



Norfolk Safeguarding  
Children Board

# **Learning from Serious Case Reviews**

## **Case V**

# Serious Case Review: Case V

This presentation sets out:

- Summary of the case
- Methodology
- Narrative
- Reference to previous SCR (Case R)
- New learning and recommendations
- The Board's response



# Serious Case Review: Case V

## Summary of the case: the Family

- Eastern European family, English as a second language
- Two children
- Family network in the local area
- History of Domestic Abuse and Violence, including coercive control



# Serious Case Review: Case V

## Summary of the case: why an SCR?

- A child died, evidence of abuse was known and there were concerns regarding the way agencies worked together to share information and manage risks
- Previous history of domestic abuse and involvement of social care
- Case was closed by Children's Services nearly two years prior to the child's death: no concerns raised or referrals made in the intervening period
- Collective memory loss of historic but significant domestic abuse at time of antenatal booking, birth and baby's discharge home



# Serious Case Review: Case V Methodology

Scope of review is from 2005, when the family arrived in Norfolk, until six weeks after Child V died.

Agencies involved were:

- Norfolk Constabulary
- Clinical Commissioning Group
- Community Health and Care NHS Trust
- Acute Hospital Trust
- Children's Services



# Serious Case Review: Case V Methodology, cont.

Methodology used a systems approach in order to identify the deeper, underlying issues that may be influencing how services are provided to children. Approach included:

- multi-agency collaboration on the SCR Panel,
- inclusion of front line practitioners:
  - 1-2-1 conversations with professionals involved in the case
  - Professional learning event
- a focus on systemic strengths and weaknesses.



# Case V: Narrative

2005: couple move from Eastern Europe to Kings Lynn area. Extended family live nearby.

2011: first child born (Sibling V); couple managing a joint mortgage

Spring 2013: oldest child aged 14 - 17 months: two incidents of domestic abuse reported to police in January & April. Alcohol abuse featured in both incidents.

April 2013: Serious sexual assault in front of Sibling V reported

- no social care or health input
- panic button installed
- allegation withdrawn
- couple separate



## Case V: Narrative, cont.

Early 2014: couple reconciled in intervening period, however DA incidents continue, resulting in consequent split in April with father threatening and attempting suicide by hanging.

- Sibling V present at address at time of incident.
- Referred to social care for Initial Assessment
- Mother moves to brother's house, however, mortgage arrangements made it difficult to ensure a permanent split
- DASH (police assessment tool for domestic abuse) completed but did not qualify for a standard high risk intervention
- Case closed by Children's Services after seven weeks: the couple had separated, risks were reduced; agencies with ongoing involvement directed to re-refer if couple reconciled



# Case V: Narrative, cont.

May 2014: **GOOD PRACTICE**

Children's Centre establish couple have reconciled and re-refer to Children's Services for Initial and then Core Assessment.

Case allocated to a Children in Need (CIN) Team.

- a solution focussed restorative approach was proposed.
- intervention was completed in three sessions over 2 months and the case was deemed fit for closure.
- The date of closure in September 2014 was not communicated to other agencies.

**GOOD PRACTICE:** Allocated Social Worker ensured inclusion of and engagement with father

No further intervention until mother booked in for antenatal in April 2015

# Case V: Narrative, cont

- Second child (girl) born May 2015 – older brother aged three and a half
- Born prematurely at 26 weeks gestation
- Hospitalised for 11+ weeks - Discharged home aged 5 months
- Health Visiting & Neonatal Community Team support for 10 + weeks, including post discharge
  
- Baby collapsed February 2016 – aged 6 months – presented at hospital
- Died less than a week later from abusive head trauma (shaking)
- Evidence of previous injury - two weeks prior to collapse

Same time-frame and location as Child R  
(NSCB SCR published January 17)



# Case V: similarities to Case R

- Kings Lynn area
- Extended family near-by
- Baby principle subject of SCR
- Long term relationship
- Not married (in Case V - joint home owners)
- Domestic abuse/violence
- Alcohol abuse - father past history of substance abuse
- Separations and reconciliations
  
- Accessed a range of local services - NHS acute, GP, Health Visitor, Social Care, Children's Centre, Police
- Children's Services interventions included Initial Assessments and Core Assessments/brief Child in Need support
- Abusive head trauma whilst in sole care of father (in Case V – resulted in child's death)



# Case V: Parallel Findings from Case R - Established Learning

- **Opportunities for assessment**

Many opportunities/many agencies/poorly informed by partnership  
One-off discussions, taken on face value

- **Application of thresholds**

Risk assessment calculation and planning vague / over optimistic judgements

Absence of harm/rather than likelihood determined threshold (NHS & Social Care)

- **Services provided**

Many contacts with many agencies

Inputs were brief – premature closure of cases

GAP re: low risk DV/DA safety planning and advice provision

Stressed operational landscape (structure, capacity and demand)

