Norfolk Safeguarding Children Board

Norfolk LSCB

Serious Case Review

Conducted Under

Working Together 2015

Child Case Q

Overview Report

Lead Reviewer
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18th November 2016

1. INTRODUCTION AND BACKGROUND TO THE REVIEW

1.1 This Serious Case Review (SCR) was commissioned following concern about the neglect and abuse experienced by two young children over a period of several years. It considers the circumstances in which services were provided to the children and their family.

1.2 All names in this review have been anonymised and the children are known as Q within this review report.

1.3 There were care proceedings in relation to the children. These were concluded in 2015 and the children have been placed for adoption.

1.4 The circumstances of the neglect and abuse of the experienced by the children led to the decision in February 2015 by the Chair of the Norfolk Safeguarding Children Board to undertake a serious case review. The criteria for commissioning a SCR as set out in Working Together 2015 were met.

2. THE REVIEW PROCESS

2.1 This review has been conducted with due regard to the principles of fairness, impartiality, thoroughness, accountability, transparency and above all with a focus on the children. The consideration of their interests and experience has been the central focus of the review. The significance of the circumstances in which they were abused and neglected has affected all those involved in the review.

2.2 The main time period covered within this Serious Case Review is from September 2012 to August 2014. Any additional historical information relevant to the review going back beyond these dates (e.g. within the parents' history) has been fully considered in the review as important contextual history.

2.3 Amy Weir, who is an experienced independent safeguarding expert, was appointed as the independent reviewer. A panel of senior managers was formed to support the process. Amy Weir wrote this report with the support and advice of the SCR Panel. Further information about the reviewer and the panel is set out in the appendix.

2.4 The full terms of reference for the review are appended to this overview report. Critical points in the case were considered in the SCR. Possible reasons for actions taken at the time and learning and improvements needed have been identified – including the significance of these insights for current practice. Where there was evidence of good practice in the case, this has also been noted. These findings will inform the LSCB's Learning and Improvement Plan and they have already led to progress in improving local practice.

2.5 This investigation has examined key documents and spoken to staff and practitioners directly and indirectly through the involvement from each agency of experienced senior managers, who have had no direct involvement in this case. Local practitioners have been brought together to consider, discuss and comment on the findings of the review. The root cause analysis "fishbone" approach to identifying key contributory factors has been used. The aim of this has been to gain an understanding of how the interaction between the various factors influenced the way practitioners responded to the children and their family.

2.6 There have been four other serious case reviews conducted by the Norfolk LSCB in the last 18 months which have found that there were issues about the effectiveness of the identification and addressing of severe neglect of children. This review also looked across these other reviews to ensure that the learning from each of the others is considered within the findings of the Case Q review.

2.7 A key focus for this review has been to ensure that the voice of the children, their wishes and feelings have been taken fully into account. As part of the review the children have also been seen by the reviewer. Understandably the children were reluctant to revisit their experiences because they feel that have already expressed their views to the professionals involved and to the Court. The elder child wrote to the Judge involved in the care proceedings to say she was pleased that the Judge had listened to her view. It was explained to the children that review like these are important as we need to use the learning from it to improve the experience of other children. They understood this and supported the process.

2.8 Other family members have also been contacted. It has not been possible to speak to mother as her whereabouts are unknown. The maternal grandparents asked to be seen

and they were seen and their views were recorded and considered.

2.9 There have been other proceedings in this case. The children have been in care proceedings and a care order was granted to the local authority with a plan for adoption. At the time of the review, the Police were still investigating the neglect of the children by mother and were trying to locate her to take the case to court. As a result of the criminal proceedings, she was found guilty and has served her sentence, which was 15 weeks' imprisonment suspended for 12 months, an £80 Surcharge and a Community Order.

2.10 Although the main scope of the SCR is 2012 to 2014, in this case there were major antecedent history and concerns prior to this. For that reason, the review has considered some of the earlier history and the pattern of service delivery then as well as the main focus period of 2012 to 2014.

The critical points considered are:

- Overview of family history and lifestyle and impact on the children - **2002 to 2010**
- Response to domestic violence and abuse within the household from **2010 to 2011** - the appropriateness of the response and whether the impact on the children was fully considered, understood and the children effectively safeguarded.
- Assessment, planning, review and decision-making - **Dec 2011 to March 2012**. Children on Child Protection Plan (5/12/11- 21/2/12) and in care (section 20) (with foster carers 9/12/11 –March 2012).
- Children removed from care – **March 2012 – September 2012**.
- Living with maternal grandparents and supported by Children's Social Care (CSC) as children in need. Children back home with mother. Case closed by Children's Social Care.
- Children with mother, escalation of concerns and removal of children into care. **September 2012-August 2014**

2.11 The possible reasons for actions taken or not taken at the time were considered:

- What factors contributed to practice decisions at the time?
- What could have been improved?
- What worked well?

2.12 The significance of these insights for current practice.

- If the same event occurred now – what factors would influence the response?
- What learning and improvements have already been implemented?
- What is working well now and what still needs to be improved?

3. NARRATIVE OF KEY EVENTS

2002-2010

Overview of family history 2002 to 2010 and lifestyle and impact on the Children from 2007

3.1 Family History and background from 2002 to 2010

3.1.1 This review focuses primarily on the period 2012 to 2014. However, there was a significant history of concerns and issues prior to this about the family. The domestic abuse between the parents and their misuse of alcohol and drugs is likely to have had an impact on the children for most of the time they were living with the parents.

3.1.2 Prior to the births of the children, there was a history of Police being involved as a result of physical and verbal abuse between mother and father. These reports continued after the children were born and there was reference to significant alcohol and drug misuse by parents.

3.1.3 The children were born in 2007 and 2008.

3.1.4 The Health Visitor (HV) received information from a neighbour that the children were not safe – it was said that mother had a black eye and the parents were misusing drugs and alcohol. The Health Visitor reported this by phone and in writing at the beginning of July 2009 to Children's Social Care (CSC). Child Q1 was said to have slap marks on her back. On 22nd July, two weeks later, the HV was told by a social worker that no visit had been completed and Child Q1 had not been examined. The full details of this episode are not recorded by CSC in the integrated chronology for this review as the CSC electronic records system – searched for this review – did not start till after this period. It is in the CSC records in November 2009 that, as there were no further concerns reported, the case could be closed.

3.1.5 In July 2010 father physically assaulted mother (a punch to the face) and both children were present. Police were concerned for Child Q1, aged 3 years, who saw all and was observed cowering in the corner. Father was bailed with the requirement that he

should not go to the home address. A referral was made by Police to CSC; an initial assessment was completed and the outcome was that there should be no further action.

2011- September 2012

3.2 Family History and background 2011 to 2012

Escalation of domestic abuse and assumed separation of parents - Children on CP Plan (5/12/11- 21/2/12) and in care (section 20) (with foster carers 9th December 2011 – March 2012).

3.2.1 In 2011 the Police were involved with the family and eleven incidents were recorded by the Police. Four of these incidents only related to father and his assault and drugs offences; all the other incidents related to violence and conflict between the parents. In August 2011 mother left the family home with the support of Police and took the children to a refuge where they remained till December 2011.

3.2.2 In October 2011, mother went out from the refuge and left the children with another resident and she later returned intoxicated. In December 2011 – mother was again intoxicated and took the children out into the street late at night with inadequate clothing; as a result, the children were removed from mother's care and made subject to Police Protection.

3.2.3 The children were in care with mother's agreement – (section 20 Children Act 1989) - from December 2011 to March 2012 – initially they were also subject to a Child Protection Plan. In March 2012, mother took the children out of care and they went to live with maternal grandparents.

