigned to weekend public protection duties became aware of the incident shortly after arriving for work on the Saturday morning by means of a routine check of all cases that had occurred the previous night. Searches were conducted to collect any previous intelligence regarding Child R and his parents. A secondary Domestic Abuse, Stalking and Harassment (DASH) risk assessment was undertaken and Child R's mother was judged to be at medium risk of harm.

5.3.10 Later on Saturday 11th October, a child protection strategy discussion took place by telephone, involving EDT and the detective sergeant. A joint response was agreed in which the police would be responsible for interviewing Child R's father, and social services for undertaking an Initial Assessment. The incident was judged to be 'level 3' according to the Norfolk Threshold Guide, and subject to a Child in Need response in line with Section 17 of the Children Act 1989.

5.3.11 On 12th October 2014 (Sunday), the investigating police officer for the assault charges became aware during a contact with Child R's mother that she was minimising the seriousness of the assault.

5.3.12 The next day (Monday 13th October 2014) Child R's father was bailed from Kings Lynn Magistrates Court with bail conditions barring him from having contact with his partner or his son. On his release, his mother contacted the family GP to inform the doctor of the events that had happened at the weekend. She reported that her son had been drinking heavily since December 2013. The GP signposted the family to the Norfolk Recovery Partnership (NRP), a service that could provide advice and treatment for alcohol related problems.

5.3.13 A social work home visit was undertaken on Tuesday 14th October 2014 by an agency social worker attached to the relevant area team office. The visit was in response to the decision that Child R might be a Child in Need according to Section 17 of the Children Act 1989. The social worker concluded that Child R was not at risk of harm owing to sufficient protective factors being in evidence and the assertion by the family that the incident had been a 'one off event' induced by alcohol.

5.3.14 Also on 14th October 2014, the named nurse for safeguarding children in the hospital discussed the case with the senior A&E Nurse who had been on duty when Child R and his mother were admitted. The named nurse reassured her colleague that as the case was high risk it would be automatically referred to a domestic abuse Multi

Agency Risk Assessment Conference (MARAC) for a risk management discussion and to social services for a child protection investigation.

5.3.15 Child R's father saw the GP on the 15th October 2014. Further detail about the incident on 10th October 2014 was recorded. In response to the consultation the GP advised Child R's father to stop drinking alcohol and contact Alcoholics Anonymous.

5.3.16 On 15th October 2014, having learnt about the incident by means of a standard A&E notification, the family health visitor undertook a home visit. A plan was agreed for the PAFT programme to continue and for mother to attend baby massage sessions. No further visits were arranged at this time. No health, development or attachment concerns were identified, although Child R's mother was expressing a wish to find housing of her own.

5.3.17 By Friday 17th October 2014, the police had noted that Child R's mother was still in close contact with and receiving support from the parents of her partner, despite being told to distance herself.

5.3.18 Child R's father contacted the out-of-hours GP service on 18th October 2015 after he had taken a small but intentional overdose of analgesics. The toxicity was below the level for medical intervention and no further action was taken.

5.3.19 The Police Child Abuse Investigation Team ceased all activity regarding the family on 22nd October 2014, because Child R's father had already been charged with Cruelty and Neglect of a Child and the baby was receiving social care support.

5.3.20 At the end of October (29th October 2014) the GP for Child R's father received a telephone call from his mother. She reported that her son's alcohol consumption was escalating and she enquired about the options available for accessing private treatment.

5.3.21 During the first week of November 2014, an email was sent directly to Child R's social worker from the investigating officer for the police dealing with the assault charges, warning that Child R's mother was both minimising the violence and talking about resuming her relationship with her partner.

5.3.22 On 12th November 2014 Child R's father sought further medical advice from his GP about his excessive alcohol intake. The GP noted that his patient had already contacted the NRP service and an appointment was being arranged.

5.3.23 The social worker's Initial Assessment for Child R was reviewed on 20th November 2014 in a case supervision session with the team manager. The supervisor agreed that the case could be closed on the proviso that the assessment was completed and domestic abuse warning letters were sent to each parent. Norfolk Children's Services subsequently closed the case one month later on 18th December 2014, after the recommendation for no further action was endorsed by the team manager.

5.3.24 The NRP service informed the GP in a letter dated December 1st 2014 that Child R's father had been seen for an assessment to ascertain his support needs. The

letter indicated that Child R's father would be undertaking hypnotherapy for substance misuse. The letter also noted that Child R's father was caring for his son overnight, on three nights a week, but only when the paternal grandparents were present. The letter was scanned into the clinical record.

5.3.25 Child R's father visited his GP again in the first week of January 2015. There appeared to be some improvement. His alcohol consumption had reduced and he stated that he was feeling better. The notes also recorded that he was seeing his girlfriend again.

5.3.26 The National Probation Service in Norfolk interviewed Child R's father for a pre-sentence report on January 15th 2015 in preparation for his trial which occurred on 3rd February 2015. He was found guilty of the offences of Assault Occasioning Actual Bodily Harm, Common Assault and Battery and Affray and was sentenced to 10 months custody, suspended for 18 months with 18 months supervision. The child neglect charge was to lie on file.

5.3.27 Child R's father was seen the next day (4th February 2015) for a routine induction appointment with an Offender Manager (OM) employed by the Norfolk and Suffolk Community Rehabilitation Company (NSCRC). A plan to support his rehabilitation and reduce his risk of re-offending was made. During this appointment he voiced his intention to resume his relationship with his partner and son. This admission prompted the OM to send a child protection referral to the Norfolk Multi-Agency Safeguarding Hub (MASH) as the pre-sentence assessment and report had concluded he was a risk to partners and children.

5.3.28 Norfolk Children's Services assessed the referral and categorised the risk as medium. The case was allocated for a second Initial Assessment on 4th February 2015 under the threshold criteria for a Child in Need Assessment as defined by Section 17 of the Children Act 1989.

5.3.29 On 13th February 2015, the agency social worker who had completed the first Initial Assessment visited the family again in order to provide continuity. A second Initial Assessment was commenced, later to be reviewed and discussed in a social work management supervision session. Following the management discussion the case was closed. Closure letters were sent to each parent.

5.3.30 The FSW visited Child R on 25th February 2015 to deliver the PAFT programme. Child R's mother produced the second Initial Assessment and closure letter which stated that no action would be taken.

5.3.31 On the same day Child R's father attended a supervision session arranged by the NSCRC. The case had been re-allocated to a new OM. Child R's father openly discussed his intention to live independently from his parents and talked about resuming his previous relationship. The OM, aware that a child protection referral had been made a fortnight earlier, contacted social care to ascertain the outcome of the referral and he was informed that the case had been assessed and closed.

5.3.32 On 2nd March 2014 the OM was informed that the couple had been assigned a two bedroomed house. During a 'Building Better Relationships' session held on 4th

March 2015, Child R's father disclosed that he had indeed resumed his relationship with Child R's mother, although they were not living together at that stage. He also kept an appointment with a worker at the Norfolk Recovery Partnership on that date.

5.3.33 Shortly afterwards, Child R's mother expressed to the FSW that she did not want any outreach support after she had moved to her new location, which was imminent.

5.3.34 Child R's father told the OM on 1st April 2015 that that he was moving in with his son and his partner that evening. On hearing this news, a referral was sent to mobilise a Woman's Safety Worker (WSW) as a safety precaution and support measure for Child R's mother; however she declined the offer.

5.3.35 By mid-April 2015, Child R's father was reporting to his OM that he and his partner were enjoying living together, were interacting positively and his dependency on alcohol seemed to be under control. He also informed the OM that his partner was about to return to work.

5.3.36 On 16th April 2015, a transfer-in visit was undertaken by a health visitor covering Child R's new address. The outcome of the visit was to step-down the Universal Plus targeted support and offer a Universal service instead, meaning that planned contacts would be less frequent and only clinic based. It was agreed that Child R would next be seen for a one year developmental assessment approximately three months later.

5.3.37 Child R's father participated in 'Building Better Relationships' group-work sessions for perpetrators on 28th April 2015 and 12th May 2015 as arranged by the NSCRC and required by the Court.

5.3.38 On 14th May 2015, Child R was left alone with his father whilst his mother worked an early morning shift nearby. Whilst his mother was at work, Child R sustained life threatening injuries indicative of deliberate harm. He was admitted to Queen Elizabeth Accident and Emergency Department later in the morning where he was given immediate medical support before being transferred to Addenbrookes Hospital in Cambridge for paediatric intensive care. He has since recovered from his injuries.

6 Care Episode 1. 29th January 2013 until 9th October 2014

The following analysis focusses on the professional interactions that occurred between 29th January 2014 and 9th October 2014 (from antenatal booking until the first domestic abuse incident that occurred when Child R was ten weeks old).

6.1 Queen Elizabeth Hospital

6.1.1 Child R's mother booked for antenatal care at 16 weeks gestation on 14th February 2014. This is slightly later than the national average of 12 weeks (Delivered With Care: NEPU 2010) but not alarmingly so. She was assessed as being a low risk clinically.

6.1.2 At the time of booking there was a departmental clinical protocol in place in the ante-natal clinic that required the booking midwife to ask every woman if she was experiencing domestic abuse. The protocol was developed in response to many research studies that linked intimate partner violence to pregnancy (Bailey 2010). It was hoped that routine enquiry, by identifying women in need of help, would reduce the likelihood of harm to the woman and her baby.

6.1.3 The sheer numbers of women attending for booking appointments meant that that face-to face time with each woman was severely limited. This raises a question as to whether the booking appointment created the right conditions for Child R's mother to discuss any difficulties she or her partner were having. It also raises a question as to whether the highly pressurised working environment of the clinic was the ideal practice environment for the midwives to ask such a complex question.

6.1.4 The idea of routine enquiry at booking was to 'normalise' the question by placing it alongside all the other routine screening questions of a personal and sensitive nature gathered at the beginning of a pregnancy. Asking all women hoped to enable victims to disclose, and the normalisation of the issue was thought to be less stigmatising. The question therefore became part of an ordered tick-box booking process rather than a skilled targeted enquiry about a highly complex issue. If the question was missed at the booking appointment, women would not be prompted with it again. The field on the booking form that related to this question for Child R's mother was left blank and the question was not raised again by any midwife before or after Child R was born.

6.1.5 When Child R's mother booked for ante-natal services the departmental protocol document was described as 'out of date' and the SCR panel learned that its use was 'extremely inconsistent'. On further enquiry, it appeared that it had never been adopted formally as hospital policy and was therefore difficult to enforce. When exploring whether the inconsistency of use was perhaps deliberate avoidance by midwives, there was an acknowledgement that practitioners would have been aware that a disclosure would require an unfamiliar, complicated and protracted response, so not asking the question might have had distinct advantages.

6.1.6 The protocol did caution midwives against asking questions about relationship issues when partners were present, on the premise that it could increase the risk to the patient, but as the notes did not record whether Child R's father was present or not, it has been difficult to say if this was a factor for the enquiry not being made. There were never any physical or behavioural signs observed or recorded that prompted staff to repeat the question during the ante or postnatal period.

6.1.7 Since routine enquiry was first mooted, there has been a wealth of practice guidance issued about the need to train professionals in the best way to ask the domestic abuse question, which should extend beyond a one-off tick box exercise at a booking appointment. The National Institute for Health and Care Excellence published NICE guidelines [PH50] in February 2014, shortly after Child R's mother pregnancy was confirmed. The NICE Practice Development Group came to the conclusion that despite there being insufficient evidence to recommend screening or routine enquiry in healthcare settings, asking patients routinely about abuse in some specialised health care settings, including maternity services, was considered good practice. The document also pointed out that people experiencing domestic violence and abuse may

choose not to disclose it.

6.1.8 As Child R's mother reiterated many times during professional interactions that violence was not a feature of her relationship with Child R's father, it is unlikely that failing to enquire about domestic abuse would have had much bearing on the outcome for Child R. However the hospital maternity service does need to improve its systems for identifying women experiencing domestic abuse during the antenatal and immediate post-natal period, including raising the confidence and competency levels of midwives in asking the question and clarifying the clinical pathways for practitioners to follow after disclosure. At the time of writing this SCR, the process for identifying pregnant women subject to abuse is already subject to discussion pending review.

6.1.9 Another stark omission in the ante and postnatal documentation was the complete lack of reference to Child R's father. There is a sense that he is present at times during the antenatal and postnatal period, but little is mentioned about him, or how he supported his partner for example, or interacted with his new son. It has long been recognised that young and/or vulnerable fathers and particularly those who have had difficulties in their past are less likely to engage during maternity consultations, so more attention needs to be paid to how young fathers in general are included and prepared for fatherhood as part of maternity care.

6.1.10 The Royal College of Midwives published guidance in 2012 entitled 'Reaching Out: Involving Fathers in Maternity Care', to encourage maternity units and midwives to properly engage with fathers. The guidance explains the positive impact on the wellbeing of mothers, babies and fathers when maternity units develop strategies to help fathers articulate their needs. It provides a sound evidence base that proactive preparation for childbirth and fatherhood can have long lasting positive effects by alleviating the anxiety and stress many fathers experience.

2. Single Agency Recommendation (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.

3. Single Agency Recommendation (Queen Elizabeth Hospital)

The Maternity unit at QEH should develop and apply strategies and systems to promote the inclusion of all fathers in maternity care.

6.2 Norfolk Community Health and Care Trust

6.2.1 At the time of the incident, community health services were provided by Norfolk Community Health and Care Trust (NCH&C). The health visiting team that provided care to Child R and his family was part of a co-located integrated team, sharing office

space with other professionals in the Children's Centre.

6.2.2 The Children's Centre provided and still provides a variety of community services including healthcare and early-help support, delivered by practitioners from different professional backgrounds. A comprehensive service specification for the Children's Centre describes in detail the core offer for children and families using the service. It incorporates a full range of Healthy Child Programme (HCP) activities, delivered by Health Visitors. It also specifies the need to provide information to families about child health related topics such as alcohol and substance misuse, presumably for preventing adverse effects on the health and wellbeing of the local population.

