David Ashcroft, Independent Chair of Norfolk Safeguarding Children Board, said:

Norfolk Safeguarding Children Board's Serious Case Reviews give organisations a vital opportunity to learn lessons about child protection and to improve the ways they work individually and collectively.

Today, the Board has published two reports: Case R, which deals with an assault by a father on his baby, and Case S, which reviews an assault by a stepfather on his three-year-old. These cases share some similarities. In both cases we are pleased that the two children involved have made good recoveries from their injuries and are being cared for in safe, stable environments

Case R saw significant communication failures between agencies, and although the Board did not identify any root causes that could have prevented the incident, it is clear that organisations need to communicate more effectively with each other. Although great strides have already been made in Norfolk in terms of joint working, it appears that the systems to support such collaboration are less developed.

The Board is committed to raising awareness of domestic abuse issues, supporting the work of the Norfolk Domestic Abuse and Sexual Violence Board (DASVB) and believes that any domestic abuse incident between adults should mean that any child in the family must automatically be considered to be at risk.
It is therefore crucial that all relevant professionals come together to share vital information when a child's risk of harm is being assessed so that the best decision can be made. Therefore, it is our view that the way organisations make decisions following such an incident needs to be reviewed.

The Board acknowledges that work is already being done to address this and that early discussions between police and children's services are now held within the Multi-Agency Safeguarding Hub (MASH) for cases of children at high risk of domestic abuse.

In terms of Case S, concerns raised by a childminder making an 'anonymous consultation' over the phone to seek the advice of a social worker in the MASH team did not lead to further action being taken to protect the child. Our view is that miscommunication between the two people involved rendered the consultation ineffective, and that the level of concern was not clear on both sides and that therefore a review of this consultation system is necessary. This work is already underway.

It is also important that people who work directly with families show a higher level of professional curiosity, rather than taking the reassurances of families at face value, and offer professional challenge to their colleagues. With this in mind, the Board has created a new Threshold Guide in order to help professionals ask the difficult questions. This approach is strongly guided by the Signs of Safety philosophy to ensure that vulnerable children receive the right kind of help at the right time.

Legally, childminders only need to undergo basic safeguarding training, and this case highlights how they may lack confidence when seeking advice on such matters and in communicating their concerns clearly. Therefore, in Norfolk we have set up a safeguarding advisory group to bring together those working in early years. We have gone one step further by extending our own 'Safer' programme, which offers more comprehensive child protection training to smaller and independent childminders across the county, as well to as large organisations.

NSCB continues to work proactively to safeguard children across Norfolk through its multi-agency response.