3.2.4 The children returned to mother's care probably in July 2012 but certainly by September 2012. It is difficult from the records which are scant in CSC to understand how and when this occurred.

3.3 Evaluation of practice from 2007 (birth of Child Q1) to September 2012

During the early years of the children's lives, there were many concerns raised and both Police and Health professionals had reported concerns to CSC about the impact of the

violence between parents and their drug and alcohol misuse on the children. The episodes are set out briefly in the summary chronology.

3.3.1 The CSC response was limited and until the end of 2011, there was no thorough assessment of the situation. The response to the incident in 2009, when Child Q1 was reported to have slap marks, was delayed and the situation was not assessed and there is no recording in CSC till November when the decision was to close the case. Although there was an allegation of physical abuse to Child Q1, there was no medical examination of her and the appropriate child protection process was not followed. When they were spoken to, the parents successfully explained away the concerns raised and suggested that anonymous calls received by agencies were malicious. The impact on the children was not fully considered, understood nor the children effectively safeguarded.

3.3.2 In October 2011, no strategy meeting was held or follow through with a child protection process completed even though mother had been intoxicated and had left the children in the care of another resident in the refuge. It was not until a further serious incident in December 2011 that the children were removed. This pattern of inaction and failure to invoke appropriate child protection procedures consistently continued and was repeated during the period 2012-2014 which is the main focus of this review.

3.3.3 A strategy meeting and initial child protection conference were held in December 2011. A child protection plan was drawn up but it was decided in February 2012 at the review child protection conference that the child protection plan was no longer required. The reason given for this was that the children had been in care from December 2011 and the looked after children process would therefore provide the framework for protecting the children. The contingency for what would occur if mother should seek to remove the children from care was not fully considered. As a result, when mother removed the children from care in March 2012 and they went to stay with her maternal grandmother, there was no agreed multiagency response in place. There was no multiagency discussion and other agencies were not consulted about whether this was appropriate or whether legal action should have been considered for the children to remain in care.

3.3.4 This was despite the fact that there had been recognition of the continuing risk of harm to the children. A letter before court action had been sent to mother in February but the follow up meeting involving the legal team was postponed first because of lack of solicitor time and then because the case changed social worker and moved to another team. There appears to have been a lack of clear planning and management oversight of the circumstances of the children. Holding an interagency meeting would have enabled all the risks to be evaluated. The needs of the children were not well served either by the child protection system or the looked after children system. As far as child protection is concerned, a strategy meeting could have been held given the children had come into care following a significant incident and that they had been subject to a child protection plan prior to that. There was an Independent Reviewing Officer (IRO) responsible for the oversight of planning for the children whilst they were in care but it is not clear whether the IRO was consulted about the children's removal from care or whether calling a discharge from care meeting was considered. Since neither of these routes for securing multi-agency oversight of planning for the children was followed, there was a lack of a full and joint appraisal of what was in the children's best interests and what should be the plan for the future.

3.3.5 Mother was cooperating during the time the children were in care and after. She had decorated the house, was making other improvements and CSC regarded this as positive and closed the case in September 2012. This led to an optimistic view that she had learnt from what had happened and had turned over a new leaf. She was being well supported by her own mother but this led to an underestimation by professionals of the additional support and supervision of her care of the children she needed.

3.3.6 It appears that the full scale and seriousness of the history and of previous incidents of domestic and verbal abuse in the household were not thoroughly considered when the case was being looked at in 2010 and 2011. It is important to act decisively with clear contingent planning at the time when children are being actively harmed but this did not happen. The lack of taking account of the past history is a key theme running through the management of the case. Mother's separation from father and her ability to cooperate and do the right things at least for a period did cloud the situation in 2012 when there were many signs of positive parenting and mother's willingness to change.

The Review Period 2012-2014

September 2012-August 2014

3.4 September 2012 to December 2012

Children with mother. Social worker was to complete Core Assessment.

3.4.1 There was a multiagency meeting held in September 2012 prior to the case being closed. Mother reported she had completed the Freedom programme and was starting counselling. Homestart had visited and raised no concerns. As a result of these positive indications, the case was closed to Children's Social Care; the case had been open from October 2011.

3.4.2 However, mother almost immediately after this told Homestart that its visits were not needed. The school during that term found it difficult to get mother to work with them. Children's Social Care, when contacted, advised the school to open a Common Assessment (CAF). There were two incidents recorded of first mother and then a child's school bag smelling of cannabis.

3.4.3 A positive initiative at this point was that a worker from the domestic violence refuge where mother and the children had been placed in 2011 - was seeing Child Q1 to explore her wishes and feelings. Mother agreed to this for a time. It allowed Child Q 1 to have a regular, safe place to speak to a known worker and she started to talk about what was happening at home.

2013

3.5 January 2013 – December 2013

Children with mother and drug misuse and unknown males at the property.

3.5.1 The case had been closed in September 2012. The school and the refuge worker remained concerned. On 15th January 2013, Child Q1 disclosed to the refuge workers that mother smacked her every day and she informed Children's Social Care. The school reported to Children's Social Care that mother was not engaging with support and the Common

Assessment Framework process (CAF). Child Q2 confirmed to school that this smacking occurred daily. Child Q1 also disclosed that she had not had breakfast and school reported that she had taken food from other children. Children's Social Care agreed with Police that an initial assessment should be completed. It is not clear why a strategy meeting was not held in compliance with Working Together 2013 to involve not just Children's Social Care and Police but also Health and, in this case, the school. However, a response was made through a home visit by the new social worker. Mother denied hitting Child Q1 and said that the children were always given breakfast. It is significant that this was a new social worker who would not have known mother or the children and who lacked the experience of the family history.

3.5.2 At the end of January 2013, Child Q1 told the school that she was smacked on the hand by mother every day. Mother apparently had a new partner who was identified as having a history of domestic violence; Child Q1 said "daddy" hits her "when he comes home". A visit was made the same day by the social worker and the refuge worker. Child Q1 asked the social worker to speak to her mother again as on the previous occasion the social worker had visited her mother had stopped hitting her.

3.5.3 In early February 2013, there was a fire at the home of mother's sister; the children had been staying wither overnight and they suffered smoke inhalation. Child Q1 came to school with a bruise on her head and mother said this had happened during the fire. Child Q1 was also said by the refuge worker to be "crawling with head lice". Mother was told by the school that she needed to treat the condition but it is not clear that this was followed up with her.

3.5.4 The social worker reported to her supervisor that she had undertaken further visits to the family – though there is no record of these visits - and that there is "a suggestion that Child Q1 has provided contradictory accounts of incidents". Child Q1's account was being questioned by the social worker probably because her mother had suggested that the child made things up.

3.5.5 On February 14th 2013, a Core Assessment was completed and the outcome was that there should be a Child in need plan. In the plan risks and protective factors were identified.

3.5.6 On 6th March 2013, the school referred a concern that Child Q1 was saying that she had witnessed a violent incident and she was distressed by this. On 14th March mother was at school smelling of alcohol. The school had identified that mother was in a relationship with a well-known local drug user. A CIN meeting was held on 27th March and mother denied that there were different people coming in and out of the children's lives.

3.5.7 In April 2013, there was a new social worker. During a social work home visit, with mother present, Child Q1 said her friend had made her make the allegations of smacking. It was recorded that the house was clean and tidy but damp. A few days later school were reporting that the children often presented as hungry, grubby and were late for school. The social worker recorded, following a conversation with school, that "Child Q1 was seen as a child who is likely to make allegations for attention".