6.2.3 The integrated team structure was complicated. The health visiting component was led and managed by a second tier 'Integrated Children's Centre leader' with experience in adult, children and early years support. The family support workers (FSWs) were another component of the integrated team, but responsible for the delivery of early help programmes as part of a bespoke outreach service. The outreach team had its own outreach team leader qualified in early years work, who also reported to the second tier Integrated Children's Centre leader.

6.2.4 The responsibility for the Children's Centre as a whole lay with an experienced Children's Centre Locality Manager who came from an early years professional background. None of the Children's Centre senior management team were qualified health professionals.

6.2.5 In 2014, NCH&C records management was supported by SystemOne, an electronic medical records system designed to support cross-organisational working. Using SystemOne inter-operability, clinicians in community health services and approximately 70% of the GP's working in Norfolk, shared access to information held on the system. GPs and health visitors using the 'share' facility could add and review information to the electronic record of selected adults who had given consent for this to happen.

6.2.6 A system to facilitate regular face to face meetings between GPs and health visitors to discuss concerns about vulnerable patients did not become standard practice until September 2014 in Norfolk, so it is unlikely that a meeting occurred during this episode of care.

6.2.7 The health visiting service met Child R's mother for the first time towards the end of her pregnancy at 37 weeks gestation, which met the NHS England antenatal visiting standard for the Healthy Child Programme (HCP) (2014).

6.2.8 When the initial antenatal contact took place, Child R's mother was living with her partner, her mother, stepfather and young step sister in fairly overcrowded conditions. The health visitor had not received any information from any other professional to suggest health or welfare difficulties had been identified up until this point.

6.2.9 There is evidence to show trusting engagement with the health visitor from the start. Child R's mother openly volunteered information to the HV about a previous violent relationship she had experienced but also reassured the health visitor that

domestic abuse was not an issue with her current partner.

6.2.10 Child R's mother also disclosed at the ante-natal visit that her partner had a past history of depression and substance misuse and that she was concerned about her partner's increasing alcohol consumption which was creating a lot of friction in their relationship to the extent that it could cause them to separate. The practitioner did not immediately identify that the combination of substance and alcohol misuse, depression and 'friction', if left to escalate, could lead to increased risk by raising questions about the infamous 'toxic trio' described by Brandon et al in 2012 (the combination of substance misuse, mental health problems and domestic violence which significantly increases the risk of serious child abuse).

6.2.11 Disclosing that alcohol, mental health problems and relationship difficulties were factors in the family dynamics a few days before Child R was born might have been a deliberate act by Child R's mother to alert the health visitor that they were of concern to her, but whether deliberate or not the conversation did not feature as an area for future professional exploration and monitoring, possibly also because the concerns mentioned were attributed to Child R's father and health visitors most commonly concentrate their efforts on mothers and babies.

6.2.12 Either way, the health visitor did not have easy access to information about Child R's father. The GP records would have been a good source of historical information about Child R's father, but he was not registered at the same practice as Child R's mother and the health visitor had no access to any clinical information about him.

6.2.13 Had Child R's father's electronic medical record been read by the health visitor, the long and complex mental health history might have played a more significant part in the health visitor's care plan or triggered a more in depth conversation with the GP who had known Child R's father since he was a child.

6.2.14 As mentioned before, SystemOne technology does have the capability to allow health visitors and Norfolk GPs to view each other's electronic records through a common portal, but for this to happen, a central common record would have to be set up, for which the patient would need to give consent for their clinical information to be viewed.

6.2.15 Setting up SystemOne shared access to electronic records for health visitors and GPs in Norfolk is fairly routine for parents and carers of babies registered with the same GP, and in this case the health visitor successfully obtained consent from Child R's mother to view her GP record. However no such arrangement was made to view information about Child R's father who was registered elsewhere.

6.2.16 Although technically possible it wasn't, and still isn't, the norm for health visitors to enable the share facility for viewing the electronic records of a parent or carer registered with a different GP from the child.

6.2.17 There is, of course, no guarantee that the health visitor would have viewed the historical information about Child R's father had the share arrangement been in place. However, it would seem sensible to introduce a protocol that places an expectation on

health visitors to seek consent to establish a SystemOne share arrangement for all parents and carers for children on their caseloads to ensure that the welfare of the child is considered in the context of his or her wider family structure. Introducing this small but significant change towards a 'think family' approach (DCSF 2009) as standard must be an advantage in safeguarding terms and will bring about a marginal gain for a majority of children in Norfolk.

6.2.18 Conversations with practitioners and managers during the course of this SCR suggest that health visitors and primary care professionals are still not communicating as well or as frequently as they might about families they have in common, so this is clearly an area for improvement. The matter of face to face meetings with GPs is mentioned elsewhere in this report, but establishing and increasing any opportunities for health visitors and GPs to meet or share information is bound to help foster a healthy and respectful professional working relationship in the future.

4. Single Agency Recommendation (Cambridgeshire Community Services NHS Trust and NHS England Primary Care Commissioners – GP Practices)

The Community Health and 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.

6.2.19 The conclusion of the health visitor after having met Child R's mother for the first time, was that the family required extra support. This was a reasonable decision – although the significant needs of Child R's father that were impacting negatively on the family dynamics were left unsupported. Two further visits were undertaken by the health visitor, a standard 'new birth visit' at thirteen days post-delivery and another for an eight week developmental assessment. Child R's father was present at both of them, but questions and advice about his own adjustment to being a father were not raised.

6.2.20 Health visitors are recognised and registered as specialist community public health nurses. They have long since embraced the concept of holistic assessment. They calculate the needs of their families by assessing parental capacity, family and environmental factors and the physical and emotional development of the child. Moving ever closer to the public health agenda, in the same way that smoking is discussed with families to prevent harm to the health and development of a child, so too could health visitors approach the issue of alcohol intake, on the premise that excessive alcohol consumption is one of the 'top five enduring priorities' defined by Public Health England (2013-14). However, raising such a deeply sensitive and personal topic without sounding and feeling judgmental or fearful, requires a great deal of knowledge, confidence and skill. To achieve this level of competence, practitioners require appropriate assessment tools and high quality supervision and support.

6.2.21 The SCR panel learned that the allocated family health visitor was newly qualified. As for all newly qualified practitioners, a practice teacher was assigned to

offer mentorship and advice to the inexperienced health visitor on the broader aspects of health visiting practice as well as to generally oversee her transition to becoming an autonomous practitioner. Ad-hoc case work advice was given as expected, although in 2014 practice teachers came under extreme pressure as an unintended consequence of a 'A Call to Action' (DH 2011) when there was a sudden influx of students and newly qualified staff, so their time and capacity to support new practitioners was somewhat challenged.

6.2.22 The main opportunity for reflection and learning would have been within regular safeguarding and child protection supervision sessions. The newly qualified health visitor received safeguarding supervision from the integrated Children's Centre Leader and line manager of the health visiting team who was not a health professional by background but had undertaken training to facilitate safeguarding supervision in general.

6.2.23 In Norfolk the supervision framework for health visitors included all child protection cases where children were subject to child protection plans, plus self-selected cases where the health visitor considered that there might be underlying or emerging safeguarding concerns below the threshold for referral. This approach is typical of many supervision models for health professionals in England. However, many health visitors regard the opportunity to reflect on families of concern as being as valuable an experience as reviewing children subject to child protection plans, simply because they are the most challenging families they work with in terms of ongoing support.

6.2.24 The health visitor for Child R whilst aware of the stressors and tensions in Child R's family did not consider them complex enough in safeguarding terms to be selected for a supervision session. A more experienced practitioner might have come to a different conclusion, particularly as the operational service specification for the team included alcohol and substance misuse as a 'child health related topic'.

6.2.25 Being able to prioritise and self-select cases from a large caseload of families with varying needs and vulnerabilities depends on the practitioner's knowledge and ability to recognise potential safeguarding factors that require a carefully planned response. Self-selection by newly qualified staff who are by definition still developing their critical analysis and safeguarding skills, is therefore inherently risky.

6.2.26 Sagoo and O'Reilly (2013) designed a system of supervision especially for health-visitors to enable robust monitoring of all children with identified additional needs who were receiving a Universal Plus service. Initial findings from an evaluation of the model showed a marked improvement in the assessment, analysis and planning for complex families receiving targeted support. Whilst this may be impractical for the county as a whole in Norfolk, it may be a useful system for newly qualified staff, to enable safeguarding risks to be identified early and acted on.

6.2.27 The importance of health visitors receiving frequent and good quality practice support post qualification from a supervisor experienced in clinical practice cannot be underestimated, and the issue as to whether safeguarding supervision ought to be delivered to health professionals by people from a non-clinical background, or line managers has been the subject of debate for many years. Certainly, the broader issue

concerning the blurring of professional boundaries has been found to introduce safeguarding risks in some SCRs and the matter is considered again in the NHS England, National Health Visiting Core Service Specification for 2015-16.

6.2.28 A robust study about professional supervision entitled 'Nursing: Communication Skills in Practice' (Webb 2011) also concluded that supervision for clinicians should primarily provide a tool for health practitioners to reflect safely, openly and critically about their clinical and professional decisions to enable high quality service delivery.

6.2.29 Some consideration needs to be given as to whether the supervisor in the Child R case, who came from a different professional background, had sufficient clinical and professional health visiting theoretical knowledge and experience to enable appropriate clinical reflection and challenge. The health professionals on the SCR panel were clear that professional supervision from a person with a good understanding of clinical practice as it applies to child protection would be hugely appreciated by health visitors in Norfolk. That said, having supervision from a practitioner from another professional background can be of benefit to facilitate the integrated thinking and practice so crucial for the safety and welfare of children, so incorporating a combination of both in some broader framework is probably the most desirable.

5. Single Agency Recommendation (Cambridgeshire Community Services NHS Trust)

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.

6.2.30 The Universal Plus service chosen by the health visitor to give targeted support was a structured activity based parenting course entitled Parents As First Teachers (PAFT). The rationale for selecting this service, the intended outcome and how the programme would benefit Child R and his family was not clearly explained in the health visiting care plan; suffice to say that the programme's aims are to increase parenting confidence and attachment by teaching parental strategies to support a child's development. The programme was to be provided by an FSW with an early years qualification, trained to deliver PAFT activities. The FSW would be operationally managed by the outreach team leader for early help support based in the Children's Centre who would also oversee the progress and effectiveness of the intervention.

6.2.31 Evidence submitted to this SCR shows that none of the programmed PAFT activities ever took place during the timescale of this SCR due to Child R either being fed or asleep when the FSW called. The FSW frequently observed and noted signs of good attachment and confident parental handling by Child R's mother, although an opportunity to observe Child R's father interacting with his son during contacts was not always possible as he was out when some of the visits took place.

6.2.32 Part of the service specification for the health visiting service in the Children's Centre was to review the progress of complex families receiving outreach support at six to eight week intervals. This was to ensure that children were receiving the right level and type of intervention for their needs from practitioners with the appropriate skill-mix to deliver the service. This type of review is a good way to manage resources and monitor whether the intervention is achieving the desired outcome.

6.2.33 During the latter part of 2014, the health visiting team within the Children's Centre noted a growing number of children and families requiring a targeted outreach service. This coincided with a sudden dip in health visitor capacity, caused by a combination of sickness, maternity leave and vacancies, leaving the team short of two experienced health visitors. The staff who remained, who were obliged to meet their core health visiting duties, could not justify taking time out to attend the outreach review meetings. The outreach review system was therefore compromised and the case review meetings were suspended. Discussion about this issue has confirmed that only one outreach review took place to monitor the effectiveness and suitability of the programme from the day it commenced until April 2015, a period of seven months.

6.2.34 The suspension of the outreach review meetings caused by lack of capacity was reported to the Outreach Team leader when she returned from a short period of sick leave. She in turn discussed the matter with the Children's Centre Leader. The matter was finally raised with the Locality Manager who had ultimate responsibility for the integrated service as a whole. However the identified risk was never entered on the Children's Centre Risk Register for organisational risk management and monitoring.

6.2.35 Evidence for this SCR has shown that that there was no mechanism or robust operational policy in place for concerned front-line health visitors attached to the Children's Centre to escalate or manage risks to their service specification. It seems that the complicated structure and the associated escalation, governance and assurance arrangements for the integrated team had not been fully developed or sufficiently understood by all practitioners working within it.

6. Single Agency Recommendation (Cambridgeshire Community Services NHS Trust)

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.

7. Multi-agency Recommendation (Norfolk LSCB)

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.

6.2.36 The question as to whether PAFT was the most appropriate type of intervention for this family has been raised by members of the SCR panel, particularly as there was little evidence that suggested attachment difficulties between mother and baby or any identified concerns about Child R's health and development.

6.2.37 The FSW did appear to engage with and support Child R's mother, although it appears that none of the programmed activities were ever completed. However, undertaking home visits was clearly providing a good opportunity to keep an eye on how Child R's mother was adapting to parenthood.

6.2.38 The constraints and the formal prescribed design and delivery of the PAFT programme limited the type and level of surveillance that would have been required to monitor any emerging or escalating safeguarding or behavioural concerns on behalf of Child R's father, so his own complex needs and adjustment to becoming a father remained unaddressed.

6.2.39 This SCR report has already highlighted the lack of focus on Child R's father in midwifery and health visiting consultations, and from the evidence submitted it is apparent that the PAFT programme, selected by the health visitor as a means of Universal Plus targeted support, focussed mainly on mother and baby interaction.

6.2.40 In 2013, the nursing research unit undertook a literature review including how health visitors engage with fathers (Why Health visiting? DH Policy Research Programme). The research describes a worrying lack of attention to new fathers. Findings suggest that health visiting services in England continue to follow deeply entrenched approaches that focus only on mothers and their children, despite the 'Healthy Child Programme' (DH 2009) insisting on proactive engagement of fathers at every level of health visiting service specifications. The report also points out that research to support health visitors as to the best way to engage and work with fathers is both limited and relatively new.

