Norfolk Safeguarding Children Board

# Learning from Serious Case Reviews

# Case S

# Serious Case Review: Case S

This presentation sets out:

- Summary of the case
- Methodology
- The case history
- Appraisal of Practice & Analysis
- Recommendations to the Norfolk Safeguarding Children Board
- Summary & conclusions
- The Board's response
- Thematic Learning from Serious Case Reviews in Norfolk

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# Serious Case Review: Case S
# Summary of the Case

Case S was commissioned because a three year old girl sustained life threatening injuries. There was concern about the way agencies worked together to safeguard the child prior to the incident.

The SCR Panel focused on learning around the multi-agency response to:

- Cross Border working and Information sharing
- Recognition, support and risk assessment of vulnerable young parents
- consultation and referral processes and the role of the Multi-Agency Safeguarding Hub (MASH)

Baby S's stepfather was subsequently sentenced and serving time for Grievous Bodily Harm. Child S has made a full recovery and is now doing well.

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# Serious Case Review: Case S Methodology

- Proportionate approach: included integrated chronology and single agency reports
- Scope of review Jan 2013 – Jul 2015
- One to one interviews with professionals with significant involvement with the family
- Meeting with mother and stepfather to get their views
- Publication delayed due to criminal proceedings against father, concluded summer 2016

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# Serious Case Review: Case S
# Background History of the case: Mother

- Child S's parents and stepfather were brought up predominantly in Essex.

- As a young teenager Child S's Mother had some limited contact with Essex Children's Services, but was not herself subject to any statutory involvement.

- Mother, aged 15, becomes pregnant with Child S; Essex Children's Services undertook a pre-birth assessment as there were concerns about family support.  Child in Need Plan was put in place.

# Serious Case Review: Case S
# Background History of the case: Mother, cont.

- Child S was born in July 2012. Child in Need Plan closed a few weeks later. Child S's maternal grandmother was assessed as significantly involved in her care. Mother had engaged well with the CiN plan, which included the Health Visitor.

- Child S had routine contact with the Health Visiting service in Essex which offered extra support, although this was not taken up by Child S's mother.

Child S's mother told the review that she was happy with the health visitors and social workers she had met and had been told about the various groups she could have gone to. However she felt that she had support from her family and did not need anything extra.

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# Serious Case Review: Case S
# Background History of the case: Father & Stepfather

- Child S's father separated from her mother not long after she was born. Intermittent contact was maintained.

- Stepfather was one of a group of siblings. There were some concerns about their care: pattern for several of the siblings of leaving the home at an early age to live with other family members.

- His mother sought help from Essex Children's Social Care as she found his behaviour difficult to manage. At 13 years old stepfather was voluntarily accommodated with foster carers.

*Stepfather himself described a high level of physical abuse and punishment and said that he went to the Local Authority and asked to be taken into care as a result.*

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# Serious Case Review: Case S
# Background History of the case: Stepfather, cont.

- Stepfather had a history of behavioural problems, including reference to some '*violent behaviour*'

- This led to foster placements breaking down and he eventually moved first into residential care and later into supported, semi-independent accommodation.

- He was subsequently supported by Essex Leaving Care Service.

# Serious Case Review: Case S
# History of the case 2013 - 14

- Jan 2013: Child S and her mum living with maternal grandmother (MGM) in Essex.

- Jan 2013: Mum presents to GP and was diagnosed with depression and, later, referral to CAMHS noted but no evidence it was made. GP does not appear to have contacted Health Visitor

- Oct 2013: Mother, aged 17, presents to Essex Children's Social Care as homeless following an argument with MGM where police were called. Moves out for a few days then returns home.

- Case closed Jan 2014. Child S continues with routine contacts with Health Visitor who was aware of issues.

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# Serious Case Review: Case S
# History of the case 2013 – 14, cont.

- Nov 2013: Mother booked for antenatal care for second pregnancy. Stepfather named as sibling's father.

- Mar 2014: Mother and Child S referred to specialist housing unit by Housing Department

- Health Visitor still identifying that mother had post natal depression but unable to get agreement for medication, due to pregnancy, or to go to counselling. Instead agrees to 'listening visits' with her Health Visitor

- Jun 2014: Child S sibling born

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# Serious Case Review: Case S
# History of the case 2013 – 14, cont.