3.5.8 The review has seen records that in April and May 2013 Police intelligence recorded that a known drug user was staying at the address and drugs, including cannabis, were regularly being used there in the presence of the children. The drug user was said to have been "off his head" at the address for four days. The drug user also told the Police who spoke to him at the address that he was looking after the children for mother. This was reported to CSC.

3.5.9 In May and June 2013 Child Q1 was saying at school that she had sometimes not had breakfast and school recorded that she was stealing items including food from other children.

3.5.10 On July 1st 2013, it is recorded by CSC that a new Core Assessment was to be commenced. In the case notes, significant risks for the children were identified but the decision was that the Child in Need plan (CIN) should continue. Given the risks noted and the extensive history of concerns, it is unclear why a section 47, multi-agency child

protection approach, was not considered given Child Q1's stating she was being smacked.

3.5.11 At the beginning of July 2013, Child Q1 said at school she was tired because they had been to a party. On 8th July both children said they had had no breakfast but mother denied this. On 15th, 16th and 27thJuly, Child Q1 said she had had no breakfast and was hungry. Police recorded that the known drug user was still in contact with the family and staying though mother denied this when asked by the social worker.

3.5.12 During August there was a discussion between Police and CSC about the presence of the known drug user at the address. His Probation Officer contacted CSC also about this issue and the risks he may pose to children on 6th August. On 7th August, CSC informed Police that the child protection process with section 47 and conference would be reopened given the risks associated with presence of the drug user. The social worker carried out a frustrated unannounced visit on 22nd August 2013. There is no record of child protection processes being instigated or of a strategy meeting being held to discuss concerns with other agencies. It appears therefore that this did not take place.

3.5.13 During September and October 2013, further concerns were reported about the children. Child Q2 suffered a dog bite and a large bruise on his forehead. The bruise was said by mother to have been caused accidentally. He also went to school with poorly fitting shoes which were causing blisters. There were holes in Child Q1's shoes. The school became concerned that the children were becoming "cagey" and did not talk as much about home at this period. The Core Assessment was completed and the case was transferred to a different team - CIN team - and a new social worker at the beginning of October.

3.5.14 There were reports made to the District Council and the Police about loud parties being held into the early hours at the home. On 5th October, Child Q1 was reported by Police who were called to the address to have been awake, downstairs in her nightwear and unsupervised at 4 am in the company of five unknown adult males. Mother was apparently upstairs and asleep when the Police arrived.

3.5.15 At the end of October 2013, a management overview of the case is recorded in CSC. According to this note on file, the Core Assessment (CA) started on 20th September

appeared not to have been completed at this point. There is some lack of clarity in the records with mention of another CA being stated in July and completed on 4th October 2013. The management overview note set out that there were continuing concerns were to be dealt with based on completing the Core Assessment – there was mention of the need to instigate child protection processes if the outcome of the Core Assessment indicated this was required. The manager was clear about the history and said that the case should be allocated within two weeks and the Core Assessment completed within timescales. The case was at this point not allocated. It was transferred to another team – the Safeguarding Team – on 1st November 2013. This was a further team responsibility change within just a few weeks with a high likelihood of lack of continuity.

3.5.16 The case was allocated on 1st November. During early November 2013, there is contradictory evidence about what was happening. The school recorded that Child Q1 reported she had not had breakfast on several occasions and was hungry. On 12th November the new social worker recorded that the school had "no huge concerns" about the children but the social worker arranged a meeting with school for 19th November.

3.5.17 The social worker visited the family in mid-November. Child Q1 told the social worker in the presence of her mother that she liked living with her mother who was nice and kind. Mother denied using physical chastisement. The plan by the social worker was to close the case though there is no indication that the history was being fully considered.

3.5.18 On November 18th 2013, Child Q1 told school she was sore and CSC was informed. This was a worrying development but a child protection response was not initiated. Mother was advised by the school to take her to see the GP. There were reports from the Housing Department a few days later of parties at the home. School had concerns about unknown people being present in the home.

3.5.19 A week later a duty social worker went to school to speak to Child Q1. Then a meeting was held with the social worker at school the same day and again concerns were raised by school about information coming from the children that there were unknown males in the home. The school was also worried about Child Q 1's soreness but the possible implications of this were not acted upon. The social worker advised the school that there

was no evidence of any male presence in the home. The social worker advised the school that they should continue to monitor the situation.

3.5.20 On 28th November the school was advised to open a CAF as the case had just been closed by CSC and there was no longer an allocated social worker. The school clearly had significant concerns and it was surprised that the case had been closed in these circumstances. It is not clear whether any escalation of the school's concerns was considered.

3.5.21 In early December, Child Q1 was still complaining of soreness at school and she said mother had not taken her to the GP. It is not clear that CSC was informed of this. During December 2013 reports to the Police and District Council of loud music and parties continued. Child Q1 was still telling school she had had no breakfast. It appears that the school, despite these continuing concerns, believed that CSC was not so concerned, had closed the case and again it is not clear why the local escalation system did not come into play.

3.6 Evaluation of Practice from September 2013 to January 2014

3.6.1 There were many worrying and concerning issues raised during this period about the welfare and safety of the children. Police, Probation and the school provided information to CSC about these issues but there was no effective response and child protection processes were not initiated either by CSC or any of the other agencies – even though this was considered at one point.

3.6.2 There were several changes of social worker and changes of CSC team. This would have made it much more difficult to ensure that there was coherent and consistent approach with the family particularly when mother denied any of the problems which were mentioned to her. For some of this period the case was closed to CSC. Even though other agencies particularly the school were continuing to identify significant concerns, these did not always get responded to.

3.6.3 There was a long period when a Core Assessment should have been completed but it was not. A management note was on file about the need to complete the Core Assessment though as the case was moving between three different teams it is not always clear what was happening. The recording in CSC is scant and some visits which the social worker mentioned having completed do not seem to have been recorded.

3.6.4 When the issue of an offender known to Police living in the family home was raised with mother, she denied that this was the case. The social worker accepted mother's version of events did not challenge this and commented to the school that she could see no signs of a male presence in the home. No strategy or other multi-agency meeting was called to consider all the emerging and known risks to the children.

3.6.5 The significance of the clear poor physical care of the children – lack of breakfast, worn out shoes, severe head lice and various "accidental" injuries were not fully investigated. Child Q1 complained on more than one occasion about having soreness but this did not – as it should have done – lead to a child protection response and investigation.

3.6.6 The school and other agencies continued to report the concerns they had. It is not clear why further escalation of these and challenge to the lack of action did not occur. However, there were several changes of social worker. The school was not fully aware of how best to escalate the concerns. On some occasions when the school had raised significant concerns, the CSC response had been to accept mother's version of events.

3.6.7 At the beginning of 2013, CSC had been subject to an Ofsted inspection which found the service to be inadequate. Between January and September 2013, there was a high rate of turmoil and changes of staff. Many agency social workers were deployed after the inspection and this was a further challenge to maintaining service consistency and continuity. This disruption of the service is likely to have had serious implications for the effective oversight and management of this case.

2014

3.7 January – April 2014

Children at home with mother – referrals about drug use and loud parties at the home – and children raising concerns

3.7.1 In January 2014, the District Council recorded that a number of people were staying at the address which had deteriorated and was "almost uninhabitable". It is not clear whether this information was shared.

3.7.2 Between January and March, the only records seen relate to the housing issues. It is unclear in the CSC record what was happening to the children at this time.