6.2.41 The evidence for this review, in line with these national findings, strongly suggests that the overarching culture within the health visiting service in Norfolk was similar to the national profile, that is, the focus being predominantly on mothers with little attention paid to the role and function of the father or their influence on a child's health and wellbeing.

8. Single Agency Recommendation (Cambridgeshire Community Services NHS Trust)

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).

9. Single Agency Recommendation (Cambridgeshire Community Services NHS Trust)

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.

7 Care Episode 2. 10th October 2014 until 18th December 2014

This episode examines the practice following a domestic abuse incident involving Child R, until the social care Initial Assessment was completed and closed.

7.1 Norfolk Constabulary

7.1.1 The assault that occurred on Friday 10th October 2014 was extreme and occurred in the street whilst Child R was being carried by his mother. During the incident Child R's mother sustained physical injuries that almost rendered her unconscious. Child R was not physically harmed, he was however extremely distressed. Child R's father, who had been drinking excessively, was arrested, charged and refused bail because the incident was judged by the officer in the custody suite to be a serious domestic incident.

7.1.2 A subsequent secondary domestic abuse assessment was undertaken based on the Domestic Abuse Stalking and Harassment (DASH) scoring system which was endorsed by the Association of Chief Police Officers (ACPO) which replaced the National Police Chiefs Council (NPCC) in 2015. The checklist assessment is designed to identify adult victims who are in dangerous and high risk situations. Once identified, their circumstances are discussed by professionals in a Multi-agency Risk Assessment Conference (MARAC) to manage the risk and prioritise safety.

7.1.3 Independent Domestic Violence Advocates (IDVAs) attached to the Norfolk MARAC take a key role in supporting individual's to stay safe. This is routine for victims deemed to be at high risk. Occasionally a victim categorised as a 'high end medium risk' may be referred for IDVA attention following a specialist assessment, but this was not the case for Child R's mother.

7.1.4 The resulting risk to R's mother was regarded as 'medium', and as the circumstances did not appear life threatening and failed to reach 14 points on the scoring system, the case fell below the threshold for routine referral to the Norfolk

MARAC for risk management. In addition, the medium risk was not considered 'high end' enough to be passed to an IDVA for follow up support.

7.1.5 The Norfolk 'Domestic Abuse Crime Booklet' is clear that police officers may utilise professional judgement if they believe the situation warrants a high risk response. SafeLives, a national charity dedicated to ending domestic abuse, advise that MARAC referrals should not always depend solely on the rigid DASH scoring system. They recommend taking into account contextual information and identified vulnerabilities on a case by case basis. An elevation to high risk without a high DASH score is therefore permissible in some cases. It could be argued that the unusual circumstances of this case may have warranted a higher rating.

7.1.6 There is no doubt that the case was unusual and alarming. The violent assault on October 2014 was extreme, albeit the first reported for the current relationship, and the involvement of a 10 week infant made it all the more serious. The picture was one of a total loss of control on the part of the perpetrator. Some professionals on the SCR panel have consistently said that the circumstances and level of risk were high enough to warrant a high risk MARAC response on the basis that Child R's mother was by this time known to have been assaulted twice in a previous relationship when she was a teenager and seemed unaware of any strategies to keep herself or her baby safe.

7.1.7 As far as the police mounting a response was concerned, the DASH risk assessment showed that there had not been an escalation in the frequency and severity of violent episodes and the imminent risk of a dangerous assault on Child R's mother was low because the perpetrator was in custody pending charges and immediate support and protection was being provided to her by her family.

7.1.8 The child protection implications which had been fully realised by the police had been appropriately referred to Children's Social Services for ongoing child protection activity, so the DASH risk assessment for the baby was deemed to be low. The reasonable working assumption by the police was that statutory social work intervention would prevent further harm to Child R by ensuring that his mother was willing and capable of protecting him, or should this not be the case, that statutory child protection measures would be taken to protect him.

7.1.9 On balance, the DASH assessment decision not to refer to the MARAC was sound, although it is acknowledged with the benefit of hindsight that concentrated advice and support from an Independent Domestic Violence Advocate (IDVA) could have been beneficial to Child R's mother for explaining the risks and for encouraging safety planning for herself and her baby. In practical terms for the county however there was, and still is, a justified concern that should the high risk MARAC threshold be lowered to incorporate cases below the risk of imminent serious harm to the adult, the service in Norfolk would be inundated and unable to operate at its current level.

7.1.10 Another important consideration is that when the incident occurred, an IDVA was operating within QEH specifically to support low to medium risk domestic abuse cases arriving at the hospital. It appears from the evidence that the hospital IDVA was not on duty at the time Child R and his mother were admitted, and was not alerted to the case when she returned to work, mainly because assumptions were made that the circumstances were assessed as high risk case anyway.

7.1.11 From the evidence submitted to this SCR there does seem to have been serious confusion within the partnership as to what cases justified a high risk MARAC referral and the assessment criteria used for defining high as opposed to low risk for victims of domestic abuse, particularly when the adult victim is a parent.

10. Multi-agency Recommendation (Norfolk LSCB)

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.

11. Multi-agency Recommendation (Norfolk LSCB)

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.

7.1.12 The duty detective sergeant in the Norfolk Multi-agency Safeguarding Hub (MASH) spoke with the Emergency Duty Team (EDT) on Saturday 11th October 2014, about the safety planning for Child R. Following an initial sharing of information, the police agreed to participate in a strategy discussion with two social care colleagues from the EDT to determine whether the case should be dealt with using a single or joint approach.

7.1.13 In an interview for this SCR, and with the benefit of hindsight, the police detective sergeant agreed that the strategy discussion that took place probably did not meet the statutory requirements for a strategy discussion laid out in national or local guidance, although it was sufficient to decide on the initial response described below.

7.1.14 The outcome of the meeting was for a joint response by the officers from the police investigation team, the Child Abuse Investigation Team and social care. This was a sensible decision designed to ensure that the adult and child protection aspects of the incident were dealt with.

7.1.15 Following the strategy discussion, but within 24 hours of the incident, the police officer investigating the assault charges noticed a sea change in R's mother's attitude towards violence. The officer noted that Child R's mother was playing down the incident and trying to make the situation look better than it was by intimating it was a one-off event. It also appeared that Child R's father's family were making contact with Child R's mother which was considered highly irregular. The police officer was rightly concerned about the impact of this change of attitude on the criminal justice proceedings. The matter was promptly shared with the police detective sergeant overseeing safeguarding duties.

7.1.16 The police detective sergeant who received the information telephoned the mother of Child R's father to point out to her directly that her behaviour was inappropriate. Evidence confirms that the police officer was the same person who had represented the police in the child protection strategy meeting. Despite being aware of the child protection activity, the concern about Child R's mother minimising the abuse was not shared with social services. It would therefore not have informed the Initial Assessment about to be undertaken by the allocated social worker. It appears that the information was dealt with only in the context of ensuring the investigation was not compromised and this would have been considered a priority for the police officer. However this information did have safeguarding connotations as well. The SCR panel has been unable to ask the social worker if this information would have changed or influenced the assessment, but either way it would have been appropriate to report this concern.

7.1.17 Further evidence to support the apparent minimisation of the violence has come to light in this SCR from police records and interviews. Child R's mother was noted to actively challenge some of the language the police had written in her statement to make it sound less harsh. She later attended the Court hearing against police advice with her partner's parents, which was both unusual and worrying.

7.1.18 Some weeks later on November 7th 2014, serious concerns about the risks to Child R, should the couple reunite, were sent from the investigating police officer directly to Child R's allocated social worker in the form of an email. The message was sent after the Initial Assessment visit had taken place, but well before the case was closed. The email informed the social worker that Child R's mother had written a letter to the police and the CPS, which belittled the incident and went on to describe her partner's good character.

7.1.19 The information contained in the email was both important and valid and based on a sound judgement that minimisation of domestic abuse increases risk to children. It was sent promptly and directly to the child's allocated social worker. The investigating police officer primarily tasked to investigate and gather evidence for the criminal assaults on Child R's mother and the neighbour assumed that a direct communication with the professional holding the lead safeguarding and child protection responsibility for Child R would be taken seriously. On balance this assumption seems fair, and although some follow-up action to confirm that the information had been received would have been useful it is unlikely that a busy police investigating officer would have held it in mind as a priority. In hindsight the sending of e-mails to alert high level concern should be discouraged as having a direct conversation with the allocated social worker or a social work colleague operating a duty service would have been preferable.

7.2 Queen Elizabeth Hospital

7.2.1 An ambulance took Child R and his mother to hospital on the evening of Saturday 10th October 2014, where they received appropriate medical attention. Child R was found to be unscathed but his mother had sustained minor injuries. At the practitioner event, an A&E senior nurse on duty in the department described the circumstances of the admission and recalled her concern about Child R's mother's

apparent acceptance and justification of the violence, which in her opinion could so easily have resulted in far worse outcomes in terms of physical injury.

7.2.2 A child protection referral was made by the A&E senior nurse via a telephone call to EDT followed by a written referral on the appropriate child protection referral form. After several discussions about the immediate management of the case, the staff in the A&E department were eventually informed by EDT that it was safe to discharge Child R and his mother from the hospital.

7.2.3 In the early hours of the morning Child R and his mother left the hospital into the safe care of Child R's maternal grandmother. In the short term, this decision was both sensible and appropriate, as where possible it is far better for infants not to be admitted to paediatric wards where disease and infection risks can compromise their health.

7.2.4 A copy of the child protection referral form was forwarded to the named nurse for safeguarding children in the hospital and a message was left about the incident on the hospital safeguarding team answer phone.

7.2.5 The referral was discussed with the hospital named nurse for safeguarding children on the following Tuesday. On hearing the detail of the referral the named nurse reassured the A&E senior nurse that as the violence was severe and a small baby was involved, the case was high risk and as such would be referred to the MARAC. Reassurance was also given to the A&E senior nurse that social care would be following up the child protection concerns. The named nurse did not contact social care to check the outcome of the referral as she was certain in her own mind that there could not, and would not be an alternative course of action.

7.2.6 The IDVA employed at the time to pick up cases of medium and low risk in the hospital worked from Monday to Friday so was not on site when the assault occurred. The IDVA was not officially informed of the incident by A&E staff on her return after the weekend, as they had received reassurance from the named professional that Child R's mother would be subject to a high risk MARAC assessment and would come to the attention of an IDVA through that route, and Child R would be protected from harm by means of a social services child protection referral.

7.2.7 The assumption that the named nurse for safeguarding children made about the management of the case was only partly correct, in that Child R's mother had not been considered at a high enough threshold for a MARAC referral and the outcome of the child protection referral was to fall below the threshold for a Section 47 child protection response, although an Initial Assessment had been initiated under Section 17 Child in Need arrangements.

7.2.8 In conversations for this SCR, the senior A&E nurse and the named nurse for safeguarding children have expressed surprise at the outcome of the referral and risk assessment decision. The named nurse for safeguarding children in particular has been at pains to say that had she been more aware about the level of risk being applied to both the victim and the baby she would have challenged social care about the threshold to try to raise it to a higher level, and she would also have taken more personal responsibility to communicate the information about the incident and

subsequent action to health colleagues and the hospital based IDVA. In the event, the information was left for the paediatric liaison health visitor to share with her community colleagues, although this appears not to have happened either. The information was finally communicated via the standard discharge letter generated by the A&E department for the GP and health visitor.

7.2.9 Since 1991 there has been a statutory requirement to employ a suitably qualified named nurse and doctor for safeguarding children in each NHS hospital trust. A named doctor in an acute hospital setting is responsible for safeguarding clinical duties and medical practice development. The role is usually undertaken on a part time sessional basis by one paediatrician as part of his or her job plan. A named nurse for safeguarding children provides a full range of safeguarding clinical and strategic expertise to the employing organisation and operates normally during office hours.

7.2.10 In Norfolk the named nurse worked from Monday to Friday, providing an important leadership function for organisational strategy, policy and service developments, training and expert advice for complex case work. The work-load of a named nurse is frequently heavy and demanding. The misleading assumptions made by the named nurse about how the incident would have been managed was in part due to the incident occurring at the weekend when she was off duty.

7.2.11 The fact that an acute hospital is open for business all day and every day inevitably means that there is an accumulation of safeguarding issues for the named nurse to manage on return to work. This backlog would have existed in addition to the routine work scheduled for the week ahead. The named nurse at QEH picked up the information regarding Child R when she returned to work and offered professional support and advice to the senior A&E nurse who was clearly concerned about Child R's safety.

7.2.12 The named nurse had complete confidence in the advice she gave to her colleague. She was utterly convinced that the incident would have been categorised as a child protection matter without question, so much so that the actual outcome of the referral was not formally followed up with social care. Being fully occupied with the amount of work that had been generated over the weekend, the case then slipped from her mind.

7.2.13 The need to manage a growing and complicated range of strategic and case specific responsibilities, particularly after a weekend and without a great deal of support presents a huge challenge for any named professional working in a busy acute hospital setting. On reflection, the named nurse at QEH agreed that the assumption she had made, born out of her own good experiences and faith in a safeguarding system that was known to work well during the week, was unwise.

7.2.14 The hospital has identified that systemic risks occur at the weekend when the safeguarding team does not operate. Safeguarding issues that arise at the weekend should be managed using the same unambiguous hospital safeguarding systems and communication pathways that are in operation during normal office hours, otherwise children using the hospital at a weekend are at a distinct disadvantage. In addition, attention also needs to be paid urgently to the hospital safeguarding children

arrangements in operation during the week to ensure that the named professionals have sufficient capacity and support to meet all of their statutory responsibilities including managing and following up complex cases, which can be time consuming as well as emotionally draining.

7.2.15 In broader multi-agency terms, safeguarding working arrangements and the inter-professional relationships of safeguarding professionals in Norfolk, particularly those who work in similar nine to five environments, were reported by the SCR Panel members to be pretty robust. Even so, it is important to foster a culture that values enquiring, checking-out and challenging the work of colleagues to guard against complacency or an over reliance on the belief that everything that should be done, has been done.

12. Single Agency Recommendation (Queen Elizabeth Hospital)

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.

