Norfolk Safeguarding Children Board

Learning from Serious Case Reviews

Case R

Serious Case Review: Case R

This presentation sets out:

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

Norfolk Safeguarding Children Board

Serious Case Review: Case R
Summary of the Case

Case R was commissioned because a ten month old baby 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:

- non-accidental injury
- professional curiosity in relation to domestic abuse
- information sharing and assessment of risk

Baby R's father was subsequently sentenced to three years for Grievous Bodily Harm. The baby made a full recovery and is now doing well.

Norfolk Safeguarding Children Board

Serious Case Review: Case R Methodology

- Traditional methodology: included integrated chronology and single agency reports
- Scope of review Jan 2014 – May 2015
- Professional learning event held to include practitioners involved in the case
- Meeting with both parents to get their views
- Publication delayed due to criminal proceedings against father, concluded summer 2016

Norfolk Safeguarding Children Board

Serious Case Review:
Case R Background History of the case

- Two young parents: born 1993. Were together for four years up until the incident leading to this SCR.

- Mother had history of a domestic abuse incident with previous boyfriend in 2010, aged 17. Not referred as a safeguarding issue, although she was under 18.

- Father suffered from anxiety, unknown to mother, which was exacerbated by drugs and alcohol, leading to occasional violent outbursts

Norfolk Safeguarding Children Board

Serious Case Review:
Case R History of the case 2014

- Mother booked in for pregnancy late (at 20 weeks). Disclosed some concerns about her partner's drinking but no enquiries were made around domestic abuse by midwife or, later, health visitor

- Baby R born summer 2014

- Health Visiting Service offered targeted support via a Universal Plus Pathway, due to mother's young age

- Mother received additional help in the form of a Parents As First Teachers (PAFT) programme.

Norfolk Safeguarding Children Board

Serious Case Review:
Case R History of the case 2014, cont.

Oct 2014, Baby R aged 10 weeks: police called to an incident involving mother, father, baby and a neighbour:

- Father drunk and abusive
- Mother pulled to the ground with baby in arms, resulting in baby alone on the pavement beside the altercation
- Father carries baby indoors and lays down on broken glass. Baby R was uninjured
- Ambulance called to take mother and baby to hospital. Father arrested

Norfolk Safeguarding Children Board

Serious Case Review:
Case R History of the case 2014, cont.

- Incident took place out of hours: reported to Emergency Duty Team early hours on Sat (1am). Strategy discussion held: no health involvement

- Domestic Abuse Stalking and Harassment (DASH) assessment undertaken. Resulting risk to R's mother was regarded as 'medium'
  - as the circumstances did not appear life threatening (failed to reach 14 points on the scoring system), below the threshold for routine referral to the Norfolk MARAC for risk management
  - the medium risk was not considered 'high end' enough to be passed to an Independent Domestic Violence Advocate (IDVA) for follow up support.

- Hospital assumed case would be high risk and escalated to IDVA

Serious Case Review:
Case R History of the case 2014, cont.

- Allocated to agency social worker to undertake assessment who does not effectively include any other partners or father
- Mother minimises incident and provides assurance that she has separated from father, who is on bail
- Father, unemployed, visits GP with his mother (paternal grandmother) suffering from increasing anxiety and depression. Mother unaware.
- Dec 2014: the case is closed by Children's Services and letter advising mother of the impact of domestic abuse on children is sent to mother

Norfolk Safeguarding Children Board

Serious Case Review:
Case R History of the case 2015

- Jan 2015: Father's Offender Manager (OM) learns that the couple are reuniting and refers to Children's Services
- Feb 2015: the same agency social worker reassesses, again receives assurances and closes case without extensive enquiry
- Feb 2015: Father starts Better Relationships programme; only attends one session
- Mar 2015: OM told that the couple are moving in together. Has concerns. No re-referral.

Norfolk Safeguarding Children Board

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

Apr 2015: Community Health takes family off Universal Plus Support plan

May 2015:

- Baby R sustained life threatening injuries
- Father arrested at hospital. Later sentenced to three years for Grievous Bodily Harm.
- Mother and father have not seen each other since
- Baby makes full recovery and is doing well back in the care of his mother

Norfolk Safeguarding Children Board

Serious Case Review:
Case R Epilogue

Mother advised the SCR Panel that, following the incident, interventions by Pandora Project (a service that offers advice, support and information to women who have or are still experiencing domestic abuse) were very valuable and helped her to understand and be alert to DA and become a more protective parent.