3.7.3 On March 25th 2014, Child Q1 complained at school of having soreness saying that mother never takes her to the GP. On March 27th 2014 Child Q2 came to school with a burn on his hand caused he said when he was making breakfast for himself. Child Q2 told the school that Child Q1 allegedly stayed alone at an unknown male's house the night before staying up late and watching television. The school immediately referred these concerns to the allocated social worker who was at school that day. An unannounced visit was to take place but this did not occur. Mother told school that this man was a friend and the other males were his nephews. At this time, Child Q1 wrote a concerning story at school about not wanting to be touched – this was discussed in school but it was not shared with CSC.

3.7.4 A duty social worker called mother on 1st April to arrange a visit. On 2nd April, an anonymous caller rang CSC to say that mother was misusing alcohol and drugs; there were said to be many other people in the house who were taking drugs in front of the children. It was also alleged that the children's father had been seen at the house.

3.7.5 A home visit was carried out by a social worker on 3rd April and Child Q1 was seen at school. The recording of the home visit is very scant and it is not clear what mother said about the two referrals which had been made. Mother's permission was sought for Child Q1 to be seen.

3.7.6 Child Q1 was seen the same day. She was described as slightly grubby but "generally clean and tidy". Child Q1 spoke positively about her mother. She said she liked her mother

because “she will put a plaster on her knee”. Child Q1 said that they all go to stay with the male mentioned at school by Child Q2 and sometimes her mother will go home for something. She said there was nothing she did not like about going to this man’s house. She did not mention seeing her father but it is not clear that she was asked directly about this. Child Q1 confirmed the accidental cause of the burn to Child Q2’s hand. The social worker recorded that Child Q1 “shared no concerns during the visit and has no worries about her home life.”

3.7.7 The social worker then spoke to the leader of mother’s skills training course who gave a very positive account of her. On 8th April a management overview note on file stated that the case could be closed once identified tasks had been completed. Concerns raised in the referral were said not to be substantiated. Mother was to be advised that if the children had unsupervised contact with the father CSC would consider further action under child protection procedures. There was still an outstanding CA. However, an Initial Assessment was completed and the case was closed on 23rd April 2014.

3.8 **May to August 2014**

During this period there were further worrying concerns about the children who were finally removed from mother’s care and care proceedings initiated.

3.8.1 Child Q1 appeared dirty and unkempt in school. She hurt other children. There was continuing Police intelligence about extensive drug use at the home.

3.8.2 On 7th June 2014, Police were called to the address because of reports that there was a loud party and drugs were being used. On this occasion, the children were not present but the house was in a terrible state. There were up to fifteen people present, many of who ran off when the Police arrived and there was a strong smell of cannabis in the house. The beds were “trashed” and the bedrooms smelt of urine and there were faeces on the floor of one child’s room. Mother was heavily under the influence; she told Police that the mess had occurred during the party and that it was not normally that bad. She undertook to clear it up by the time the children returned the next day. The attending officer was very concerned, was not convinced by what mother was saying and suggested that CSC need to visit to check that this was not just a one-off incident.

3.8.3 On June 10th 2014, Child Q1 was at a neighbour's house and called the NSPCC Helpline which then contacted the local Police. Child Q1 had been involved in discussions at school about the role of the NSPCC. She said that her mother "was always partied out, she takes drugs and hits me". She also said that someone had touched her inappropriately and that it was sore down there. Mother's whereabouts were unknown and the children were at a neighbour's house. The children were subject to Police Protection and placed with maternal grandmother. The Emergency Duty Team was involved and held a telephone strategy discussion with the Police.

3.8.4 The case was allocated to a new social worker on 11th June 2014. Mother was seen on 11th June and she was advised that Achieving Best Evidence (ABE) interviews were to be carried out with the children. Mother was cleaning the house. There is no record in the case notes of a further strategy meeting having been held.

3.8.5 The children were interviewed. Child Q1 stated that mummy drinks alcohol and 'does drugs'. She said that "mummy's friends come round in big groups and mummy smokes white lines and sniffs it up her nose". She also described mummy drinking wine and passing out on the sofa and no one being able to wake her up. Child Q1 described getting home sometimes and mummy not being there, not knowing where mummy is and having to go to mummy's friend's home. She said that mummy sometimes did not cook them tea so she has tea somewhere else. She said that she had made the call to ChildLine when she was at a neighbour's house who asked whether she wanted to speak to ChildLine so she did.

3.8.6 Child Q1 was also asked about what she had said about her private parts being touched. She stated that it had happened, when she was last at school, when a boy in her class touched her privates with his hands.

3.8.7 Child Q2 said that they slept downstairs on the sofa as upstairs was too messy.

3.8.8 On June 12th 2014, mother was interviewed by the Police under caution. She denied taking drugs and drinking in front of the children. She also denied smacking the children, stating that she only used 'time out' to discipline the children. Mother suggested that Child

Q1 has “an attitude” and had been stealing at school and from the house; mother said she dealt with this with 'time out'. Mother stated that Child Q2 was very clinging towards her and that she believed this was because they had seen her being a victim of domestic abuse. Mother agreed that the house could be in better condition but stated “she did not have the money to sort it out”.

3.8.8 On 13th June, the social worker visited mother as arranged but she was not at home. Mother did not answer her phone. The social worker visited school and agreed the children could not go home until the home conditions had improved. The social worker rang mother again who said that she was not at the house because she was in the city trying to get an abscess sorted out.

3.8.9 The social worker requested by email to managers on 13/6/14 that a strategy meeting should be held for the case to proceed to an initial child protection conference.

3.8.10 The children’s maternal grandmother told the social worker that mother had seen the children and the outcome was seen as very positive. On 16/6 mother said that she was unclear as to why Child Q1 would make the allegations she had. She denied drinking or using drugs. She admitted that she did have friends round because she was lonely. It is recorded in the CSC case notes that, as mother had sorted, tidied and cleaned her bedroom the children could return home; mother said she would sort out the other two rooms as soon as she could.

3.8.11 On June 17th 2014, it appears that the children had returned to their mother’s care. The social worker called the Police officer for the case, who was newly in role, to inform her that it was intended to return the children home. The Police officer went along with this plan though she lacked a full knowledge of all the history. The Police were still considering prosecution of mother for neglect. Other agencies – particularly the school – do not appear to have been consulted and no interagency planning meeting was held.

3.8.12 The social worker visited and mother and grandmother were cleaning the home. The children were said to appear to be happy to be home. The same day, an anonymous call was made to Police saying that the mother had gone out leaving the children alone. When

spoken to, mother denied going out. On 19th June a further anon call was made to NSPCC saying that the children were being neglected. On 19th June Child Q1 was said to be smelling of urine at school and also said she had not had a bath for several days. On 24th June Child Q1 said she had not had breakfast.

3.8.12 On June 25th 2014, a neighbour called CSC because the children were at her door hungry and unclothed with mother unconscious on the sofa. The social worker went out straightaway – there were other adults in the house, loud music, the house was untidy, smelling of cannabis and there was little food in the fridge. Later the same day the social worker visited as arranged but mother was out; a neighbour told the social worker that she and others often fed the children. On June 26th 2014, the social worker visited and there were two men present. Child Q2's feet were very dirty. The home was still a mess but there was some food in the fridge. On June 27th 2014, an anon call was made to NSPCC; it was stated that the children were being neglected and that this person had had serious concerns for two months.

3.8.13 On June 30th 2014, an initial child protection conference was held and the children were made subject to child protection plans. The same day Child Q1 reported at school that she had not had breakfast and the school recorded that she had holes in her shoes. On July 4th 2014 Child Q1 went to school with no breakfast and wearing inappropriate shoes.

3.8.14 On August 14th 2014, there was a core group meeting. Several positives were reported but also serious concerns were recorded about the lack of progress on the issues set out in the child protection plan.