7.3 Norfolk Children's Services

7.3.1 The social services EDT covering the Friday evening shift on 10th October 2014 were informed by the hospital of the assault involving Child R. They responded quickly and were soon reassured by medical staff that he had not been injured. The social worker made enquiries about Child R's father which returned information that he had been detained, charged with the assault and refused bail.

7.3.2 Within a few hours EDT were confident it was safe for Child R and his mother to be discharged into the care of relatives, on the proviso that mother and baby were medically fit and that there would be no contact with Child R's father. The decision was promptly passed to the A&E Department.

7.3.3 The EDT social worker arranged for a strategy discussion to take place by telephone later that Saturday because of the unusual nature of the case and the severity of the incident. The purpose was to facilitate a discussion to decide whether the threshold for likely or actual significant harm had been reached and clarify what type of response should follow.

7.3.4 EDT communicated with the hospital three times in total about the immediate safety arrangements for Child R and his mother but they did not inform them that a strategy meeting was to take place on the Saturday afternoon. As a result hospital staff remained unaware and unable to participate in, or share any information about their observations and interactions with the family.

7.3.5 The 2013 version of the 'Working Together' statutory guidance gave clear instructions about how social care should respond to a referral, conduct a strategy meeting and manage the feedback to those who had initiated the referral.

7.3.6 From the evidence submitted to this SCR it appeared that the rationale for the decisions made by EDT following the referral and after the strategy meeting were not relayed to the hospital, other than by informing the A&E senior nurse that Child R could be discharged from the unit.

7.3.7 Informing the referrer about outcomes of meetings and the rationale behind decisions is an essential and valued part of the child protection process, particularly for professionals with safeguarding responsibilities of their own. The process increases staff awareness of safeguarding practice as a whole and helps to allay any anxiety they may have about what happens to the child following discharge. The referrer in this case was an A&E senior nurse, who was left wondering what child protection steps had been taken.

7.3.8 Communicating directly with hospital clinicians can be extremely difficult owing to their shift patterns. However, it is possible through established hospital safeguarding arrangements, and it is important that feedback incorporates the next steps in relation to any child protection process, in addition to any instructions about immediate action. As recognised safeguarding partners, health practitioners are encouraged to challenge and question, but cannot do so if outcomes are not shared.

7.3.9 From discussions undertaken by the SCR panel it is evident that the failure to feedback information to referrers at the hospital and elsewhere has been noted before, and that this omission has been found to be generalised across the social care services in Norfolk. The LSCB is currently taking measures to monitor this problem to enable the system to improve.

13. Single Agency Recommendation (Norfolk Children's Services)

The current Local Authority out of hours 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.

7.3.10 The decision to undertake a formal strategy discussion at the weekend presented the usual difficulties of organising a multi-agency meeting when key service providers were shut for business. Holding the strategy discussion for Child R on the Saturday would have inevitably meant that important practitioners and some electronic recording systems which held highly relevant information would not be available to inform the discussion. The strategy discussion for Child R went ahead anyway, involving three practitioners from two agencies, the EDT manager and EDT social worker and the police detective sergeant covering safeguarding duties that weekend.

7.3.11 They decided that an Initial Assessment should be commenced under section 17 of the Children Act 1989 because the likelihood of significant harm was judged to be low and a child protection investigation would not be necessary.

7.3.12 The rationale for applying a 'Child in Need' threshold was based on the facts that Child R had not been physically injured, was in a safe place and his mother was

cooperating and being supported by relatives. The impact on the infant's emotional well-being from being involved in the incident and the potential risk of significant harm should Child R be in close proximity to domestic abuse in the future was not considered as a potential source of significant harm. It was also noted that the perpetrator was in detention and refused bail, so would not have contact with Child R or his mother. This assumption was correct, but only in the short term.

7.3.13 Follow-up action was to be undertaken by the police and social care to cover the criminal justice and safeguarding aspects of the case respectively. The safeguarding referral was then sent to the appropriate social care team in the community for a social worker to commence an Initial Assessment.

7.3.14 The outcome of the strategy discussion was based entirely on information that had been collected during Friday night and Saturday morning and as such the rationale was drawn from a very small and limited pool of information. A better approach would have been to focus the discussion on the immediate safeguarding requirements and make a recommendation that a repeat statutory strategy meeting should take place on the next working day to gather intelligence from the partnership and consider the likelihood of significant harm in the longer term.

7.3.15 The telephone strategy discussion which occurred on Saturday 11th October 2014 fell short of the minimum requirements in Working Together 2013 and the Norfolk LSCB guidance document which both stipulate that a Strategy Discussion should involve a social worker, social work manager, police officer and health professional **as a minimum** to enable the sharing of all available information and secure agreement from the partnership with regards to the type of response and follow-up actions. Key health professionals were neither invited nor available to participate and evidence suggests that the health visitor and the hospital in particular held some interesting information that would have been helpful in the context of risk assessment and forward planning.

7.3.16 The national and local procedural guidance for Norfolk allow for more than one strategy meeting to be undertaken if required. Holding a further Strategy Meeting on the next working day would have enabled the discussion to be chaired by the relevant senior manager of the social work team to which the case was allocated. More importantly, it would have enabled key members of the safeguarding children partnership to attend to fully appraise them of the situation, facilitate information sharing and incorporate their views. The decisions from the meeting would therefore have been made on the basis of the widest information possible, provided by professionals who knew the family well and who continued to have a role in their care.

14. Single Agency Recommendation (Norfolk Children's Services)

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.

15. Multi-agency Recommendation (Norfolk LSCB)

Norfolk LSCB must audit the membership of strategy meetings/discussions to ensure compliance with the statutory minimum requirements for participation.

16. Multi-agency Recommendation: (Norfolk LSCB)

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.

7.3.17 The children's services social care structure operating at the time of this review followed a service re-design undertaken in 2010. The re-configured service had reduced the number of duty teams in the county from 6 to 3 and a Multi-Agency Safeguarding Hub (MASH) provided a 'front door' for referrals to enable quick risk assessment and decision making. Some of the comments made by practitioners for this SCR suggest that the operational structure placed the Children's Services workforce in Norfolk under considerable strain.

7.3.18 The allocated locality team responsible for Child R was based in a busy urban area and referrals were steadily increasing over 2014 and 2015. The increase in workload coincided with a high vacancy rate in the social work establishment, ameliorated somewhat by the employment of agency social workers.

7.3.19 An Ofsted Inspection in 2013 had judged Norfolk Children's Services to be 'Inadequate' and managers and practitioners in the county were trying hard to improve the situation at the front line. In reality however, social workers were travelling longer distances for casework activity, and were spending considerable amounts of time in their cars instead of seeing clients. In the office, they were dealing with copious amounts of paperwork and administrative tasks. The working environment for the locality team holding case responsibility was described by practitioners as both stressful and demoralising during the course of this investigation.

7.3.20 The Initial Assessment was commenced on 14th October 2014 when Norfolk were operating an assessment process that continued to follow the Initial and Core Assessment procedure described in 'Working Together' (2010). Following an improvement notice from the DfE in 2013, Norfolk Children's Services made the

decision to concentrate on improving initial assessments and core assessments, rather than immediately working to the 2013 single assessment model. The SCR Panel member for the Local Authority was confident that using the 2010 timescales at this time was acceptable to practitioners and did not create any confusion in practice.

7.3.21 The evidence to inform the following SCR analysis about the social work Initial Assessment for Child R has been drawn from documentation and conversations with the team manager and assistant team manager working in the social care office at the time. It has not been possible to interview the social worker allocated to the family, so the following analysis has not been able to ascertain or represent views and issues from this key practitioner's perspective.

7.3.22 A visit to Child R's mother, with consent, was undertaken by the agency social worker on Tuesday 14th October 2014 following a briefing from the team manager. The agreed system in Norfolk for health visitors and social workers to undertake Initial Assessments jointly for children under five years old did not happen on this occasion and an explanation as to why this system failed has not been ascertained.

7.3.23 The pre-arranged Initial Assessment was recorded under the headings of parental capacity, family and environment, and child development, the three domains of the 'Framework for the Assessment of Children in Need and their Families' (HM Gov 2000). Positive observations were recorded under the domains of family and environmental factors and for Child R's developmental needs. The notes for the parenting capacity domain alluded to previous pushing and shoving within the relationship but not to any serious violence. Child R's mother reassured the social worker that Child R's father's aggressive outburst was caused by a combination of drinking alcohol whilst in a highly emotional state. This was supported by Child R's grandmother who was present during the assessment. Both were supremely confident that domestic abuse would not pose a risk to Child R in the future.

7.3.24 The detail of any information from the wider children's partnership was minimal in the notes of the Initial Assessment, and it is not clear how much of a contribution other agencies made or were asked to provide. The assessment clearly logs the names and telephone details of health professionals in QEH and the duty health visiting duty team as contributors to the assessment, and there is indicative evidence that conversations with these professionals did take place. However there is little information in the assessment documentation as to what those contributions were. Neither of the health practitioners can recall the conversation with the social worker and their notes appear not to have recorded the subject matter or the outcome of the call.

7.3.25 Evidence has been produced that shows that the wider partnership, particularly health professionals and the police, had a considerable amount of knowledge about the family including some references to father's past aggressive behaviour, vulnerability and alcohol misuse. Mother's forgiving attitude towards the violence was also seen as problematic by some agencies and the SCR panel has seen an email that was sent by a police officer directly to the social worker on November 7th 2014 outlining concerns that she was minimising the domestic abuse incident. The email is not filed, recorded or mentioned in the Initial Assessment documentation so whether it was received or how it was factored into the analysis is not known.

7.3.26 The final risk analysis listed a number of protective factors including that: Child R was not having contact with his father; his father was acting responsibly by seeking help for his alcohol and emotional issues; there was no previous history of violence in any other context and in Child R's mother's opinion, the baby was not in any danger from his father. A single risk factor was identified regarding mother's shared intention to resume her relationship with her partner when the bail conditions expired.

7.3.27 The discussion that formed this analysis was a record of the conversation during the initial and only visit to Child R's family. Information was taken at face value and accepted without question. The conclusion of the assessment therefore, was that there were no child protection concerns and no further social work intervention would be necessary. It is not unreasonable therefore to conclude that had fuller information been sought from the partnership, an entirely different conclusion and plan might have been reached.

7.3.28 A research study 'Ten pitfalls and how to avoid them' (NSPCC 2010), designed to offer advice about making evidence-based judgements to safeguard children, describes in detail common pitfalls in the assessment process. The study warns practitioners about making an initial hypothesis on the basis of incomplete information and of accepting and becoming over committed to it without seeking out information that might refute it. The study also suggests that if attention is focussed only on the most visible or pressing problems, background history and less obvious detail is frequently insufficiently explored. The aforementioned pitfalls can both be detected in the notes of Child R's Initial Assessment.

7.3.29 The study also sets out the primary role and function of social work case supervision and the importance of encouraging and enabling supervisees to review their decisions through a process of self-reflection. It also describes the important role that supervisors play with regards to providing the necessary challenge about the reasoning and evidence base that lies behind the practitioner's recommendations.

7.3.30 Child R was discussed in case supervision on 20th November 2014, facilitated by a newly appointed team manager. The supervision session consisted of an in depth discussion about the case and nothing more. Comprehensive supervision notes were not agreed either during or after the session, so the file in relation to the assessment and plan for Child R was not reviewed or signed-off as part of any robust or formal management oversight process.

7.3.31 An action was agreed that following completion of the assessment, warning letters would be sent to each parent when the case was closed, highlighting the serious risk that domestic abuse posed to children and warning them that further steps would be taken if another referral was made. The team manager has told SCR panel members during an interview that she would have also given a verbal instruction to the social worker to gather further information and undertake another visit to Child R's mother and father to test the likelihood of further violence. Whilst this is probably true, there is no written record to support this evidence.

7.3.32 It appears from the social worker notes of the supervision session that a key action for closing the case was the writing of a letter to each parent to warn them against a further episode of domestic abuse. In 2010 the NSPCC (Stanley et al)

undertook a body of research about children and families experiencing domestic abuse. The research findings criticised the use of domestic abuse warning letters as a 'no further action pathway' or as a means of sole intervention for cases where there was considered to be low level violence. A recommendation from the NSPCC study was for social care services to review the practice of sending warning letters to parents as their research had concluded that they were generally ineffective and could increase risk rather than reduce it.

17. Single Agency Recommendation (Norfolk Children's Services)

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.

7.3.33 No evidence has been found during the course of this SCR that confirms that further intelligence was sought from other agencies as a means to complete the assessment. The closure of the case was therefore authorised without further work being done. Warning letters were duly written and sent as instructed. The authorising manager placed a note on the file at the point of closure stating that there had been a delay in completing the Initial Assessment, giving the reason as 'work-load pressures'.

7.3.34 The tenor of the SCR Panel discussions strongly support the view that the social workers and managers across Norfolk were facing considerable challenges in 2014. It appears that despite efforts being made to raise the quality of assessments, there were underlying performance tensions and pressures on managers and social workers to complete assessment tasks on time, aggravated by a somewhat cumbersome 'Care First' IT system and a growing number of outstanding case files needing to be completed and processed.

7.3.35 However, the SCR panel members have also agreed that the Initial Assessment for Child R was a particularly poor example of its genre. From the documentation it could be deduced that the social worker and the responsible team manager were somewhat complicit in formulating and underwriting assessment decisions that clearly did not follow the county's procedures for either quality or timescales. This leads to consideration of what else was going on for the practitioner and manager at the time.

7.3.36 When interviewed, the team manager described the front-line social workers as holding a case load of 30 - 40 cases each. Capacity to manage this workload was problematic, in that there was a backlog of cases waiting to be written up at the very time that staff were being directed (following an adverse Ofsted Inspection finding) to complete assessments within required timescales.