Jun 2014: minor incidents noted by Health Visitor around Child S –

- Mother slow to comfort her
- Contact by Children's Centre re a bruise. Mother advised Health Visitor Child S had gone to GP, but child not seen.
- Mother reported Child S had taken infant sibling out of bouncer and thrown her on floor. Baby was not injured
- Child S's father had taken her to A&E following a fall

Health Visiting continue to undertake 'listening visits'

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# Serious Case Review: Case S
# History of the case 2013 – 14, cont.

- Sep 2014: family move from Essex to Norfolk where maternal grandfather resides.

- Sep 2014: Essex Health Visiting attempt to contact Norfolk Health Visiting, but are unsuccessful. Notes are transferred.

- Sep 2014: Stepfather's Personal Adviser (PA) from Essex Leaving Care service informed of the move by his mother. PA not aware of his new relationship – contacts with stepfather had been mostly around help with housing and PA was unable to engage with him for any other work

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# Serious Case Review: Case S
# History of the case 2014 – 15

- Dec 2014: Health Visitor completes Child S's two year check. Notes warm relationship with stepfather

- Dec 2014: Mother takes Child S to GP surgery on Xmas Eve, with bruising on her ear. GP told it was due to rubbing her ear; no other bruising and GP provides medication for ear infection.

- Feb 2015: Child S registers with local childminder. Between Feb and Jul 2015, childminder began to have some concerns around Child S:
  - Child S appeared less willing to be with stepfather
  - Four incidents recorded in that time relating to bruising or disclosures that stepfather was hurting her

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# Serious Case Review: Case S
# History of the case 2015, cont.

Apr 2015: childminder phones MASH for an anonymous consultation (child not named). Advice given to record any further incidents.

Jul 2015: Stepfather phones for an ambulance. Child S taken to A&E at local hospital with significant head injury and other bruising on her body.

- Stepfather's explanations of injury treated with suspicion
- Paramedics make a safeguarding referral
- Stepfather interviewed by police and charged with assault

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# Serious Case Review: Case S
# Appraisal of Practice and Analysis

Key aspects of the case appraised:

- Cross border working and information sharing
- Child S's presentation to the GP in Dec 2014
- Recognition, support and risk assessment of vulnerable young parents
- The concerns of the Early Years Provider (childminder) and the role of the Multi-Agency Safeguarding Hub (MASH)

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# Serious Case Review: Case S
# Appraisal of Practice and Analysis

## 1. Cross border working & information sharing

Information sharing across Local Authority borders recognised challenge

With Child S, routine information sharing generally did take place

Issue was less about the sharing (transfer of Health Visitor notes) and more about the way it was communicated, i.e. no real handover/context provided about specific concerns and vulnerabilities

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# Serious Case Review: Case S
# Appraisal of Practice and Analysis

## 2. Child S's presentation to the GP in Dec 2014

- GP's response to presentation subject to a full investigation commissioned by local Clinical Commissioning Group (CCG) with support of one of Norfolk's named GPs

- GP has reflected that there were strong indications of Non-Accidental Injury (NAI) based on presenting symptoms and acknowledges these were missed.

- Context: GP had seen full list of patients Xmas Eve morning (16 for 12 minute allocations). Did not know family concerned and no indication of safeguarding in notes

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# Serious Case Review: Case S
# Appraisal of Practice and Analysis

## 2. Child S's presentation to the GP in Dec 2014, cont

- Subsequent actions taken by GP practice:
  - surgery takes safeguarding and their responsibilities very seriously.
  - Practice has taken part in joint training event organised by CCG to refresh knowledge around NAI
- No reason to consider that there are wider concerns about awareness or safeguarding responsibilities.

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# Serious Case Review: Case S
# Appraisal of Practice and Analysis

## 3. Recognition, support & risk assessment of vulnerable young parents

**Mother**

- Good practice: pre-birth assessment for Child S when mother aged 16. However, assessment not undertaken for second pregnancy
- Health visiting offer of 'listening visits' helped but may not have addressed underlying post natal depression effectively
- Mother's referral to CAMHS following Child S's birth not followed up

# Serious Case Review: Case S
# Appraisal of Practice and Analysis

**3. Vulnerable young parents, cont.**

**<u>Stepfather</u>**

- Stepfather had been provided support through Essex Leaving Care service but chose not to engage

- During his time as a child in care, Stepfather's plan recorded that he should be supported to '*access a local counselling resource when he is ready'*. If he did not take up this offer, he should be referred to a Leaving Care Mental Health Worker. This was not pursued

# Serious Case Review: Case S
# Appraisal of Practice and Analysis

**3. Vulnerable young parents, cont.**

**Both parents**

- Were frustrated and unhappy with the contribution of the other to the care of the children and appear to have been ill prepared to cope with the stresses of parenthood.