Outcomes verified by social work team when they closed the case.

http://www.pandoraproject.org.uk/

Norfolk Safeguarding Children Board

Serious Case Review:
Case R Analysis of Practice

Professional Curiosity:

- There was a lack of professional curiosity around domestic abuse by health professionals during pregnancy despite some clear signals from mother
- There was little or no engagement with father who was struggling with anxiety and depression and not confident about his ability to parent
- Case was closed without reference to other agencies involve

Good practice:

- Initial referral from Probation services when parents reunited
- Recognition of mother's additional needs by Community Health when Baby R was born

Norfolk Safeguarding Children Board

Serious Case Review:
Case R Analysis of Practice, cont.

Fora for Discussion and Information Sharing

- Out of hours referrals were not effectively reviewed following the weekend to test the decision-making and risk assessment

- Excluding health from the Strategy Discussion meant that valuable information was not shared or considered by all partners working with the family at the point of Child Protection interventions

- Different agencies had different understanding of risk and risk assessment was not child centred.

Norfolk Safeguarding Children Board

Serious Case Review:
Case R Analysis of Practice

Collaborative working, decision making and planning

- The social care assessments did not adhere to Norfolk's Joint Visits Protocol and were not inclusive of partners or the father
- Information sharing between partners and within the NHS was inconsistent which did not enable joint working to develop effective safety plans

Ownership & Management Grip

- There was little evidence of organisational escalation and operational risk management systems in place (including contingency planning arrangements)
- 'Wicked issues' for strategic leaders include out of hours arrangements, policy implementation, and governance around the Domestic Abuse agenda

Serious Case Review:
Case R Recommendations: Single Agency

- A total of 24 recommendations were made, of which 16 were single agency

- Single agency recommendations and resulting actions are monitored under Section 11 of the Children's Act, tracking agencies' safeguarding duties through a self assessment process

- Section 11 systems in Norfolk are robust, with annual challenge days picking up on specific issues within all partner agencies

Norfolk Safeguarding Children Board

Serious Case Review:
Case R Recommendations for Norfolk LSCB

NSCB must **audit**

- Organisational escalation and risk management systems
- Strategy discussions

NSCB must review **governance arrangements** with the Domestic Abuse & Sexual Violence Board (DASVB) around:

- MARAC assessment and risk threshold, the role of IDVAS and the alternative referral pathways for managing low to medium risk cases.
- measuring how established risk assessment tools can improve the overall response to babies, children and young people experiencing domestic abuse in the county including within multi-agency forums and MARAC.

Norfolk Safeguarding Children Board

Serious Case Review:
Case R Recommendations for NSCB, cont.

NSCB must **undertake a whole partnership review** of safeguarding **arrangements in place outside of working hours**

NSCB must ensure that the agreed NHS and Local Authority Children's Services **Joint Visiting Protocol** for undertaking assessments is regularly audited and reviewed

Agencies providing **services in integrated Children's Centres** in Norfolk must undertake a full service review

NSCB SCR sub-group must **assess how generalised the themes from this SCR are across the partnership** and the level of priority they should assume in the LSCB work-plan

Norfolk Safeguarding Children Board

Serious Case Review:
Case R Summary & Conclusions

Case R is one of two recent Serious Case Reviews involving young children who sustain life threatening injuries

Both cases have strong links with domestic abuse and young fathers who could not regulate their stress effectively when caring for their children

Risks to Baby R were not recognised, understood or assessed. His experience of his parents' relationship and his father's violence were not taken into consideration in decision-making or planning.