# Case V: Established Learning, cont.

- **Inter-agency collaboration and participation**

Poor overall – uninformed, unchallenged & not communicated

Professional deference/ isolated silo approaches/ lack of proactivity

Systems in health did not facilitate discussion between Health Visitor, GP & midwife

- **Supervision and oversight**

Low priority, poor quality, poorly recorded

- **Family engagement – invisible father**

Little engagement, assessment or work with fathers (NHS and Social Care)

# Case V: Established Learning, cont.

- **Policies and procedures**

Issues re c39d (coming to police notice) system (social care to NHS)  
Routine enquiry for Domestic Violence (DV) in antenatal period and  
Out of Hours systems in Hospital

- **The impact of alcohol and domestic abuse**

Minimisation / assumptions re parenting capacity of non-abusive parent  
Low attention to safety planning  
General skills, abilities & competencies in working with DV/DA.

# Case V: New Learning & Recommendations

## Multi-agency support to victims of Domestic Violence when involved in Criminal Justice process

- Successful prosecution is important for securing the safety and wellbeing of children and vulnerable adults.
- National research has suggested that agencies working together can reduce case attrition by empowering victims to stay engaged with the criminal justice process. Systematic, early coordinated support for victims is currently not prioritised by the partnership

**Recommendation 1: Norfolk LSCB, partner agencies and the Domestic Abuse and Sexual Violence Board (DASVB) must develop and agree a system to enable early multi-agency coordinated support for a non-engaging parent involved in an evidence-led criminal justice investigation.**

## Case V: Recommendations, cont.

### **Team functioning - disagreement/personality difference discouraged professional discourse.**

- A professional difference of opinion about a risk assessment, managerial decision and care plan remained unresolved due to hidden tensions within the team dynamics.

**Recommendation 2: Norfolk LSCB should seek assurance that partnership organisations have robust and easily accessible systems in place to support team functioning and staff wellbeing. This includes regular reminders and updates about the supports on offer and how staff can access them.**

# Case V: Recommendations, cont.

## Understanding risk and limitations of interventions when working with DA/DV and coercive control

- The use of solution focussed brief therapy as a means to improve a parental relationship when domestic violence features in the history requires structured programmed support and specialist skills and training

**Recommendation 3: Norfolk LSCB and Norfolk DASVB should ensure the children's services workforce has a thorough understanding of the risks and limitations of solution focussed interventions for couple's relationship counselling, when domestic abuse is suspected or identified.**

## Case V: Recommendations, cont.

### **Systems, processes and practice of neonatal intensivists paid little attention to safeguarding.**

- Safeguarding information gathering and sharing systems for neonates were underdeveloped. Safeguarding and domestic abuse concerns did not come to the attention of neonatal intensive care professionals and were not given sufficient weighting from admission until discharge.

**Recommendation 4: NHS neonatal acute and community services should implement systems to routinely gather and/or share safeguarding and domestic abuse information, particularly at admission, transfer and on discharge.**

# Case V: Recommendations, cont.

## **Cultural awareness and competency of workforce needs improvement**

- Practitioners were unaware of the DfE funded Innovations Project final report designed to improve cultural awareness and competency in the County

**Recommendation 5: The NSCB should redistribute the Safeguarding and Community Inclusion Final Project Report on Eastern European families and consider ways of increasing cultural competency and improving practice across the County.**

# Case V: Recommendations, cont.

## **Use and effectiveness of interpretation services - variable**

- The use of interpreters across the partnership was inconsistent and did not always follow best practice guidelines.

**Recommendation 6: Norfolk LSCB should review the uptake and effectiveness of interpreter services for safeguarding children purposes in Norfolk and develop a strategy for improvement if indicated**

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

## DOMESTIC ABUSE

- The Domestic Abuse Strategy has been informed by learning from this and other SCRs. Ratified by Norfolk's Countywide Community Safety Partnership in July 2018 and presented to Board Sept 2018.
- Progress evidenced by Norfolk accolades: winner of outstanding work to combat domestic abuse in the public health category award at the Municipal Journal Awards in June 2018.



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

## CULTURAL COMPETENCE

- The final [report on cultural competence](#) is available on the NSCB website under local research
- Action plan to follow up Innovation Project on work with Eastern European families agreed with innovation partners, i.e. Cambridgeshire & Peterborough LSCBs to include:
  - Refresh pool of cultural competence trainer pool and undertake train the trainers session across the three regions
  - Audit activity to monitor cultural awareness and engagement of fathers



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

## **SECTION 11: AGENCY SELF ASSESSMENT**

- S11 process developing beyond compliance checks
- Greater focus on agencies evidencing how they are disseminating and embedding learning from SCRs
- To include peer challenge and testing self assessment against working together in everyday practice

## **DISSEMINATION OF LEARNING**

- SCR Roadshow for learning around Non Accidental Injuries and child death in planning stages