7.3.37 The desire to alleviate any stress on the workforce, yet keep up with the throughput, presented a dilemma for the relatively inexperienced team manager. Having heard a verbal account of what seemed to be a thorough and well-reasoned

professional assessment from a competent and experienced social worker during a supervision session, the team manager felt that the case was suitable for closure. The case was authorised for closure without reviewing the notes or articulating in detail the management rationale for the decision. With the benefit of hindsight, the team manager has realised that the case was closed prematurely.

7.3.38 Sadly it has not been possible to interview the family social worker and this has limited the analysis for this part of the SCR. However, practising in the face of a generalised culture driven by a need to demonstrate improvement on meeting assessment timescales might not have encouraged the meticulous care and attention to detail that is necessary when formulating care plans for vulnerable children.

7.3.39 Professor Eileen Munro raised concerns in her 2012 review of child protection services that social work in England was generally becoming target and performance driven at the expense of focussing on quality. She suggested that social workers were distracted by performance management tasks at the expense of undertaking in depth face to face work with families. There was also a high turnover of staff in the profession and morale was judged to be low. All of these points seem highly relevant to this SCR.

7.3.40 There has been a total recognition by Norfolk Children's Services that the service design in place during this SCR timescale was not effective. Some changes have already been made, notably that cases are kept open for longer and are not closed during police investigations or pending Court activity.

7.3.41 In addition, the current performance management criteria in Norfolk have changed to one of quality audit and service user experience rather than meeting deadlines, and services have been redesigned to concentrate resources over smaller geographical areas. A new assessment process that incorporates 'Signs of Safety' principles has also been implemented to facilitate a more family and child centred response. (Turnell and Edwards, 1997).

7.3.42 NSCB are considering other systems changes to improve inter-professional practice in the county as a result of other SCRs, and the findings of this report will be incorporated into any further improvements that are considered necessary.

18. Multi-agency Recommendation (Norfolk LSCB)

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.

7.4 Norfolk Community Health and Care NHS Trust

7.4.1 The health visitor for Child R and his mother received brief yet comprehensive information about the domestic abuse incident by means of a routine A&E notification form that arrived on Monday 13th October 2014. Similar information would have been sent to the GP but evidence for this SCR suggests that during 2014, the GP and Health

Visitor did not have a particularly robust working relationship and no proactive attempt to speak to each other about Child R was made by either health professional. An arrangement was made however to go and visit Child R's mother with the FSW on the 15th October 2014.

7.4.2 The health visitor and the FSW learnt from Child R's mother that a social worker had visited the day before, to complete an assessment and no action was deemed necessary. This must have sounded reassuring. When the question of violence was raised, Child R's mother insisted that domestic abuse was not and had not been a feature in her life. She reassured both the FSW and the health visitor that her relationship with Child R's father was over, as she would not tolerate being with someone who was violent towards herself or her child; she also reported that he had been sacked by his employer. Child R's mother however, did suggest that Child R's father needed specialist help for his alcohol consumption.

7.4.3 Being informed that Child R's father was out of the picture and that the relationship was over persuaded the health visitor and FSW that Child R's mother could make responsible decisions and was capable of protecting her son. Their observations were recorded and the health visitor concluded that the risk to Child R was low, particularly as mother continued to be willing to engage and accept support. A plan was agreed for the FSW to continue to visit and for Child R's mother to attend baby massage sessions, but further home visits from the health visitor in person were not thought to be necessary as the situation was considered to be stable.

7.4.4 The visit to support Child R and his mother was timely and thoughtful although it may have been helpful to incorporate into the conversation how risk can escalate following a report of a domestic abuse, especially when couples separate. Introducing the importance of safety planning would have been good practice but once again this may simply have been due to a lack of knowledge and experience in relation to family violence and abuse on the part of the newly qualified health visitor.

7.4.5 During an SCR interview the health visitor expressed surprise that she had not been personally briefed about the incident on 10th October by either the hospital, social services or the police, or invited to the strategy meeting to discuss the case. She would have expected to undertake a joint visit with the social worker according to local procedure. This reflection is valid, however it is also important for practitioners to seek out information when they are aware of potentially serious incidents that could affect the health and welfare of children on their caseloads and be fully involved in any plan to support them. From the evidence submitted it appears that despite a fair amount of professional curiosity which led to an immediate home visit, there was no formal or direct contact with the social worker to find out more about the incident or the Initial Assessment that was undertaken.

7.4.6 Recommendations about a lack of professional and inter-professional curiosity, information sharing and communication are all too common in SCR's and this one is no exception. The SCR panel agreed that there were significant communication failures which applied to more than one agency that led to Child R's health visitor receiving only scant information. However, questions also need to be asked as to why no proactive efforts were made to contact colleagues in other agencies who were known to be involved with the family.

7.4.7 Measures need to be taken to look at whether 'silo working' (working separately and in isolation) could be an issue in Norfolk and if so, implement systems to change it, or whether a culture exists that causes professionals to defer to social care as the final word that cannot be challenged. Either way, training and support systems to enable health practitioners to be more proactive in seeking out information, determining the nature and pace of safeguarding plans and challenging other agencies, are essential for all practitioners working in community health settings.

7.4.8 The established joint visiting standard for health and social care to undertake Initial Assessments together also failed in this case, and requires a joint review involving Commissioners, NHS Providers and Children's Services. It has therefore been included as recommendation 16 of this report for the NSCB to action.

7.4.9 Recommendations in the Community Health and Care Trust's Single Agency Report identified the need to improve the way domestic abuse incidents are picked up and recorded, but further work needs to be undertaken to enable health visitors particularly, to hone their skills as confident inter-professional practitioners.

8 Care Episode 3. 18th December 2014 until 14th May 2015

This final episode of care looks at the professional interactions from the time that the first Social Care Initial Assessment was closed until the day that Child R presented in the hospital with injuries consistent with deliberate harm.

8.1 National Probation Service (Norfolk and Suffolk LDU)

8.1.1 In 2014 probation services were subject to a major national reorganisation. The responsibility to supervise low to medium risk offenders was to be outsourced to new private community rehabilitation companies (CRCs) leaving the National Probation Service to manage high risk offenders and people subject to public protection arrangements. During the timescale for this episode of care, the probation services in Norfolk were in a state of transition.

8.1.2 The National Probation Service in Norfolk first met with Child R's father to draft a pre-sentence report prior to his conviction for Actual Bodily Harm, Common Assault and Battery and Affray.

8.1.3 The pre-sentence report painted a picture of Child R's father having been a seriously troubled child and young person often requiring treatment for recognised mental health problems and school difficulties. As an adult, he continued to struggle to cope emotionally and was particularly thrown at the thought of becoming a father, taking large quantities of alcohol as a coping mechanism. As far as violence was concerned, he admitted to pushing and shoving his partner at times but nothing more. A routine check with children's social care was undertaken which confirmed that there was no active involvement with regards to Child R. The pre-sentence report concluded that Child R's father was a 'medium' risk of serious harm to the public, partners and children and according to the Offender Group Reconviction Scale (OGRS), also at medium risk of re-offending.

8.1.4 Child R's father received a Suspended Sentence Order of 18 months custody, suspended for 18 months. During this time he was required by the Court to undertake

supervision, attend an accredited programme for perpetrators and participate in a specific activity of at least 10 days to manage his alcohol consumption. Failure to comply with any of the three conditions would constitute a breach and necessitate his return to Court.

8.1.5 The day after sentencing on 4th February 2015, Child R's father was assigned to and seen by an Offender Manager (OM) employed by the Norfolk and Suffolk Community Rehabilitation Company (NSCRC). Using the standard national Offender Assessment and Sentence Management System (OASys), Child R's father was judged to be a medium risk of harm to partners and children due to domestic abuse. This meant he could pose a heightened risk to Child R should his relationship with his partner resume.

8.1.6 The medium risk of harm to others was set out clearly in the initial sentence plan, which required Child R's father to complete a 30 hour treatment programme for perpetrators of domestic abuse entitled 'Building Better Relationships' (BBR). It also required him to attend a group session provided by the NSCRC to meet the Alcohol Specified Activity Requirement (ASAR) to allow an assessment of his alcohol problem and provide him with strategies to control it.

8.1.7 A panel member for the SCR stated that an ASAR should ideally start as soon as possible and even run concurrently with the BBR programme to reduce risk of harm and re-offending. In this case the OM prioritised BBR over the ASAR and a decision was made to commence the ASAR activity after the BBR programme had finished. As a result, Child R's father did not receive any formal programmed work for his alcohol problem, and was still waiting to participate when Child R was admitted to hospital with life threatening injuries on 16th May 2015.

8.1.8 The OM gave Child R's father informal support and advice regarding his alcohol intake during supervision sessions. An entry in the OM notes in April 2015 records that Child R's father was not drinking heavily and had been told he was not an alcoholic by NRP. There is some evidence that he was indeed managing to control his alcohol intake at this time. He did not however mention that he had chosen to disengage from the NRP service had failed to respond to several appointments that were offered to him. It may have been useful for the OM to contact NRP directly to know exactly what support his client was getting from the service, although alcohol consumption was not implicated in the incident of May 14th 2015, and the decision to postpone the ASAR would not have made a difference to the outcome that led to this SCR.

8.1.9 During the first supervision session on 4th February 2015, the OM heard that Child R's father was re-kindling his relationship with his partner and son. On hearing this the OM immediately dispatched a child protection referral form to children's social care in line with the heightened risk identified in the Initial Sentence Plan. Consent was given by Child R's father for the referral to be sent following an explanation from the OM that social services would need to consider the impact of this news on the safety and welfare of his son. Children's Services responded ten days after the referral was sent advising the NSCRC that social care had closed the case as no child protection risks had been identified.

8.1.10 The case was reallocated to another OM in the team towards the end of

February 2015, who was made aware of the child protection referral initiated earlier that month and also of the outcome that no child protection concerns had been identified by social care.

8.1.11 Evidence confirms that the decision to close the case happened to coincide with Child R's father expressing to his OM that he wanted to live independently from his parents. The OM thought about the implications of this desire. On one hand, his wish to be independent seemed encouraging, but on the other, the loss of the support from his immediate family, which had helped to limit his client's alcohol intake, was concerning. The risk that this could pose was discussed openly with Child R's father. He was urged to consider what this could mean to himself, his partner and his son but alerting social care seemed unnecessary to the OM as an Initial Assessment had only just been completed and closed.

8.1.12 Early in March 2015, Child R's father attended a pre-group session in preparation for commencing the 'Building Better Relationships' (BBR) Programme. Attending the accredited BBR programme was a Court requirement for Child R's father which would aim to give him insight and an understanding about his behaviour and the impact it had on his relationship. He participated well in the pre-group session, talking openly about not being able to manage his anger, particularly when he had been drinking alcohol. He also declared that he was back in a relationship with his partner, although not living together. This information was not shared with the OM by the BBR group facilitator, although Child R's father told the OM himself within a week of this declaration.

8.1.13 Child R's father updated the OM on 12th March that his partner had acquired a property which he would be moving into in the very near future. This significant change of circumstances of having day to day contact with his son did not result in a repeat referral to social care as may have been expected. The OM explained why this was so during an interview for this SCR.

8.1.14 The OM considered that he had a good working relationship with Child R's father. During the office based supervision sessions their conversations were consistently insightful, reflective and honest. Child R's father spoke openly about his intentions to put his offence behind him, and his sincerity and the fact that social care as the lead agency for children had already undertaken a recent safeguarding assessment for Child R led the OM to genuinely believe that the home situation would be safe.

8.1.15 After the couple moved into the new house on April 2nd 2015, the OM referred Child R's mother to a Women's Safety Worker (WSW) to focus solely on the safeguarding of Child R and his mother whilst Child R's father confronted his attitude and behaviour in the 'Building Better Relationships' programme. This is good practice and complies with accepted principles and minimum standards of practice designed by 'Respect' in 2004 on the premise that risk of harm to women and children increases considerably when offenders engage in perpetrator programmes, partly because of the demands made on the perpetrator to accept responsibility but also because victims may be less vigilant due to a false sense of security that the abusive behaviour is being sorted out.

8.1.16 Support from a WSW is offered nationally to all women whose partners are enrolled on a BBR programme. It does however, require consent from the woman to engage and a willingness to participate. Child R's mother declined the offer of support from NSCRC. This is not peculiar to Norfolk in that research has shown engagement to be variable and generally low across the country (Bullock et al 2010) and a national program of work is underway to see what can be done to improve the situation.

8.1.17 At the next pre-arranged office visit, the OM continued to hear nothing but positive and encouraging descriptions from Child R's father indicating that he was recognising and controlling his alcohol intake and his temper, was experiencing a much improved relationship with his partner and was feeling optimistic about finding a job and his future in general. The OM took this account at face value, concluding that the couple, by making every effort to rebuild their relationship were successfully entering a new phase of their lives.

8.1.18 The SCR learnt that Norfolk and Suffolk Community Rehabilitation Company would probably not have been operating a home visiting service within the scope of this SCR, as home visits were not a service standard prior to the national restructuring of the Probation Service and therefore not a service requirement. This meant that all of the supervision sessions were office based and an opportunity to observe Child R's father in the home environment with his partner and son did not occur.

8.1.19 The significant changes in circumstances for Child R's father were viewed in a positive light rather than major life changes that could potentially increase risk, particularly to Child R and his mother. A combination of past history, the current loss of established family support networks, financial difficulties connected to taking on a property and continued unemployment, all at a time when Child R's mother and father were trying to rebuild their relationship and adjust to parenthood would have introduced a much higher level of risk for them all, and specifically for Child R.

8.1.20 Within a few weeks of moving in together another major change to the family's circumstances came to light. The OM learned that Child R's mother was returning to work after completing statutory maternity leave meaning that Child R's father would become Child R's sole carer, albeit just for a few hours every morning. This significant information did not raise concern and did not trigger a referral to social care.

8.1.21 Over-optimistic assessment has been a recurring theme in this SCR and this is yet another example. However, never having seen the home environment and only meeting Child R's father in the rather artificial environment of a probation office may not have given the OM the best sense of how his client was managing his new situation or the impact that the new life changes were having on his family.

