Norfolk Safeguarding Children Board

Norfolk SCR
Child V

Contents

1 Acknowledgements

1.1 I would like to acknowledge the cooperation and support of the Norfolk Safeguarding Children Board (NSCB) Serious Case Review (SCR) Panel who have given their time and generous access to notes and procedures. My thanks also to Abigail McGarry and Andrea James as coordinators of the SCR process and to a number of professionals who participated in practitioner interviews and learning events to enable key evidence to be gathered, questioned and represented in this report.

1.2 Family Participation

1.3 Child V's parents were contacted by NSCB by letter at the beginning of the SCR process to invite them to give their perspective on the services they received during the period of the review. An invitation was accepted by Child V's mother in March 2018 to discuss the findings of the report. NSCB would like to thank her for her participation.

SCR Panel Members		
Name	Designation	Agency
Abigail McGarry	Norfolk Local Safeguarding Children Board Manager	Norfolk LSCB
Andrea James	Child Death Overview Panel and Serious Case Review Administrator	Norfolk LSCB
Debby McKechnie	Head of Quality assurance and Effectiveness	Norfolk Children's Services
Lucy Parsons	Deputy Designated Nurse for Safeguarding Children	Pan - Norfolk CCGs Public Health Norfolk County Council
Joanne Brooks	Named Nurse for Safeguarding Children	Cambridgeshire Community Services NHS Trust Norfolk Children and Young People Health Services
Teresa Coe	Named Nurse for Safeguarding Children	Queen Elizabeth Hospital Kings Lynn
Anne Pringle	Deputy Named Nurse Safeguarding Children	Norfolk Community Health and Care (NCHC)
Lorna Hughes	Safeguarding Lead (City Locality)	Cambridgeshire Community Services NHS Trust

SCR Panel Members		
		Norfolk Children and Young People Health Services
Dave Freeman Andy Coller	Detective Inspector Temporary Detective Superintendent	Norfolk Constabulary

2 Independent Overview Writer

2.1 The Independent Overview Writer for this case is Briony Ladbury RN, RM, HV cert, FP certificate, BA (Hons) Protecting Children, ENB Specialist Practitioner Award (Child Protection), MSc in Inter-Professional Practice (Society, Violence and Practice).

2.2 Briony Ladbury has held senior roles within the NHS as a safeguarding children specialist in both strategic and practice contexts, producing and quality assuring NHS contributions to SCR's, and leading on the development of NHS participation in SCR's for London and nationally. She has undertaken training in investigative techniques including the standard NHS Root Cause Analysis Approach, the Learning Together Systems Methodology for SCR's (SCIE 2012), Improving the Quality of Children's Serious Case Reviews (DfE 2013) and the SCR Learning into Practice masterclasses (DfE 2016).

3 Purpose of a Serious Case Review (SCR)

3.1 An SCR is commissioned according to the statutory guidance found in 'Working Together to Safeguard Children' (HM Gov 2015). Regulation 5 (2006) requires an LSCB to undertake reviews of serious cases in specified circumstances to enable lessons to be learned for future service delivery and design.

3.2 One of those specified circumstances includes when a child has died and there is cause for concern as to the way in which the Local Authority, their Board partners or other relevant persons worked together to safeguard the child.

3.3 The purpose of an SCR is to provide a sound analysis of what happened and why, and what needs to happen in order to reduce the risk of recurrence.

3.4 Working Together (DfE 2015) stipulates that an SCR should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;

- Is transparent about the way that data is collected and analysed;
- Makes use of relevant research and case evidence to inform practice.

3.5 This SCR has been undertaken with these principles in mind, and includes personal reflections from some of the professionals closely involved with Child V, Sibling V and their parents.

4 SCR Commissioning Rationale

4.1 Case V involves a baby of 6 months who sustained serious head injuries that resulted in her death in Addenbrooks Hospital Paediatric Intensive Care Unit in March 2016. The injuries were judged to be consistent with a shaking action indicative of deliberate harm. Expert opinion based on radiological examination also reported evidence of previous head trauma and a fracture to Child V's arm that most likely occurred in the two weeks prior to her death. Child V's father was subsequently convicted of manslaughter on 20th December 2017.

4.2 Child V had an older sibling (Sibling V) who was aged 4 years and 4 months at the time of his sibling's death. By the time Child V died, the family had received services from several agencies based in Norfolk.

4.3 The NSCB SCR group considered Child V's case and recommended that the case met the criteria for an SCR according to Chapter 4 of Working Together to Safeguard Children (2015). An SCR was duly commissioned in March 2016, shortly after her death.