3.8.15 On August 19th and on August 20th, there were home visits by the new social worker. The property was in a poor state with smashed windows and the children were very dirty. There was cat excrement and clothes all over the floor. Child Q2 had an infected wound from which the stitches had not been removed. The children were removed and mother was arrested for neglect.

3.8.16 Thereafter, court proceedings were started and the children were made subject to Interim Care Orders on 23/9/14.

3.9 Evaluation of practice from January to August 2014

3.9.1 The physical care of the children and the state of the home deteriorated significantly during this period. As during the earlier history of the case, single issues were responded to one by one and it took several months for decisive action to be taken.

3.9.2 The school (and Police) continued to report concerns and to support the children. The closure of the case in April 2014 was surprising given the high levels of concern which existed. It is clear that mother's assurances and denials of the difficulties and Child Q1's struggle to tell the truth about what is happening consistently clouded matters but there had and were continuing serious concerns and it was clear that the school was not consulted.

3.9.3 On 10th June 2014, Child Q1 had called ChildLine, mother had left the children alone, they were removed from her care – subject to Police Protection and mother was interviewed by the Police. It is difficult to see how the children were back home living with their mother within a few days of this. There was a telephone strategy discussion called between EDT with the Police but this was not followed up by a strategy meeting to ensure that other agencies were involved.

3.9.4 Between June and August 2014, there were several anonymous calls about neglect on the children and problems noted. The children were rightly made subject to a child protection plan on 30th June 2014. However, the case notes and social worker report refer to the need to consider a legal letter before action but not before a further core assessment is completed. It was already clear that mother was failing to meet the children's needs and to safeguard them so legal advice and action was indicated as an immediate need.

3.9.5 It is particularly of concern that Child Q1's statements were not taken further. The fact that she was still mentioning having soreness and was not medically examined is of concern. She was interviewed in an Achieving Best Evidence (ABE) interview; at that point she suggested there had been an incident in the school toilets. It is extremely difficult and embarrassing for a child of this age to mention such things and the fact that she did was of

note. It may also be that she sought to find an explanation which would not implicate any adult. Research shows that assessments of whether a child may have been sexually abused require time and the establishment of a relationship with someone with whom the child feels secure.

3.9.6 When the children were removed in August, it was the physical state of the home which was a significant factor in this occurring. There has been a pattern in this case of professionals considering the physical state of the home and failing to see the welfare and emotional circumstances of the children or to hear what they were saying. There is no direct evidence that child sexual abuse had occurred but the possibility of child sexual abuse also needed to be fully considered.

4. The experience of the children

4.1 The children have been seen by the reviewer. We did not speak directly about their experiences because the children had indicated that they did not want to go through everything again as they felt that they had told their story to many others. The records of the children's experience and the evidence accepted in the care proceedings demonstrate the neglectful and abusive experiences they have had during their childhoods.

4.2 There is some evidence that the care of the children initially was better in 2007/08. They were immunised and received appropriate health care.

4.3 However, for much of their lives in the care of their parents, the children were exposed to high levels of verbal and, on some occasions, physical abuse between the adults around them. Both parents also used drugs and drank excessively when the children were present. They were also exposed to the anti-social behaviour of their parents and of other adults.

4.4 When mother had separated from father, there were several risky males identified as living at the home address at various times. Some of these were well known to the Police for drug and other offences.

4.5 The emotional care and protection which the parents and, laterally mother, gave to the children was erratic and inconsistent. It appears that father had been unable to provide consistent, safe and warm care to the children to the point that the children told professionals that they did not want contact with him.

4.6 Mother tried at times to be a good and responsible parent and to show to professionals that she could give the children positive experiences and maintain a stable, clean and safe environment for them to live in. However, she too easily slipped away from this and her own substance misuse and association with inappropriate adults, whom she allowed to live in the family home, undermined and negated all her efforts to care safely for the children. She was vulnerable and exploited on several occasions by inappropriate males.

4.7 When the children were in care for a few months 2011/12, mother was assiduous in keeping to the contact arrangements to see the children and she clearly had a commitment then to keep trying. When they went home her drug misuse, association with inappropriate males and her resultant behaviour was to lead her to fail to meet the children's basic needs consistently.

4.8 The physical care provided to the children and the state of the home environment fluctuated between being reasonable to being grossly inadequate. On many occasions, mother did not provide the children with breakfast and Child Q1 frequently said she was hungry and was given food at school.

4.9 The level of emotional warmth which the children received from their mother was adversely influenced by her reliance on drugs and alcohol. This presented a very confusing experience for the children particularly the elder child who clearly felt responsible not only for herself but also for her younger sibling. Mother's association with inappropriate males, noisy late night parties at the home and violent episodes there exposed the children to frightening and unsafe experiences.

4.10 For a lengthy period over more than a year Child Q1 spoke about her distress at home and about the poor care she and her brother were receiving. She spoke on several occasions about being hungry, being kept up late and about mother being under the

influence of drugs. It was fortunate that she not only had a receptive school to share this information with but also a worker from the refuge where the family had lived for a period. At times Child Q2 also spoke about problems at home and confirmed what his sister was saying. Child Q1 was given a receptive environment at school and the access to additional independent support to enable her to express her views also was good practice and gave her an invaluable opportunity.

4.11 There is good evidence that the children's views and statements were not always believed by all professionals. Mother's account of how they "made things up" was accepted and followed on several occasions and the children's views discounted. At times, it is also clear that the children behaved warmly with mother and expressed positive views about being with mother which confused matters. This was natural. They were still in mother's care, worried about their situation and always hoping that things would improve.

4.12 In June 2014, Child Q1 rang ChildLine to say that she was not being cared for appropriately. Police Protection was used to remove the children from home. A few days later the children were returned to mother's care because mother had cleared up the house and denied that what had been said by Child Q1 was true. A further few weeks passed before there was a further crisis and the children were removed permanently from their mother's care. It is not surprising therefore that Child Q1 expressed her gratitude to the Judge, for listening to her views.

4.13 The children are intelligent, lively youngsters. They are settling into their new family and their new schools. They are having a rich and positive experience with the new carers who are doing all they can to provide the children with the best possible experience.

5. Family involvement in the review

5.1 Father's whereabouts are unknown and it has not been possible to contact him to inform him that a review is being undertaken.

5.2 At the time of the review, Mother's whereabouts were known and it was not possible to involve her.

5.3 The children's maternal grandparents were seen by the reviewer. This confirmed that the maternal grandparents were very involved in trying to support mother with the care of the children at some periods.

5.4 Mother's parents explained that mother did not like being on her own and she always seeks out other people. Mother and her two sisters were adopted by the maternal grandparents when mother was seven and her sisters were six and eight years old. All three children had been subject to considerable neglect and they had also been sexually abused. The children's mother had been an "easy" child to care for but when she was 15 years she became "wild" and difficult to manage. She stopped going to school even though she had been doing very well.

5.5 The maternal grandparents' view is that the situation deteriorated when mother took the children to the refuge where they believe she met people who were a negative influence. Her drinking became much worse and she was away from friends and family.

5.6 The grandparents cared for the children for a few months in 2012 before mother took them back home again at some point after June 2012. The grandparents presumed that CSC remained involved. Their own contact with mother reduced at this time and they saw less of the children as mother made them feel unwelcome when they visited her. The grandparents found it difficult to talk to anyone about their worries particularly since there were several different social workers.

6. THEMATIC ANALYSIS

This section addresses and suggests possible reasons for actions taken or not taken at the time.