8.1.22 The 'rule of optimism' and over-reliance on what parents say has been a consideration for child protection work since it was first described 1983 (Dingwall, Eekelaar and Murray). Many subsequent studies have shown that it is still common for practitioners to place an undue level of acceptance on what parents tell them, and the overwhelming belief that all is going well creates the conditions to see only potential and favourable outcomes that eventually undermine child-centred thinking.

8.1.23 Enabling practitioners to analyse and interpret new information in terms of

strengths and risk to a child is important. This can be done with a combination of direct observation, tools that support holistic assessment and analysis of risk, and supervision that facilitates practitioner reflection on the impact of their decisions on children in the household.

8.1.24 As mentioned at the beginning of this section, at the time of the incident the probation services in Norfolk were reorganising in line with national policy and were in a state of transition, an inherently risky time for any organisation. The SCR panel has learned that as a result of the changes and in common with other parts of the country, staffing numbers in Norfolk dropped and caseloads increased, creating a great deal of organisational stress with regards to getting the work done.

8.1.25 At the time the NSCRC were supervising Child R's father the 'Practice Framework National Standards for the Management of Offenders for England and Wales' had not been published. The document had been drafted over the previous two years and was finally published in August 2015. However, the safeguarding children responsibilities when managing offenders had been clearly articulated in several preceding documents, and information sharing and home visiting to reassess a child's welfare and safety had been accepted as an example of good practice.

8.1.26 The revised standards contained within the 'Practice Framework National Standards for the Management of Offenders for England and Wales' (2015) take into account the changes in the way offender management services are delivered, and the new Community Rehabilitation Companies will be expected to implement them in full including adopting purposeful home visiting when a change in circumstance might precipitate re-offending or exacerbate safeguarding concerns for a vulnerable child or adult.

19. Single Agency Recommendation (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).

8.2 Norfolk Recovery Partnership

8.2.1 Norfolk Recovery Partnership (NRP) is an umbrella service for people with drugs and alcohol problems. It is jointly commissioned and provided by a range of organisations and requires the full engagement and participation of clients. Norfolk and Suffolk Foundation Trust (NSFT), the NHS trust responsible for mental health services in Norfolk, provided the drugs and alcohol support to people accessing the service. Modelled on a self-help approach, NRP would not have provided, nor be expected to provide, the level of intensive work that would be delivered during an Alcohol Specified Activity Requirement ordered by a Court.

8.2.2 Child R's father was advised by the GP to refer himself to the NRP service for advice and support which he did in November 2014 shortly after he had been charged with Actual Bodily Harm, Common Assault and Battery and Affray. The GP was informed of the contact. NRP took details from Child R's father and noted the impending Court case. The service made a sterling effort to engage with Child R's father between December 2014 and February 2015, offering four appointments which Child R's father did not keep.

8.2.3 Following his conviction and after sentencing, Child R's father attended for another appointment on March 4th 2015. The discussion that ensued was a positive one. Child R's father explained that he was back at home living with his parents and was successfully controlling his drinking with their support. He also disclosed that he was caring for Child R for three nights per week, also under the supervision of his parents. To the NRP worker, in the absence of any child protection concerns, this would have seemed a sensible and safe arrangement rather than a risky or undesirable one.

8.2.4 Mentioning the matter of being convicted, sentenced and allocated to the NSCRC post sentencing did not feature at all during the interaction, so to all intents and purposes the NRP worker remained under the impression that the Court case was still pending. A letter regarding the initial NRP contact was sent to the GP in line with NRP protocol.

8.2.5 No further opportunity to meet with Child R's father occurred, as three subsequent appointments were missed. The service discharged Child R's father on 1st April 2015 due to failure to engage. This seems an entirely justifiable decision under the circumstances and on the basis of a single one to one support session, despite a total of seven appointment offers being given over a five month period. The discharge however, was not notified to the GP in the usual way and the reason for this has not been able to be ascertained, other than it was an administrative error.

8.2.6 By way of incidental learning from this SCR, informing the GP of a failure to engage for alcohol support is important both in social and medical contexts, and a review of the NRP discharge process needs to be undertaken to provide assurance to NSFT that it works well for every case.

8.3 Norfolk Children's Services

8.3.1 Norfolk Children's Services became aware of Child R for the second time on 4th February 2015 after a referral was received from an OM working for NSCRC. Consent had been obtained from Child R's father to make the referral but not from Child R's mother.

8.3.2 Background information about Child R's father, plus a full account of the OM's concerns about his client's intention to resume contact with his son, were recorded in full in the social care documentation. A summary of Child R's previous involvement with social care was also noted.

8.3.3 The second referral was assessed as an 'amber' level of risk according to the MASH risk rating scale and as such a follow on action from social care was required within a response timescale of one working day.

8.3.4 The agency social worker who had undertaken the first Initial Assessment was assigned to undertake a second one. The referral was judged to be 'level 3' according to the Norfolk Threshold Guide requiring a Child in Need Initial Assessment in line with Section 17 of the Children Act 1989. Information from the multi-agency partnership to inform the Initial Assessment consisted of one enquiry from a duty health visitor who reported no concerns.

8.3.5 An unannounced visit on 4th February was unsuccessful. Child R and his family were eventually seen on 13th February 2015. The visit took place at Child R's grandmother's house, where Child R and his mother were living. Both of Child R's parents were seen and spoken to. Child R's father did not officially reside at this address when the assessment was done, although he frequently stayed there. The social worker learned that Child R's mother had been placed on a high priority housing list due to overcrowding and the intention was to resume their relationship and share a home together.

8.3.6 Evidence for the assessment consisted mainly of extracts from the conversation that took place between the parents and the social worker. Both parents were adamant that the abuse and the level of alcohol intake implicated in the assault of October 10th 2014 were totally out of character. They both insisted that Child R was not at risk, particularly as Child R's father was 'seeking help' to control his alcohol consumption and improve his ability to make his relationship work. The couple admitted to some financial strain from being reliant on benefits income which was somewhat aggravated by Child R's father having been unemployed for several months, but he was actively looking for a job.

8.3.7 The assessment notes described what the social worker had observed and heard during the interaction with the family, concluding that Child R was a well attached and well looked after infant, who saw both parents every day and who was receiving additional support from extended family members. The information was analysed and listed as protective strengths and risks.

8.3.8 Protective strengths were summarised as follows:

- Only one reported incidence of domestic abuse had occurred before;
- No previous reports of violence had occurred in any other context;
- The violent incident was out of character and resulted from excessive alcohol intake;
- Child R's mother did not see Child R's father as a danger to her son;
- Child R's father was seeking help for his alcohol and relationship issues; and
- The couple were closely supported by their extended families.

8.3.9 Two risks were also identified:

- The previous domestic assault on October 10th 2014 was of significant concern; and

- Child R's parents had resumed their relationship which could expose Child R to physical or emotional harm

8.3.10 The link between excessive drinking and violence has long since been recognised, so much so, that there is a high tolerance level within society that excuses and accepts violence aggravated by the consumption of alcohol. Many studies have concluded that whilst alcohol does not necessarily cause violence, its disinhibiting properties can precipitate violence in people with underlying violent and aggressive personality traits (Responsible disinhibition: S.Galvani 2004). The assertion by Child R's mother that the previous assault was out of character and was caused by excessive alcohol intake should have been a reason to be cautious. Hearing Child R's mother's view that no danger existed demonstrated a common but concerning acceptance of the violence, albeit a one-off incident, as well as a possible lack of awareness about how to keep herself and Child R safe should another incident occur.

8.3.11 In addition the proactive statement that Child R's father was 'seeking help' independently for his alcohol and relationship difficulties, whilst reassuring was somewhat misleading as this course of action was prescribed as part of his probation conditions, not merely a matter of choice.

8.3.12 In depth information from all relevant professionals in the partnership was not actively sought and significant information from medical, police and probation colleagues did not inform the risk assessment process. Background checks on the family would have provided evidence for the 'toxic trio', a factor identified in 86% of SCR's studied by Brandon et al between 2009 and 2011 and which is still associated with increased risk and poorer outcomes for children today.

8.3.13 Finally and most importantly, the risks associated with an impending and significant change of circumstances were not reflected in the assessment conclusion. The stated intention to move house and live as a family away from existing extended family and community support, coupled with the likely financial impact of setting up a new home at a time when one parent was unemployed were all likely potential longer-term stressors that needed to be thoroughly explored in terms of their future impact, and it was this very concern that led to the child protection referral being made by the OM in the NSCRC.

8.3.14 As did the first Initial Assessment, the second Initial Assessment concentrated on a one-off snapshot of the family circumstances in their current situation, rather than a longer term view. The decision to close the case was based on a single conversation with Child R's parents, taken at face value. Child R's lived experience and the harm that he and his mother had experienced and possibly could experience again seemed remote from the assessment reasoning process. The rationale mirrored the exact same thinking as that of the first Initial Assessment by relying on and accepting the account given by the parents without further investigation, question or challenge

8.3.15 The recommendation that Norfolk Children's Services had no role to play was upheld following management oversight. An entry on the Care First system indicated that the social work team manager was satisfied that sufficient protective factors were in place to keep Child R safe. Echoing the outcome of the first Initial Assessment of six months earlier, the team manager agreed with the recommendation to close the

case and closure letters were sent to each parent stating that there was no ongoing work to be done.

8.3.16 Risk assessment in general relies on a quality of reasoning that enables a thorough balance in terms of likelihood and impact, and many risk analysis tools have been developed to assist safeguarding practitioners to calculate risk systematically. All of them rely on gathering full information which can then be probed and questioned to enable judgements about the future based on past history as well as current circumstances.

8.3.17 This balanced approach, which incorporates a high level of professional curiosity in the face of uncertainty, should drive any risk assessment and subsequent management oversight process. Management oversight in particular should provide the conditions to systematically question the rationale for any judgement made by introducing professional challenge as well as support and advice. This enables practitioners to thoroughly explore the meaning of what they have seen and heard and the impact of their judgements on the child. It also reassures the manager that the decision has been made on a range of evidence and opinion.

8.3.18 In 'Common errors of reasoning in child protection assessments' (2009), Professor Eileen Munro lists some common faults in the social work assessment process; for example failing to consider alternative perspectives or revise initial or previous thinking, not considering all the available information from the past as well as the present, failing to take a long-term view and lastly, forming judgements from direct reporting in preference to analysing a range of information.

8.3.19 All of these common errors are evident in the social care notes of the second Initial Assessment as they are for the first. For instance, whilst the seriousness of the previous domestic abuse assault and the resumption of the relationship were correctly noted as a risk, the direct and positive statements from Child R's parents were all taken in good faith and optimistically interpreted without question as strengths that would protect Child R in the future.

8.3.20 Protective factors do not in themselves negate risks and it would have been sensible and safer to cross examine them using a deliberate and alternative perspective. This devil's advocate approach would give consideration as to whether there was masked risky behaviour or hidden harm. Had the management oversight created the conditions for a systematic process of reflection, challenge and alternative thinking, the perceived strengths in the risk assessment for Child R would most probably have been re-evaluated to form a more balanced opinion.

8.3.21 The SCR panel has not been able to talk to the family social work practitioner. However a discussion with the team manager confirmed that the decision to close the case followed a detailed verbal report from the social worker to the team manager following a single home visit to the family.

8.3.22 The social worker, who had prior knowledge of the family, told the team manager that Child R's father was working well with the probation service and was motivated to change which was at this time indeed true. In addition there had been no further incidents and the family appeared to be settled. On the basis of this

conversation a conclusion was reached that social care did not have a role with the family as no safeguarding concerns were identified.

8.3.23 Comprehensive formal management oversight, clarifying the strengths and weaknesses of the rationale, risk assessment and recommendation to close, was not found on file and the team manager confirmed during interview that the authorisation to close the case was made on the basis of the social worker's verbal report. Having reflected on the case the team manager admits that the decision was made on the basis of what the family said and that the paucity of information from other professionals with working knowledge of the family weakened the risk assessment to a large degree and affected the risk rating and forward planning.

8.3.24 The external factors that were influencing practice and decisions in that particular office on that particular day mirrored the broader and generalised organisational and cultural challenges for social work teams that were evident six months earlier, namely that the lack of capacity to get through the vast amount of work coming to social care attention created a culture of gatekeeping the flow of cases, leading to hasty decisions to avoid overload of the system. Comments made in relation to the first Initial Assessment about the emphasis being on meeting organisational targets rather than quality seem also to have been relevant at this time.

8.3.25 What is apparent however, is the risky lack of documentation in relation to the assessment, analysis, decisions and care plans in either the social worker record or the operational management oversight documentation. The system to ensure that minimum practice standards were adhered to together with the system to provide robust scrutiny of casework prior to management sign-off appeared to fail on the two separate occasions that Child R came to the attention of Children's Services.

8.3.26 As mentioned before, Norfolk Children's Services have already taken action to improve the quality of assessments and management oversight of case work. The county has also been subject to an improvement programme in recent months and the findings of this review in relation to standards of risk assessment and recording will be taken into account as part of that review and redesign.

20. Single Agency Recommendation (Norfolk Children's Services)

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.

21. Single Agency Recommendation (Norfolk Children's Services)

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.

8.4 Norfolk Community Health and Care NHS Trust

8.4.1 The social worker undertaking the second Initial Assessment for Child R contacted the Children's Centre to obtain information. He was directed to the duty health visitor who scanned the electronic files and returned a judgement of no concerns. The reason for the enquiry was not fully explored by the duty health visitor and the family health visitor was not notified about the call. Having answered the question, the duty health visitor considered the job done.

8.4.2 A 'Duty Health Visitor' system provides an immediate response from a qualified practitioner during office hours for any contacts coming through to the service whilst his or her colleagues are out and about. It is a more efficient way of managing and prioritising enquiries and has replaced the practice of taking messages and leaving them for practitioners to deal with when they return to the office. Duty health visiting systems are arranged by assigning a health visitor from the team establishment on a rotational basis. Invariably the duty practitioner will be extremely busy fielding enquiries for a large geographical area, and the nature of the role is often to manage the enquiry and move on to the next.