Since May 2015, the time of the incident, Norfolk has developed and improved its response to Domestic Abuse

Norfolk Safeguarding Children Board

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

Working with DASVB to deliver a Beacon Project addressing Domestic Violence with three co-ordinated elements:

- One Front Door
- Penta interventions
- Drive Perpetrator programme

Daily MARAC meetings now taking place within the Multi-Agency Safeguarding Hub to pick up on all high risk domestic abuse incidents, including those that occur out of hours

Reporting regularly to Board on joint visits between Social Care and Health Visiting and identifying gaps and barriers to best practice

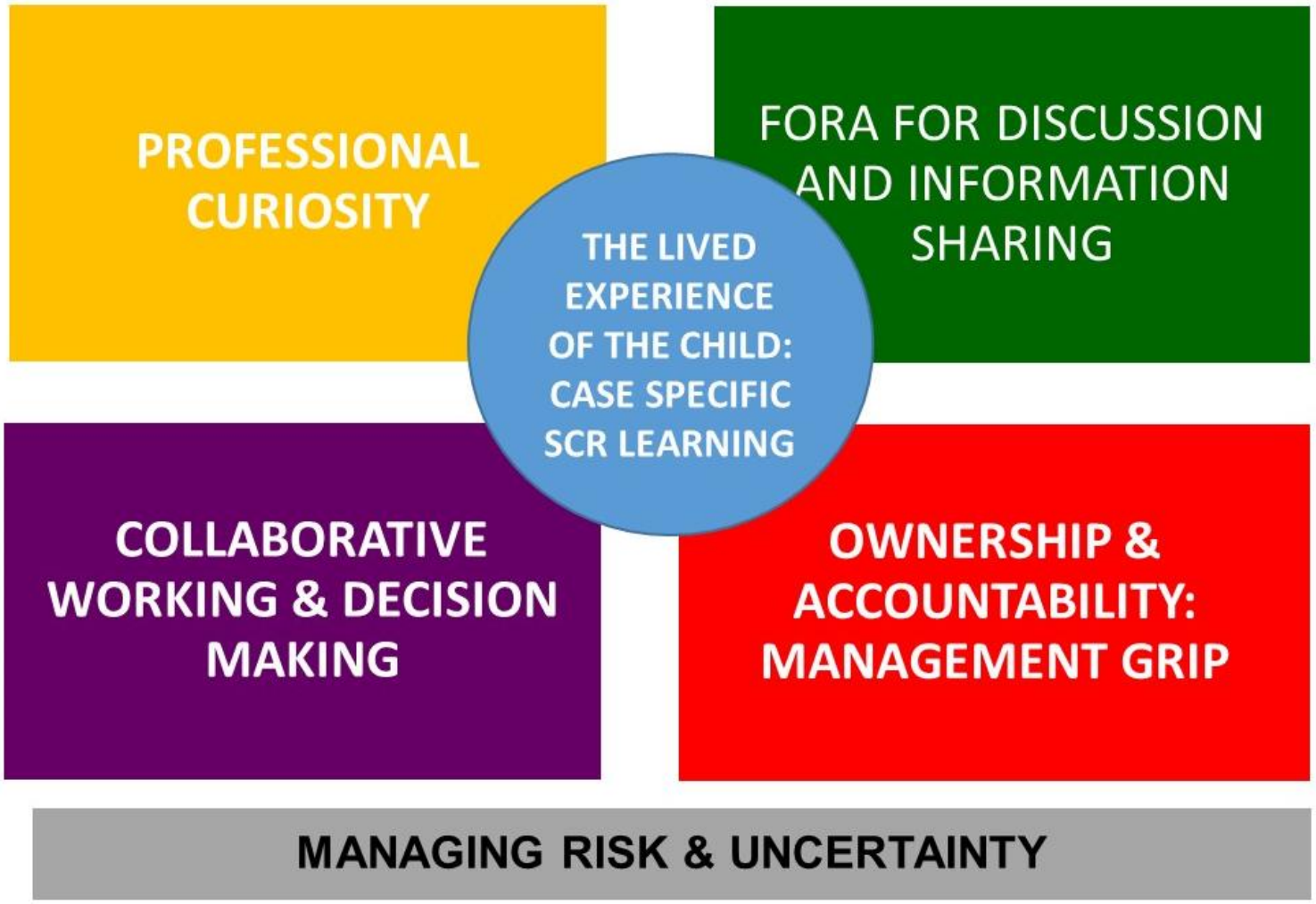
Norfolk Safeguarding Children Board

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

- **Audits** planned for Strategy Discussions
- **Assurances provided** that agency social worker no longer practises in county
- SCR roadshows planned to **disseminate learning and general themes** from this and other SCRs
- 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

Norfolk Safeguarding Children Board

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?

Norfolk Safeguarding Children Board