- Described growing up and witnessing a degree of violence from parents to their children both personally and within their communities which meant that punishment, such as ‘occasional slaps’, were understood a normal part of parenting

- Acceptance of physical chastisement of the children will have contributed to a situation where there was a risk of escalation when combined with other frustrations.

# Serious Case Review: Case S
# Appraisal of Practice and Analysis

## 3. Vulnerable young parents, cont.

**Both parents**

- Neither mother nor stepfather felt at the time they would have sought help or welcomed any attempts by outside agencies to challenge them or help them think differently.

- Stepfather's strongly expressed view that it was the problems in the adult relationship that ultimately resulted in the circumstances leading to Child S's injuries.

*"It was never the kids' fault….it's the parents having the conflict…nothing could have helped except both of us being mature enough to say this isn't working".*

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# Serious Case Review: Case S
# Appraisal of Practice and Analysis

## 4. Childminder's consultation with MASH

Recollections of the childminder and the Social Worker about their conversation are quite different.

**<u>Childminder</u>**

Childminder concerned to separate facts from her own opinions, but asserts that she clearly stated bruising and then followed the advice provided, i.e.

- to speak to Mum unless she could clearly state Child S was being abused
- to record any comments or concerns
- to refer to MASH if concerns escalate, e.g. if Mother reacted oddly

# Serious Case Review: Case S
# Appraisal of Practice and Analysis

## 4. Childminder's consultation with MASH, cont.

**MASH**

Very experienced Social Worker involved; he was not able to recollect the call in detail, due to the sheer volume of calls taken in one day. Stated that:

- without the parent's consent they could not discuss an individual child
- adamant that if at any point he had been told about specific concerns, including unexplained bruises, he would have said immediately this needed to be a referral not a consultation and he would need to know the child's name
- also absolutely clear that it is completely contrary to his practice to advise someone to keep a list or diary

# Serious Case Review: Case S
# Appraisal of Practice and Analysis

## 4. Childminder's consultation with MASH, cont.

- Recognition that childminders do not generally have routine experience of child protection. Early Years providers receive basic safeguarding training for Ofsted registration

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

- There are inherent risks in any system for '*consultation*' in which the child is not identified and in the Social Worker's words "*achieving a 100% safety net with consultations is not realistic".*

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# Serious Case Review:
# Case S Recommendations for Norfolk LSCB

Case S resulted in three recommendations:

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

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

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# Serious Case Review:
# Case S Recommendations for NSCB. Cont.

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

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

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# Serious Case Review:
# Case S Summary & Conclusions

Case S is one of two recent Serious Case Reviews involving young children who sustained life threatening injuries

The outcome for Child S was that she was seriously injured and her family life fundamentally changed. Whilst her physical injuries have not proved to be life changing, the impact for her and her sibling's emotional development should not be underestimated.

The limited involvement of agencies inevitably meant that there were correspondingly limited opportunities to understand or respond to Child S's needs, or indeed her family's needs.

Whilst some flaws in practice have been identified it is not the assessment of this Serious Case Review that professionals were anything other than focussed on providing a good quality service to Child S.

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# Serious Case Review: Case S - The Board's Response

- Supporting the development of a **consistent and joined-up front door** for vulnerability – strengthening the MASH, and improving the pathways for referral is a priority shared by the NSCB with Adults Safeguarding Board and the Countywide Community Safety Partnership and other partnership boards.

- Children's Services in MASH delivering a series of **workshops for frontline practitioners** to give participants the opportunity to:
  - learn about which agencies are part of MASH
  - how we work collaboratively
  - individual roles and responsibilities within and outside of the MASH.

- **Multi-agency audit** planned to analyse the current nature of consultations, including use of the consultation line, and develop systems to monitor and analyse risks

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

- Sector specific **Early Years Advisory Group** (EYAG) established 2016 – 17 to include childminders as well as representatives from nurseries, Children's Centres, after school providers and Health Visitors

- EYAG work programme to include **disseminating learning** from this and other SCRs.
- **NSCB's Safer Programme** continues to work with the Early Years sector providing training and policy support.