8.4.3 The duty health visitor is seldom the person who has formed a relationship with the family, or the person who would have the most thorough and up to date information about any inter-agency activity, so they rely very heavily on reading case records. The practitioner on duty that day has explained that when the social worker called time pressures had caused her to flick through the notes rather than conduct a thorough search. This led her to an incorrect conclusion that there were no concerns to report, based on the limited information she had seen. On reflection, she has also acknowledged that for this case, it was an error of judgement not to have informed the family health visitor of the enquiry from the social worker.

8.4.4 From the evidence submitted, it seems that the internal information sharing system from the duty team to other parts of the system was rather ad-hoc. The Trust have recognised that the system could be improved. Their single agency report includes a recommendation that any contact from social care must be explored fully and passed immediately to the family's allocated practitioner.

8.4.5 The FSW delivering the PAFT programme to the family had been aware of Child R's mother's desire to have her own house for some time and had formally supported her application for a home of her own shortly before Christmas in 2014. She was also aware that the long-term plan was for Child R's parents to reunite.

8.4.6 At a PAFT support visit on 25th February 2015, Child R's mother showed the FSW a children's services closure letter that she had received in response to a second Initial Assessment that she had participated in ten days earlier. The letter stated that further work had not been deemed necessary by social services. The FSW did not report having seen the letter to Child R's allocated health visitor, who remained unaware that a second child protection referral and Initial Assessment had ever been undertaken. This suggests the significance and importance of sharing this information had not been fully realised, possibly because there didn't appear to be a problem.

8.4.7 Once again, this tells us that the communication responsibilities of practitioners and the internal information sharing systems in the Children's Centre were weak, and that parts of the integrated team may have been operating independently of one another despite being co-located and sitting together in the same room. This, coupled with poor communication from other members of the partnership, meant that vital intelligence was effectively being hidden away from practitioners who really did need to know.

8.4.8 By the middle of March 2015 Child R's mother had been allocated a new house and was actively preparing to move. The last visit by the FSW occurred at the end of March. Both parents were present and both informed the FSW that they would not require any further outreach support in their new home. The FSW both recorded and reported this conversation to the allocated health visitor who took immediate action to verbally handover the case to the locality team that would take over Child R's care, outlining the couple's turbulent history including the violent assault that involved Child R. Concern was expressed about Child R's mother declining the offer of targeted support after she had relocated.

8.4.9 Shortly after the family had moved on April 1st 2015, the new health visitor undertook a transfer-in visit. Full notes including the past history of the incident in October 2014 were available to the new practitioner and she had been made well aware of the professional concerns of her colleague.

8.4.10 During the visit, the health visitor noted only positive parenting and interaction between the family members. Questions relating to her colleague's concerns, past medical history, previous relationship problems and their new circumstances were omitted from the assessment. Even so, the health visitor came to a professional judgement that there were no safeguarding concerns or additional needs evident. The health visitor further reflected on the visit at an interview for this SCR and remains of the opinion that from what she had seen and heard, the family were looking forward to a 'fresh start' and there were no indications that Child R could be at risk.

8.4.11 Following the contact the health visitor stepped down the health visiting offer from a universal-plus service to standard universal care. The reason for this course of action has not been fully ascertained, other than the health visitor being totally reassured by couple's determination to make things work.

8.4.12 The next time Child R would be seen would be for a one-year development check some three months later in the local clinic. He would no longer be seen regularly nor seen at home.

8.4.13 The decision was made on the basis of a short period of observation and discussion which led the health visitor to believe that Child R was safe in the care of his parents. This is yet another example of an over simplistic and over optimistic assessment. The past history and the concerns articulated by a colleague did not influence or feature in the plan which was to remove support from the family rather than maintain it.

8.4.14 The single agency report submitted to this SCR has already identified important issues that must be addressed urgently. The SCR panel agree that many of the judgements followed a pattern of being adult rather than child focussed, made on the basis of single contacts, insufficient information and sometimes aggravated by a reluctance of professionals to have difficult conversations, particularly in relation to domestic abuse or other tricky issues.

8.4.15 To formulate sound professional judgements about children, health visitors as safeguarding professionals must be proficient at assessing risk to children by critically analysing a range of complex information from professionals and family members. Risk assessment is important and essential in order to keep children and families safe, but it also serves to protect professionals and organisations by enabling practitioners to articulate and justify the decisions that they make. Systems, practice aids and risk assessment models can be designed specifically for health visitors to support them in their work which is both demanding and complicated.

8.4.16 In November 2015, Norfolk Health Visiting Service has been provided by Cambridgeshire Community Services NHS Trust. Cambridgeshire Community Services NHS Trust will take over the responsibility for implementing the recommendations in this review and will provide assurance regarding any improvement programmes through the relevant NHS assurance framework and to NSCB.

22. Multi-agency Recommendation (Norfolk LSCB)

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.

8.5 Primary Care GP Services

8.5.1 Two primary care teams were involved during the timescale of this review. Mother and Child R were registered with a busy GP practice in an urban area of Norfolk. Child R's father continued to see his own GP who had delivered care to him and his family since he was a child in a rural part of the county.

8.5.2 Primary care services in England operate as independent businesses working to a national contract. The safeguarding arrangements in their surgeries follow good practice standards and guidance, although each team will be organised to suit their population requirements and working patterns.

8.5.3 Both surgeries, as for the majority of GP services in Norfolk, operated an electronic records management system called 'SystemOne', a system also adopted for community child health professionals. However, the limitations of how SystemOne is used, as discussed elsewhere in this report, did not provide an opportunity for information exchange about Child R's father with any other health professional, particularly the health visitor, working with the family after Child R was born.

8.5.4 The GP knew the family well. He could recall caring for Child R's father as a small child and young person, often needing to offer him treatment and support for emotional problems and severe anxiety. A pattern emerged whereby Child R's father would seek treatment for anxiety followed by long periods of remission when he felt well and able to cope. The GP was confident that Child R's father had a good insight into his emotional needs and would seek help when required. There was no history of violence being an issue.

8.5.5 Child R's father presented to his GP complaining of anxiety once during his partner's antenatal period and after a gap of over two years. On reflection this may have been due to the fact that he was about to become a father for the first time; however he did not disclose this fact to the doctor.

8.5.6 The next significant contact with the GP was after Child R's father was arrested on October 10th 2014. He was living at his parents' address at the time and the GP reported that he was accompanied and supported by his mother during many of the consultations regarding his alcohol intake. The GP was given an account of the violent altercation between Child R's father and his girlfriend, but was not informed or given any detail about Child R's existence or the infant's involvement in the incident.

8.5.7 The evidence submitted to this SCR suggests a growing concern on the part of Child R's father and his family about the effect of alcohol on his behaviour, combined with a commitment and desire to control it. The GP did not directly refer Child R's father for a service but encouraged him to self-refer to the Norfolk Recovery Partnership (NRP) for alcohol support. This was done in accordance with NRP's recommendation that successful engagement would be more likely if the patient self-referred. The advice was heeded and Child R's father made contact with NRP. After Child R's father's engagement with the NRP service, the GP saw his role as offering support and encouragement to him to stay the course and abstain from drinking.

8.5.8 The GP received a letter from the NRP early in December 2014, informing him that his patient was engaging in treatment to control his alcohol intake. A sentence in the letter also alluded to the fact that Child R's father was caring for his son for three overnight stays per week, supervised by his parents. The letter was scanned and filed, but the information not summarised and recorded in the main electronic record.

8.5.9 At an interview for this SCR, the GP explained that he did not know his patient had become a father until May 2015, when Child R sustained life threatening injuries. He had certainly not been informed by the family that his patient had a baby son at the time of his arrest, and was not informed of this fact by any other professional. No information was received from, or requested by the social worker, offender manager or the health visitor in relation to the safeguarding of Child R, and NRP failed to inform the GP when Child R's father was discharged from their care.

8.5.10 The only time Child R is mentioned is within the letter from NRP. As far as the GP was concerned, his patient was single, had no dependent children and was living at his family home, being supported by his parents. He was seeking appropriate help for his anxiety and successfully engaging with NRP to manage his alcohol problem, which was part-way responsible for his behaviour, and the criminal justice system would manage the aftermath of the domestic abuse incident. It is easy to see why the GP felt confident that the situation was under control.

8.5.11 On reflection the GP has said that had he been informed or more aware about Child R and the extent of his involvement in the violent altercation, he would have acted very differently. He was fully aware of the safeguarding implications to children of domestic abuse and of alcohol abuse or mental health problems, although not fully aware of the increased likelihood of harm when all three were present.

8.5.12 The passing reference in the scanned NRP letter alluding to Child R's father being a parent, although highly relevant was not immediately accessible in the GP electronic record. The nature and pace of a GPs daily workload does not allow for every written document to be read prior to or during a consultation. Normally, letters and reports are brought to the attention of the clinician when they arrive in the surgery, after which then they are scanned and filed, and this is considered best practice. It does appear from the evidence submitted however, that this key information, on this occasion might have been missed or simply just slipped from the GP's memory.

8.5.13 The GP agreed that in future he would be more vigilant and ask many more questions about the circumstances of any adverse events that his patients are involved in so that relevant information can be transferred into the clinical notes. Key life changes such as becoming a parent for a patient known to be vulnerable should also be highly visible in the clinical notes to assist information exchange and care planning.

8.5.14 Child R was registered shortly after birth at his mother's GP practice. The GP saw Child R on several occasions in relation to immunisations and minor ailments, for which he received appropriate care. However the consultation notes were consistently 'minimal' in nature, including those for a contact that took place in the GP surgery three days before Child R suffered life threatening multiple injuries.

8.5.15 An A&E notification was received by Child R's GP practice on 14th October 2014 following the domestic abuse incident that occurred in the street. It was the same notification received by the health visitor. The document gave the GP a good account of the violent circumstances and subsequent paediatric examination undertaken on 10th October 2014. The A&E notification was passed to the GP to read and also scanned for the electronic record, although it appears from the notes that the letter was not summarised into the clinical section of the notes, thus reducing the likelihood of the incident being recalled for any later consultation.

8.5.16 An immediate conversation about the incident and its consequences was not initiated by either the GP or the health visitor and neither professional looked at the records of the other via the SystemOne sharing facility. This showed a distinct lack of immediate professional curiosity about an incident which affected their patients.

8.5.17 The implementation in September 2014 of a county-wide system to enable

health visitors and GPs to meet at regular intervals was welcomed in Norfolk, particularly as a previous SCR had noted that their relationship and communication was poor. The new standard fell in line with best practice guidance in the GP Practice Safeguarding Children Toolkit (RCGP/NSPCC 2014) and addressed concern nationally that health visitors and GPs were having less contact following the cessation of GP attachment and the move towards locality based health visiting services.

8.5.18 Invitations were sent by the GP practice for the health visitor to attend the GP practice meetings as expected, and evidence suggests that from September 2014, a month prior to the domestic abuse incident, the health visitor attended as required, fortnightly at first and then monthly. However, even with a face to face meetings Child R was not the subject of a professional conversation.

8.5.19 The evidence submitted to this SCR, whilst confirming that the health visitor attended the meetings is less clear about how the meetings worked in practice. Both professionals knew that Child R had been involved in a violent altercation in the street, yet it seems that the matter was never discussed, possibly because the infant had not required medical treatment. The effectiveness of regular meetings in a safeguarding sense would depend largely on whether they facilitated a two-way conversation about families of concern, including those where safeguarding issues had been identified. In this instance the system appeared to fail.

8.5.20 On 11th May 2015, the GP saw Child R and recorded a history of a rash in both ears. The clinical record for the contact was 'red inflamed pinna' (external part of the ears). During the interview for this SCR, the GP confirmed that the redness applied to the outer parts of both ears. However due to the lack of information recorded, the GP admitted some difficulty with recalling exactly what he had seen or said during the consultation, although the prescribing of antibiotics supports a diagnosis of inflammation through infection rather than redness caused by trauma.

8.5.21 There is no evidence which links the red inflamed pinna to the bruised ears that were noted as part of the child protection medical examination a few days later, but the lack of recall and clear unambiguous notes is concerning. Had the information about a previous safeguarding incident been recorded, the examination, recording and following action may have been more robust.

8.5.22 GPs have long since been described as key to the child protection process and, as for any other service in the safeguarding network, it is reasonable to expect primary care systems and clinical practice and recording to follow safeguarding standards. The sheer numbers of patients being seen in a busy surgery and the short time allocated to each case, plus the likelihood of seeing different clinicians, makes systematic consultation, recording and information exchange about vulnerable families even more important.

8.5.23 Since the health service reforms of 2013, safeguarding practice has assumed a much higher profile in primary care to enable a shift in the balance and incentives from clinical and medical to a more medico/social model of care. GPs are expected to fully meet their safeguarding responsibilities for vulnerable people by introducing robust safeguarding systems and processes into their surgeries that enable a more holistic approach, and the CQC are currently embarking on a rigorous inspection of

Primary Care that includes lines of enquiry about safeguarding children practice.

8.5.24 The Royal College of GPs has developed a comprehensive toolkit that covers safeguarding systems and practice for clinicians working in general practice (GP Practice Safeguarding Toolkit, RCGP/NSPCC, 2014). It has been designed to help surgeries prepare for CQC inspection and enable more appropriate responses to children who are vulnerable. The learning from this SCR gives the GP service a further opportunity to improve using the findings from this report in conjunction with the professional guidance that is available.

23. Single Agency Recommendation: NHSE Primary Care Commissioners and GP Practices

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.

9 Generalised Findings

Whilst this SCR has analysed and made recommendations about the practice of individual agencies delivering care to Child R and his family, some generalised themes have emerged that apply to more than one organisation. This suggests some underlying and deeper cultural issues in the multi-agency safeguarding children system as a whole in Norfolk which NSCB will need to address.