6.1 There were several **key episodes** in the case when more effective and sustained action could have been at least considered even if not taken at an earlier stage to challenge mother and to ensure the protection of the children.

Some of these are outside the immediate scope of this review but are relevant in illustrating the lengthy delay in effective protection of the children being achieved.

- July 2009 Health Visitor received information and reported by phone and in writing on to Children's Social Care (CSC) that the children were not safe – mother had black eye, parents misusing drugs and alcohol. Child Q1 said to have slap marks. It appears no visit was made by CSC.
- July 2010 – Father struck mother in the face in front of the children. No child protection assessment or visit made by CSC.
- October and December 2011 - Mother was very drunk in charge of the children; on the first occasion an optimistic view was taken and the children remained with their mother. On the second occasion, the children were subject to Police Protection, were made subject to child protection plans and were removed into care. There was no contingency or follow through of legal action. In March 2012 the children were taken out of care by mother and grandmother and shortly afterwards they were back with mother.
- January 2014 – the home was described as "almost uninhabitable".

6.2 Within the prime focus of the review, there were many **key episodes when earlier intervention could have occurred**: the three major ones were:

- Between October 2012-October 2013, significant and serious concerns about the welfare and safety of the children were reported - cannabis was being smoked in the home, numerous concerns raised by school by Child Q1 being smacked and coming hungry to school. By the new year and certainly by May 2013 a drug user well-known to the Police was living at the home. Police were called in October because of a noisy party in the home, Child Q1 was found alone downstairs at 4 am in the company of unknown males. There was no timely response and there was delay with no CSC assessment being completed or child protection process invoked.
- June 2014 - On 7th June 2014, Police were called to a rowdy party with many drug users present. The children were not there but the house including the children's bedrooms were in a terrible state. On 10th June Child Q1 called ChildLine and the Police took the children into Police Protection The next day a social worker was allocated to the case, there was no strategy meeting, nor evidence of legal advice being sought and the children returned to mother within a few days even though Police were considering action against mother for neglect.
- June to August 2014 – On 30th June 2014, the children were made subject to child protection plans. Numerous concerns about the care and safety of the children continued to be raised and the home situation did not improve. The children were finally removed following allocation of the case to a new social worker within a day of her first visit on 19th August; she contacted Police after a further home visit and the children came into care.

6.3 **Delay, drift and the management of cases of neglect**. There were several periods during the history of this case when the planning was not clear and more effective, focused

responses could have been provided. In Ofsted's recent thematic study of neglect (June 2014) identified drift as a feature of neglect case.

One third of long-term cases examined on this inspection were characterised by drift and delay, resulting in failure to protect children from continued neglect and poor planning in respect of their needs and future care. No children however were found to be at immediate risk of harm at the time of the inspection. Ofsted - June 2014.

Although there were two brief periods when the children were subject to child protection plans, there was no effective mapping and measuring of the instances of neglect or the impact of the neglect on the children over time and to evaluate the effectiveness of the interventions which were put in place.

There were more than five different social workers involved with the family between 2012 and 2014. On several occasions the children's case moved from one team to another and this occasioned some of these changes of worker. Assessments were not always completed in a timely way and, even when concern on concern about the children's welfare and safety was being raised, there was for the most part a lack of a coherent plan to challenge mother and to ensure that the children's needs were the paramount consideration. At some points even when the Police had been involved because of issues about the care of the children no social work involvement occurred to follow up on this for months.

There is considerable research which evidences the cumulative and pervasive impact of neglect on the development of children and their life chances. If it is not identified and assessed effectively at an early stage and if remedial action is not taken, then children are likely to suffer long term consequences for their future.

6.4 **Appreciation of family history and the impact of violence**. Insufficient account was taken of and weight given to the long history in this family of a violent relationship between the parents and of mother's tendency to associate with risky males and to misuse alcohol and drugs.

6.5 **Working together to protect.** In order to manage cases of neglect, it is essential that professionals talk regularly, discuss concerns and respect the views of others and act on them. There was a wealth of information from a variety of different agencies – Police, school, probation, and housing as well as many anonymous calls from the public – about the problems in the family and about the harm which the children were experiencing. The children themselves were also sharing a great deal of information about the issues and their poor presentation was frequently a concern. On several occasions these concerns were not acted upon by CSC nor escalated further by other agencies and the mother's explanations were accepted. Mother's denials of serious episodes and her explanations that anonymous calls were malicious and that Child Q1 made up stories and had "attitude" were not challenged. Alternative hypotheses were not considered nor appropriate reflective analysis completed.

6.6 **Impact on the children of violence and neglect**. The emotional and developmental impact of the neglect the children experienced and the violence and drug and alcohol abuse they witnessed was insufficiently considered. Their lived experience at home was not understood and assumptions were made that they were happy and contented since mother could improve at times and then was seen as providing "good enough" physical care. There was a lack of analysis of the impact of the adults' behaviours on the children – not just mother's behaviour but also those of other adults she allowed into the household. Mother's parenting and her risky behaviours were considered in assessments but the children's experience was not fully explored. Mother's vulnerability including her own poor early life experience and the impact of abuse in childhood was not fully investigated nor was support put in place for her to deal with this. In this case, this led to a delay in the action which was taken to protect the children from suffering further harm.

6.7 **Response to indicators of possible sexual abuse.** On several occasions, Child Q1 complained about having soreness. Child Q2 had told school that his sister had been away alone in a man's house and the Police found her unsupervised with unknown males in the early hours of the morning. Despite many indicators of concern, the possibility that this child may have been sexually abused was not considered for a lengthy period. It was only after she had called ChildLine that she was asked about this. She gave an explanation that another child at school had touched her and this was accepted; this was looked at but what Child Q1 had said could have been kept in mind and checked out further. A strategy discussion should be held whenever any possible indicators of sexual abuse are identified.

7. FINDINGS

7.1 There was much positive effort and good practice in this case to provide the children with receptive and accessible independent support.

7.2 There was a considerable amount of information known to professionals and agencies about what was happening to the children and in the household over a long period. The significance of the children being present during various key episodes and the likely impact on them was identified. Unfortunately, this information was not always fully

shared with CSC and CSC did not always seek out further information from other agencies. For example, the school did not receive information about the domestic abuse notifications from Police. The school was made aware via the domestic violence refuge. It is not the practice in Norfolk for domestic violence notifications to be shared with schools although it is common practice in some other parts of the country. There was an overreliance on mother's account of events which were insufficiently challenged and scrutinised.

7.3 There were several missed occasions in the history of the case when more assertive and decisive action could have been taken to challenge the mother about the care and emotional well-being of the children.

7.4 There was a very long history of domestic abuse between mother and father – in some instances of which the children were present and noted to have been affected. Mother was also involved in violent arguments with others which the children witnessed. The needs of the children were not fully identified or assessed.

7.5 It is clear that the children were significantly neglected and abused. Mother's erratic behaviour and inconsistent parenting enabled her to mask the true extent of the difficulties and to hide the impact on the children; she was able on several occasions to recover even after a significant crisis, make an effort and project positive parenting.

7.6 Mother's preoccupation with her own needs particularly when under the influence of drugs or alcohol meant that she was unable to prioritise her children's needs and even led her to associate with unknown adults which exposed the children to risk. Mother aspired to do well but she could not sustain it even with the support of her own mother.

7.7 There was an over focus on the physical conditions of the home and mother's assurances that she would clean up and all would be fine. As a result, the children's experiences and the full impact on the emotional well-being of the children of the behaviour of the parents and other inappropriate adults they associated with was not appreciated or responded to appropriately.