- Developed a **Thematic Learning Framework** to include learning from this and other Norfolk SCRs to better address the recommendations at a strategic level, supported by whole system leadership

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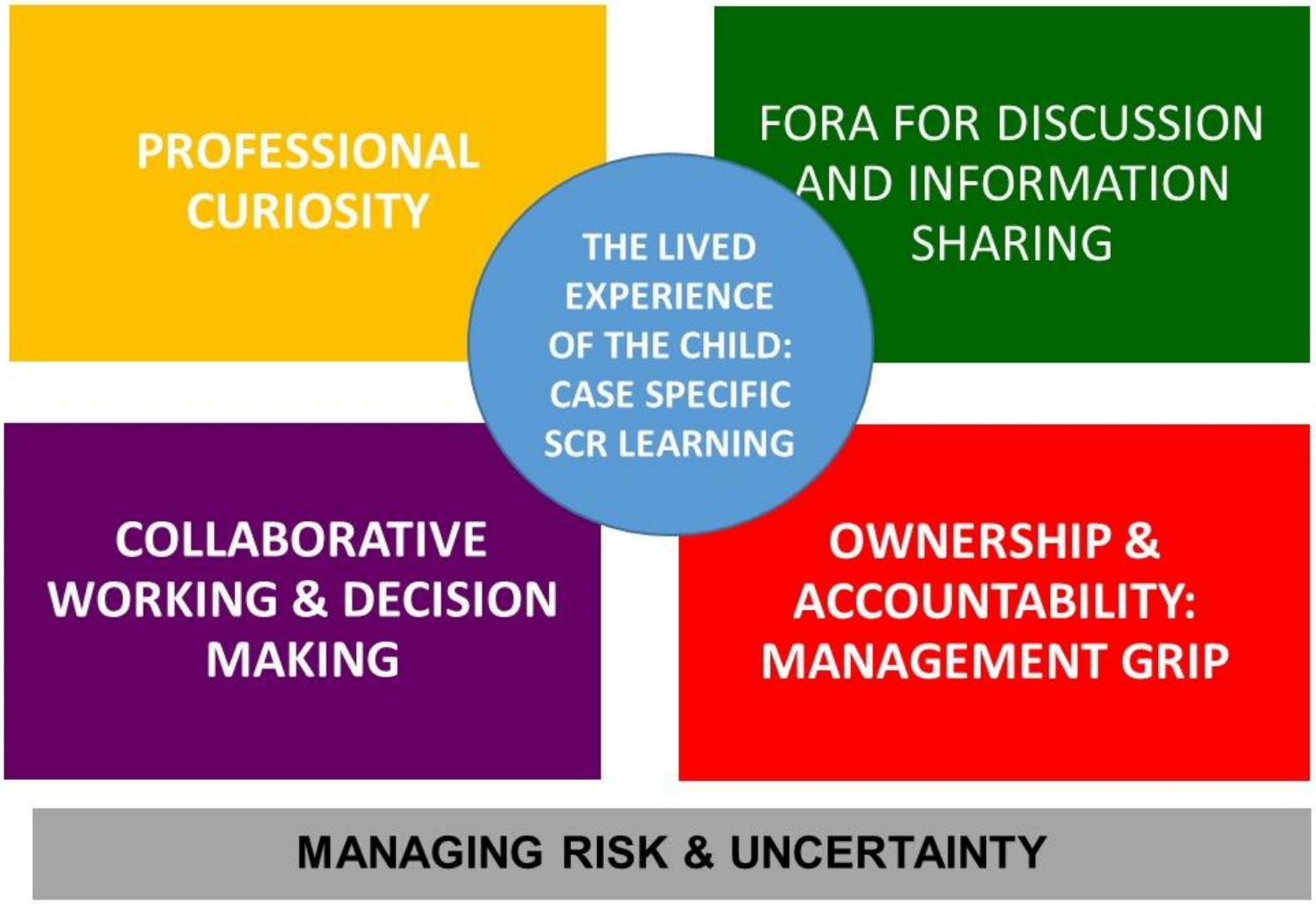
# Serious Case Review:
# Thematic Learning Framework



# Norfolk Safeguarding Children Board: Challenges

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

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

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

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

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