9.1 Engagement with father

9.1.1 Meaningful engagement with Child R's father with regard to his parenting capacity was negligible, despite the fact that a number of professionals knew about his troubled past and concerning behaviours. There is no evidence that suggests that information about Child R's father's problems was deliberately withheld from the authorities by the family. In fact, a lot of detail about his difficulties and vulnerability was known and recorded. However, much of the information about him remained unexplored, unshared or untested in the context of how it might impact on Child R's health, safety and welfare.

9.1.2 The SCR panel have asked questions about whether practitioners in general felt intimidated by Child R's father or mother and whether this coloured their approach to the family, but this seems not to have been the case. Neither was there any evidence of the family deliberately evading professional input, albeit that they were selecting carefully what information they wanted to share. It appears that many of the professional conversations that should have been initiated with the family and professional colleagues about Child R's father's difficulties, were either superficial or avoided altogether.

9.2 Child-centred Assessment and Planning

9.2.1 For most of the agency contacts and assessments, the documentation consisted of one-off observations and descriptions of what had been reported by the parents, without question or clarification of what was being said and taken very much on face value. Evidence in case files suggested that the 'rule of optimism' guided the conclusions of several professionals in the partnership and the overall tenor of the assessment was in the main adult focussed.

9.2.2 Reference to Child R's lived experience in agency notation is minimal and there is little evidence of the use of formal risk or needs analysis tools or care plans to clearly articulate any perceived risks or needs, the rationale for judgements, or the focus of the work to be done to improve outcomes for the child in the short or long term.

9.3 Interagency Communication and Collaboration

9.3.1 There was very little pro-active interagency or inter-professional communication or information sharing by any agency before, during or after contacts with the family. Decisions remained uninformed, unchallenged and sometimes not communicated at all. Evidence suggested a general tendency within the partnership to defer to social care decisions without challenge, or to make broad assumptions that colleagues must have done all that needed to be done, or of adopting a 'fait accompli' attitude. Either way, working in professional isolation is not acceptable for safeguarding work and needs to be rectified.

9.3.2 It became apparent during the course of the SCR that language and interpretation was a major source of professional confusion across the partnership. For example, when discussing this case the police tended to categorise extreme or severe abuse in terms of injuries that either constituted actual or grievous bodily harm, probation talked of lesser or greater offences and health professionals felt that any assault or abusive behaviour could have harmful effects and required an action. The different perceptions and translations therefore created a difference in opinion of what was high risk or low risk and further influenced the expectations of professionals as to how agencies should or would respond.

9.3.3 Professional identity and role confusion have always been problematic in the context of inter-professional practice and it continues to be both important and safe to observe and maintain professional boundaries. It is unlikely that a common language will ever be truly achieved, but a common understanding of the roles and responsibilities of professionals in the partnership and promoting an awareness that misinterpretation can create or increase a risk is possible. As language and interpretation have been identified as an issue during this SCR, they should feature in the learning events associated with the case.

9.4 Application of Thresholds

9.4.1 There was some evidence of confusion within the partnership about the rationale and application of the NSCB thresholds and how they connected with other assessment processes; for example how NSCB thresholds influenced the police assessment for domestic abuse and similarly how they were applied to the assessment criteria used for support pathways aligned to the 'Healthy Child Programme' (DH 2009). There was also a poor understanding across the partnership of how social care

applied step-up or step-down criteria or how 'no action' decisions were arrived at.

9.5 Alcohol, Domestic Abuse and Mental Health

9.5.1 The combined risk factors of alcohol abuse as a disinhibitor, violence and mental health issues, commonly described as the 'toxic trio', did not appear as significant indicators of risk and vulnerability in the notes of professionals working with the family. This was of particular importance when substantial changes to the lived experience of Child R placed him in the sole care of his father.

9.5.2 The traumatic violent event that occurred a few months earlier may very well have been a 'one-off', but it was unusually public, serious and significant. It is evident that Child R's mother minimised the violence she had suffered and believed it would not happen again, a common dynamic in families where violence is a feature. However from the critical review of documentation and practitioner discussions the SCR panel members and practitioners acknowledge that an element of minimisation and acceptance of the incident may have influenced professional decisions too.

9.5.3 Information that alluded to past mental health problems and sporadic alcohol abuse was known by several agencies, but did not seem to influence the planning that took place.

9.6 Supervision and management oversight

9.6.1 Supervision and management oversight is an important component of practice for any professional holding casework responsibilities. However, for this case the supervision sessions across the wider children's sector workforce did not appear to adhere to a robust framework that facilitated systematic professional reflection, scrutiny and challenge, or record the rationale for making and signing-off decisions.

24. Multi-agency Recommendation (Norfolk LSCB)

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, professional curiosity, 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 of 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

10 View from the family

10.1 Both of Child R's parents agreed to talk to SCR panel members and for their historical records and information to be reviewed. NSCB are immensely grateful for their participation. Child R's mother and mother were seen separately towards the end of the SCR process.

10.2 Child R's mother wanted only to review the final report and be informed of the findings. However, she was keen to say that after her son sustained the injuries that led to this SCR she had been receiving support from a local domestic abuse support service. Since receiving that support her understanding of domestic abuse and the strategies that can be learnt to keep herself and Child R safe have been hugely helpful to her. She thought that had she received similar support earlier on, after the first incident for example, she may have been more aware and able to protect her son. This is clearly an important learning point for NSCB to consider.

10.3 Child R's father spoke at length about his struggle with anxiety and depression that started when he was a child and which is a feature of his life now. He had received medication on numerous occasions to try to relieve the symptoms and he spoke fondly of his parents who had consistently supported him.

10.4 He also remembered being short tempered in his youth which continued into adulthood, sometimes spilling over into bursts of aggressiveness towards people or property.

10.5 As a young adult he was introduced to alcohol and drugs and admitted that alcohol consumption was a serious problem at times including during the time of his relationship with Child R's mother. He had tried various strategies to keep it under control and had sought professional intervention.

10.6 Child R's father was tremendously anxious when his partner became pregnant, it had not been planned. His emotional state caused him to seek help during his partner's pregnancy from the GP, in the knowledge that he needed help to manage the anxiety he felt with regards to becoming a father. He described the consultation as a 'cry for help'. He was aware that other professionals were engaged with his partner during the pregnancy, such as the midwife and health visitor, but they didn't proactively engage with him and he didn't seek advice from them.

10.7 When asked about the social services interventions Child R's father had little to say. After the second referral when the couple had reconciled and were living on their own they were contacted and visited by the social worker. He did not want to engage with the service. He remembered that he did not speak to the social worker during the visit so the social worker spoke to his mother instead.

10.8 Child R's father admitted he had absolutely no experience of looking after children and relied on his mother to care for Child R when his partner could not do so. He recalled how he had taken his son to a local 'stay and play' session and had felt really uncomfortable being mindful that he was the youngest father there. The experience was not a positive one and he didn't go again.

10.9 He recalled the morning that Child R sustained his injuries, stating how he felt totally unprepared to care for Child R on his own and admitting he did not know what he was doing in relation to looking after his son. In hindsight at the end of the interview Child R's father told the interviewers that 'if he could go back, he wouldn't have looked after child R on his own'.

10.10 When invited to comment on what services might have helped him he suggested more opportunities to talk about his needs and more access to talking therapies for managing his anxiety and aggression, admitting that he primarily he used drugs and alcohol as a coping mechanism, which caused even more problems.

11 Conclusion

11.1 Child R's family received services from several agencies in the partnership and the engagement was not found to be particularly problematic. However, the quality of the engagement was not entirely meaningful, and did little to improve Child R's lived experience. There is also a question of whether agencies were placing enough effort into engaging Child R's parents rather than extended family members who did not have parental responsibility for Child R.

11.2 From the recorded material and discussions with practitioners, it might seem fair to conclude that Child R's parents had a mutual desire and intent to make their relationship work and a sincere belief that their situation and behaviour would not be harmful to their son. Evidence does show however that some of the information being shared by the family was selective in nature and was therefore not entirely reliable. This is by no means unusual and should be familiar to all professionals working in a safeguarding context with vulnerable families.

11.3 Throughout this investigation the evidence suggests that professionals tended to over rely on what they were being told by family members. Decisions and care plans for Child R were being drawn largely from infrequent conversations with the parents or grandparents of Child R and not from members of the safeguarding community.

11.4 Actively exploring and seeking out information about Child R's father in the context of him being a parent and primary carer did not feature highly in any agency assessment process. Work being undertaken solely with Child R's father focussed almost entirely on his own rehabilitation, welfare and risk of re-offending with the result that the impact of his situation on his caring role as a parent and primary carer for Child R was not considered in any depth.

11.5 Had professionals exercised more professional curiosity by seeking out intelligence held elsewhere in the partnership, and had the available information been put together and applied more robustly to the context of the lived experience of Child R, it is highly likely that a much more complex and worrying picture would have emerged. However, this investigation has also concluded that service design and organisational processes and systems did not always assist practitioners to work effectively or facilitate information exchange, and NSCB need to look at how these systems and processes can be improved by member agencies from across the partnership.

11.6 The numerous background risk factors and the situational hazards brought about by significant changes to the family's circumstances should have been central to any single or multi-agency professional assessment in order to calculate the likelihood and impact of risk and enable the most appropriate response for a safe outcome. The utilisation of risk assessment tools that are focussed on risks to children, coupled with robust professional safeguarding supervision that is tailored to the primary role and function of the practitioner, will help to ensure that children are kept in mind.

11.7 Inter-professional practice and the relationships between practitioners and managers working within their own agencies and teams, and indeed with colleagues from different professional backgrounds seemed, on the surface, to work well. But on closer examination there were significant gaps in inter-professional communication rendering professional challenge almost impossible. Notably, the skills, confidence and safeguarding competencies required for truly effective inter-professional practice were not highly visible in many of the accounts submitted for this investigation.

11.8 Norfolk have made strides towards integrating teams, joint working and promoting inter-professional practice in the county, but the systems to support and enable every practitioner to work in this way appear to be less developed. Some very important learning for the NSCB partners has been identified in this SCR to ensure that single agency safeguarding arrangements are robust.

11.9 It is fair to say that no root causes were identified that directly caused or failed to prevent or predict the incident that led to the injuries Child R suffered in May 2015, and it is also fair to say that there is no certainty that any of the findings in this SCR would have changed the outcome for Child R. They serve only to raise questions regarding aspects of practice that contributed to a range of single and multi-agency professional actions at the time which, if done differently, might have changed the responses of the professionals involved.

12 Assurance and monitoring

12.1 The learning outlined in the analysis for this report, has been translated into recommendations designed to improve systems and practice for safeguarding children in Norfolk. Norfolk Safeguarding Children Board is responsible under Section 14 of the Children Act 2004 for scrutinising and advising the partnership about the lessons learned from an SCR. The Board will hold agencies to account for the implementation of the single agency actions included in this report and for any other learning associated with it.

12.2 Periodic assurance will be sought by Norfolk Safeguarding Board as to the pace and progress of improvement plans and in regard to how the learning is being embedded within the participating organisations.

13 Summary of Recommendations

SINGLE AGENCY RECOMMENDATIONS	
Norfolk Constabulary	
Number	Recommendation
1 Page 13	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	
2 Page 19	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.
3 Page 19	The Maternity unit at QEH should develop and apply strategies and systems to promote the inclusion of all fathers in maternity care.
12	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	
4 Page 22	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.
5 Page 24	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.
6 Page 25	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.
8 Page 27	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).
9 Page 27	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	
13 Page 34	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.
14 Page 36	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.
17 Page 39	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.
20 Page 51	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.
21 Page 52	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	
19 Page 46	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	
4 Page 22	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.

23 Page 58	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.
MULTI-AGENCY RECOMMENDATIONS	
Norfolk Local Safeguarding Children Board	
7 Page 26	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.
10 Page 29	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.
11 Page 29	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.
15 Page 36	Norfolk LSCB must audit the membership of strategy meetings/discussions to ensure compliance with the statutory minimum requirements for participation.
16 Page 36	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.
18 Page 40	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.
22 Page 54	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.
24 Page 60	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. <ul style="list-style-type: none"> • The engagement of fathers • Child-centred risk assessment • Inter-professional practice, communication and joint working • Working in isolation, silo-working and professional deference

	<ul style="list-style-type: none"> • 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
25	<p>Norfolk LSCB should receive:</p> <ul style="list-style-type: none"> • Assurance that all single-agency recommendations for this SCR are implemented • Assurance that agencies have disseminated the learning throughout their organisation

14 Norfolk Local Safeguarding Children Board SCR Response

Work is already underway to improve the safeguarding children systems in Norfolk based on learning from previous SCRs undertaken in recent months. Norfolk Safeguarding Children Board is intending to formulate a response to the findings in this review that will explain how the recommendations from this review will be considered in the NSCB work plan.

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16 GLOSSARY

A&E	Accident and Emergency Department
ACPO	Association of Chief Police Officers
ASAR	Alcohol Specified Activity Requirement
BBR	Building Better Relationships
CRC	Community Rehabilitation Company
DASH	Domestic Abuse Stalking and Harassment
DASVB	Domestic Abuse and Sexual Violence Board
DFE	Department for Education
DH	Department of Health
EDT	Emergency Duty team
FSW	Family Support Worker
GP	General Practitioner
HCP	Healthy Child Programme
HV	Health Visitor
IDVA	Independent Domestic Violence Advocate
LDU	Local Delivery Unit
LSCB	Local Safeguarding Children Board
MARAC	Multi-Agency Risk Assessment Conference
NCB	National Children's Bureau
NCH&C	Norfolk Community Health and Care Trust
NEPU	National Perinatal Epidemiology Unit
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NSCB	Norfolk Safeguarding Children Board
NPS	National Probation Services
NRP	Norfolk Recovery Partnership
NSFT	Norfolk and Suffolk Foundation Trust
NPCC	National Police Chiefs Council

NSPCC	National Society for the Prevention of Cruelty to Children
OASys	Offender Assessment and Management System
OGRS	Offender Group Reconviction Scale
OM	Offender Manager
PAFT	Parents As First Teachers
QEH	Queen Elizabeth Hospital
RCGP	Royal College of General Practitioners
SCR	Serious Case Review
WSW	Women's Safety Worker