7.8 The case was opened and closed in CSC on several occasions even when there was a

lack of significant evidence to demonstrate that the children were safe and the risks had been addressed. There were frequent changes of social worker and team responsible for the casework within CSC resulted in a lack of consistent overview and thorough, sustained management of the case. There were also in the case long delays in following up on serious concerns and delays also in completing comprehensive (core) assessments of what was happening.

A recent Ofsted thematic study of neglect has highlighted that:

Three recent studies of social work intervention found extensive evidence of thresholds for access to children's social care being too high and of professionals giving parents 'too many chances' to demonstrate that they could look after a child; often in the face of substantial evidence to the contrary and regardless of the needs of the child. (Oftsed March 2014)

7.9 On several occasions, serious concerns about the welfare and safety of the children, which were significantly harmful, were not treated as requiring a multi-agency child protection response. There was a dearth of strategy meetings which should have been called on the many occasions when it was clear the children's safety had been significantly compromised. There appears to have been a lack of appreciation of the need to involve other agencies and to hold interagency meetings when serious risks had been identified.

7.10 Although there were several explicit indicators that Child Q1 may possibly have been sexually abused by an adult this was not investigated for many months nor was a medical examination considered. There was no strategy discussion to consider the action to take.

7.11 It is very difficult for any child to tell strangers how bad things are at home. Some professionals failed to appreciate the tension there is for a child in showing disloyalty to a parent by making such disclosures and the impact this has on the child's own sense of guilt about sharing information about "bad" things which may have happened to them. Mother's explanations were believed over the children's. The children shared their worries about their experience of living with mother on many occasions and over a long period, at school, with the refuge worker, with Police and some of the social workers. However, Child Q1 and Child Q2 also presented a more positive view of life at home with her mother on occasions.

This is not an atypical response from children who desperately want to be loved and cared for by their parent.

There is a great deal of research evidence that significant numbers of children do not disclose they have been sexually abused. Ungar et al (2009) set out the optimal conditions for facilitating disclosure.

"being directly asked about experiences of abuse; having access to someone who will listen, believe and respond appropriately; having knowledge and language about what constitutes abuse and how to access help; having a sense of control over the process of disclosure both in terms of their anonymity ad confidentiality; and effective responses by adults both in informal and formal contexts."

7.12 The significance of information received from members of the public about – mainly through anonymous calls in this case - were too readily and regularly treated as malicious and unfounded.

7.13 It is very difficult to manage cases involving neglect. In a recent study by Horwath and Tarr, it was identified that social workers struggled to be child-centred during the assessment and planning process. They lacked insight into the day to day experience of the child and had a limited understanding about the impact of neglect. In this case all the professionals involved found this difficult.

7.14 The authors advocate the need to have a focus on each child's lived experience and their immediate needs and then that a time frame based on their longer term needs should be worked out. Alongside this, the response of parents needs to be considered. Do the parents understand their child's needs? Are the parents able and willing to meet the child's needs and what is their capacity for change? This detailed and informed analysis was lacking in the case.

8. **CONCLUSIONS**

8.1 In this case there was an over-acceptance of the circumstances in which the children were living and a lack of full appreciation of the experience and stressful life they were living. There was a need to challenge mother more effectively and consistently. The practice across the agencies lacked a framework for professionals to record, monitor and share the examples of neglect of the children and to consider the impact of this over time on the children. In the local area, plans are being developed to have in place the Graded Care Profile as a useful base and framework for professionals to share concerns to make sure a holistic view is being adopted.

8.2 Panel members and practitioners involved in this review identified many of the shortcomings of the way the system had been operating. There is a consensus that joint working needed to be more robust. The importance of multi-agency discussion about concerns was recognised and it was seen to be clear that everyone was seeking to work in the best interests of the children but they were all working in isolation. It is importance not only of sharing information but also of staying involved and, if necessary, to insist on being involved.

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

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

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

8.6 Ofsted published a study in 2010 about lessons from SCRs. The key points made in that publication can all be applied to this case:

- inconsistency in the application of thresholds for neglect;
- poor professional understanding of neglect;
- difficulties in engaging with hostile or avoiding families;
  and
- professionals failing to provide sufficient challenge to parents in cases of neglect.

9. Recommendations for LSCB to consider and action

Each of the agencies involved with the family has identified a number of recommendations. The implementation and impact of all of these actions will be monitored by the Norfolk Safeguarding Children Board.

The following recommendations are made to the LSCB as an overview and summary of all the recommendations which have arisen from this review. They reflect the key learning from this review. **The Norfolk Safeguarding Children Board should:**

9.1 **Address the identification of and response to Neglect to children**. Ensure that a well-coordinated, shared strategy and multi-agency operational framework is in place to oversee work with children who are subject to neglect and monitor its impact. This must ensure that professionals understand the cumulative impact and long term consequences and damage resulting from neglect on children's health and development. The LSCB should ensure that the implementation of the Graded Care Profile is expedited - as an identification and assessment tool operating within the local Signs of Safety framework across all agencies.

9.2 **Receive regular performance monitoring and reporting in relation to child neglect cases** across early help, child in need and child protection interventions to ensure there is challenge about the effectiveness of multi-agency working to tackle neglect.

9.3 Continuing to encourage developments and improvements in the local response to **domestic violence and abuse**. This should include consideration of whether all schools should receive notifications from the Police of domestic abuse incidents. Ensure that current information about children subject to child protection plan is available to Police Officers.

9.4 **Ensure that the identification of and response to the possibility of Child Sexual Abuse is well understood** and effective. Ensure that professionals are aware of the indicators of child sexual abuse and that the impact of the LSCB strategy is regularly monitored.

9.5 Ensure that all staff are aware of their **duty to escalate concerns** when they consider that a child is not appropriately protected and/or is suffering from neglect or other forms of abuse. Ensure that all agencies have appropriate escalation policies and procedures, including a procedure for challenging the decisions of children's social care services where cases are not accepted for assessment, child protection investigation or are being closed or stepped down to early help services. Consider setting up practitioner fora for discussions to share concerns, manage uncertainty and agree action?

9.6 An **interagency directory of operational contact details** for each agency should be developed by the LSCB and this should be updated every quarter.

9.7 Collaborative working - **Joint working to safeguard** - Review and reconsider policy and procedure concerning how children can be effectively safeguarded if they come into care when there remains uncertainty about the continuing risk of significant harm if they should return home. If Police Protection is taken, an interagency Rapid Action meeting should be called urgently. Ensure that there is multi-agency involvement when assessments are being undertaken and when significant decisions are being made.

9.8 **Hearing and responding to children's worries**. Promote practitioner events to evaluate and improve the quality of engagement with children and young people who are at risk.

9.9 The LSCB should disseminate the findings of this review so as to raise the particular importance of systematic joint working, assessment and decision-making in safeguarding as well as the essential requirement to listen to and respond promptly to worries raised by children.

10. Next steps - Progress Report / Learning

Since this review was set up a number of measures have been put in place to respond to the learning from the case.

10.1 The LSCB has been addressing the response to and management of neglect. A Neglect Identification Tool has been developed and this, together with the Graded Care Profile, is being rolled out through training across the county with all agencies. This is being done in tandem with the Signs of Safety approach.

10.2 All the local partners are continuing to develop and improve the response to domestic violence and abuse through the Domestic Abuse Change Programme with the support of the Community Safety Partnership.

10.3 The Children's Services Improvement Plan, developed in response to the Ofsted inspection in January 2013, sets out actions to be taken in relation to some of the issues which have emerged from this and earlier SCRs.

- Improve the timeliness and quality of all multi-agency meetings to safeguard children
- Improve the consistency, timeliness and quality of all assessments – to include an effective analysis of risk and protective factors
- The management of cases of neglect also was an issue with partners acknowledged demonstrated a lack of shared responses

Appendix A - Scope and Full Terms of Reference

Terms of Reference- Case Q - Context of SCR and Terms of Reference - Case Q

Introduction:

This Review / Serious Case Review will be carried out in accordance with the requirements as set out in Working Together 2015.

The aim of this SCR will be:

- ***To investigate what went wrong and why as well as what went well in the case***
- ***To identify any learning and resulting recommendations for action***
- ***To invest in providing opportunities for practitioners to learn from their own and others' experience, building confidence and empowering effective safeguarding practice for the future***
- ***To provide a SCR report for publication.***

Terms of Reference

*1. All Serious Case Reviews should consider themes and questions to provide an analysis of practice and to identify learning. The SCR Lead Reviewer and the Agency authors are asked to consider **why** events occurred as they did, based on a clear account of **what** took place and the actions of the practitioners and others involved. Agency reports should be based on a clear and accurate chronology. They should provide an analysis of any factors considered important.*

2. Working Together 2015 sets out the criteria, purpose and process for conducting a Serious Case Review.

***3. In general terms** the following themes should be considered and addressed where relevant.*

- ***Assessment, planning and review***

Consider the key relevant points/opportunities for assessment (include all assessment processes across all agencies). Comment on the quality of assessment and analysis, the involvement of the multi-agency network and use of relevant historical information. How did agencies engage the family in the assessment and decision-making process?

- ***Services provided***
- *Were opportunities to offer early help taken advantage of?*
- *Were services provided to the family linked to the conclusion of any assessments, was this timely and outcome focused? Were these focused on the needs of the children?*

- *What was the parents' perspective on what was offered / not offered?*

- ***Neglect or Abuse***

Were concerns about neglect recognised by agencies, and were they understood and analysed as part of any assessments undertaken or support provided by agencies.

- ***Children's lived experience***

When, and in what ways, were the children's lived experiences considered and any concerns identified, and how were these taken account of in the decision-making and delivery of services. Where and when were the child/ren seen and spoken to? What was the physical environment in which the children lived? Do we have an accurate record of addresses and locations where the child/ren were cared for?

- ***Parental Behaviours - Domestic violence and Substance Abuse***

Were adult behaviours and their impact on the children sufficiently considered addressed? In this case there were issues of domestic violence and substance abuse.

- ***Family engagement***

Were there any difficulties in engaging with the family? How were these addressed or overcome? Did the agencies consider whether the abilities or disabilities, racial, cultural, religious, linguistic identity of the child/ren or the family had an impact on their situation and whether any associated implications were evident within the assessment, planning and provision of services?

- ***Thresholds***

Were they understood and applied appropriately across the multiagency network.

- ***Working Together and the effectiveness of local safeguarding***

Evaluate the ways that agencies worked together and the role of professional leadership within the network. Were concerns or issues appropriately and promptly escalated and resolved? Did decision-making involve all relevant agencies and professionals?

- ***Policies and procedures***

Were relevant agency and interagency procedures and guidance, including any joint working protocols followed? If they were not followed is it clear why not – what were the barriers?

- ***Supervision and management oversight***

Is there evidence of appropriate supervision arrangements, did supervision allow for reflection and was it of an appropriate quality. Is there evidence of appropriate line management arrangements in place and adhered to?

Specify if any of the above general themes are not relevant to your agency and/or service and the reasons why. Alternatively, if the Agency report author feels that the analysis required to answer a specific issue has already been covered under a previous heading, this should be explained rather than omitting that topic.

4. Specific issues to consider in the review of this case.

In this case the following have been identified as issues for consideration that should be examined by each agency. However, The Lead Reviewer and agency authors should not limit their review to those issues already identified. There may be other more important themes for each agency which are different from these.

1. *What were the outcomes set when the children were subject to Child Protection Plans in 2011? Were these met when the case was closed in September 2012 and what step-down arrangements were in place?*
2. *What action was taken as a result of the referrals and notifications during 2013/14 and particularly the contacts/disclosures made by K herself and the repeated referrals from school?*
3. *Why was the "voice of the child" not sufficiently heard in this case?*
4. *What assessments were made of mother's ability to protect K and A and to provide for their well-being?*
5. *Was the decision-making to close this case in April 2014 justified and soundly based? What evidence was there of improvement in the family's circumstances? What plans and contingency arrangements were in place, particularly when the family proved difficult to contact?*
6. *How effective was the liaison between police and social care in respect of decisions to apply police protection?*
7. *What assessment was made of the grandparents and other family members when K and A were placed with them? To what extent did this mitigate the risks they were exposed to?*
8. *How was the return to the care of the children's mother monitored and supported?*
9. *To what extent does this case show awareness and understanding of the effects of neglect, and to what extent were staff in all agencies aware of recent policy, training and practice development around neglect? Were there barriers to applying this knowledge?*

10. *How well was information and knowledge of this family shared between agencies, and what evaluation was there of the cumulative impact of the concerns and risks that were referred and recorded?*

5. The Timeframe for this Review will be from the end of the first period subject to CPPs (September 2012) to their removal to foster care (August 2014).

6. The Review Process and Framework

6.1 The investigation will include:

- *Reviewing and collating detail of practitioner experience and explanation from interviews and document reading*
- *Specifying 'why' questions when considering critical path events*
- *Revisiting the experience of staff locally - using single interviews and group discussions in each agency to ask "why" questions and seek answers to any issues of concern identified, as well as detailing positive practice*
- *Collating and analysing responses – contrast how it was at that time and how the service is now – use gap analysis to reach findings*
- *Considering any relevant research or other SCR evidence applicable to this review*
- *Writing up SCR report for publication*
- *Disseminating lessons / findings and actions required.*

6.2 Methodology

The meetings with individuals and groups of practitioners directly involved with the case will explore:

- *Critical points in the case*
- *Possible reasons for actions taken, or not taken, at the time*
- *The significance of these insights for current practice.*

The critical points in the case will be defined during the course of the review.

An adapted version of the "fishbone" diagram – a tool used within Root Cause Analysis - will provide the framework for taking a whole system approach, which will explore:

- *What were the factors might have contributed to practice decisions at the time?*
- *What could have been improved?*

- *If the same event occurred now – what factors would influence the response?*
- *What is working well now and what still needs to be improved?*

The purpose of this process is to achieve an understanding of how the interaction between the various factors influenced the way practitioners responded to the Q children and their family.

Practice at individual and organisational levels will be openly and critically analysed against national and local statutory requirements, professional standards and current procedural guidance. Where decisions and actions did not adhere to good professional practice standards, the reasons for this need to be considered and recorded.

Appendix B - Membership of the LSCB Serious Case Review Panel - TBC

Amy Weir - Independent Lead Reviewer

Anne Pringle: Deputy Named Nurse, Safeguarding Children – Norfolk Community Health and Care (NCHC)

Jane Black: Designated Nurse for Safeguarding Children – NHS Norfolk

Suzie Fiske: Named GP for Safeguarding Children (*Norfolk and Waveney)* – Designated Safeguarding Children Team

Stuart Chapman: Detective Inspector – Norfolk Police

Kelly Waters: Safeguarding Advisor for Schools – Children's Services

Jackie Cole: Independent Reviewing Manager – Children's Services

Bob Cronk: Head of Local Neighbourhood Services – Norwich City Council

Jo Sapsford: Safer Communities Co-ordinator – Norwich City Council

Margaret Hill: Community Services Manager – Leeway Domestic Violence and Abuse Unit

Appendix C - List of References

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