4.4 The organisations that have participated in this review are as follows:

Organisation	Description of Involvement	Commissioning Arrangement
Norfolk Children's Services	Social Care, Referral and Assessment	Norfolk County Council
Norfolk Community Health and Care Trust (From Nov 2015 Cambridgeshire Community Services NHS Trust)	Health visiting and Community Health Support for children	Pan - Norfolk CCGs Public Health Norfolk County Council
The Queen Elizabeth Hospital NHS Foundation Trust, Kings Lynn	Maternity, Accident and Emergency NHS Acute Care and Safeguarding Service	Norfolk CCGs
Norfolk Constabulary	Police Police Custody Investigation Unit	

Organisation	Description of Involvement	Commissioning Arrangement
	Police Domestic Abuse Safeguarding Team Police Child Abuse Investigation Unit Multi Agency Risk Assessment Conference Multi-agency Safeguarding Hub	
NHS Primary Care	GP and primary care nursing services	NHS England (Midlands and East Region)

5 Methodology for Investigation

5.1 Learning and Improvement Framework

5.1.1 The SCR has been undertaken in accordance with the NSCB Thematic Learning Framework, which outlines four thematic areas of practice that need to be considered when undertaking the analysis:

1. Professional Curiosity;
2. Discussion and Information Sharing;
3. Collaborative Working and Decision Making;
4. Ownership and accountability.

5.1.2 Utilising the four thematic headings outlined above, lines of enquiry for this investigation were further broken down to include the following:

- Opportunities for assessment;
- Application of thresholds;
- Services provided;
- Inter-agency collaboration and participation;
- Supervision and oversight;
- Family engagement;
- Policies and procedures;
- The impact of alcohol and domestic abuse.

5.2 Agency participation

5.2.1 Whilst not insisting on the submission of formal individual agency reports, Norfolk Safeguarding Children Board requires that nominated SCR panel members from key agencies participate fully and take the lead responsibility for coordinating their own single agency SCR contribution.

5.2.2 Single agency documentation has been provided by NSCB panel members when it was considered that it would add value to the evidence base for the analysis. Supplementary information has included original records, protocols, and procedures. Where clarification was needed regarding any of the data, the NSCB panel members have followed up formal requests for clarification, responding either in writing or verbally.

5.2.3 Written information about the SCR process was circulated to all participating practitioners and SCR panel members accepted the ongoing responsibility for supporting their staff and for keeping them informed of progress.

5.3 Chronology

5.3.1 A tabular multi-agency integrated chronology was compiled that consisted of all agency contacts with the family after they first arrived in the UK in 2005.

5.4 Scope and timeline for the investigation

5.4.1 The SCR panel studied the events in a multiagency chronology that covered a period from 2005 until six weeks after Child V died. The most significant events and relevant safeguarding practice occurred within four distinct episodes of care. The investigation takes into account both children in the family. Whilst the death of Child V is the reason why this SCR was commissioned, there is significant learning to be found in relation to the lived experience of the older sibling (Sibling V). The four episodes of care are as follows:

1. Practice following an allegation of a serious sexual assault;
2. The response and actions following an attempted suicide by Sibling V's father;
3. Practice that occurred following Sibling V's parents' reconciliation;
4. Agency activity from the antenatal booking until one month following Child V's death.

5.5 Practitioner Interviews

5.5.1 Front line practitioners were interviewed by members of the NSCB SCR panel using the SCR interview practice guidance developed by the Board. Managers and front-line practitioners took part willingly, despite being shocked and saddened by the case. They have all given candid accounts of their interactions with the family including an honest account of what it was like working within their agencies at the time of this investigation.

5.6 Learning the Lessons

5.6.1 Practitioners and managers were invited to a one-day practitioner event to formulate and discuss early findings. Learning was drawn from discussions and reflections about some of the reasons why actions were taken or not taken, triggering a useful debate about what changes could or should be made to improve single and multi-agency outcomes for children in Norfolk.

5.6.2 Every effort has been made by the SCR panel to ensure practitioners are aware of the analysis and findings in this final SCR report ahead of publication, to give them a right of reply and an opportunity to clarify or put right any inaccuracies before publication.

5.7 Publication

There was a considerable delay between the SCR report being completed and publication, due to criminal justice proceedings. Arrangements to enable the parents to participate were revisited after the trial had completed.

6 Report Structure

6.1 Prologue

6.1.1 The prologue makes reference to a previous SCR published in January 2017 about a similar child, seriously injured in extremely similar circumstances. NSCB has asked that this review is mindful of similar or identical learning points in the previous SCR that are already subject to improvement. As duplication often serves to confuse and is of little value, this seems a reasonable request. The Prologue serves to connect the reader to the findings in the previous report that are also common to this one.

6.2 Background and Context

6.2.1 A small amount of historical, contextual and cultural information has been given ahead of the main report to give the reader an impression of how the family functioned prior to the selected timeline for this SCR investigation.

6.3 Narrative Summary

6.3.1 The narrative summary gives a short and readable overview of the services and interventions received by the family for the total period of time being examined. It does not describe every agency contact in detail, but concentrates on the most relevant facts and interactions that occurred.

6.4 Analysis and Findings

6.4.1 Data has been analysed and triangulated using a systems approach where possible, taking into account the organisational and practice landscape at the time. Practice anomalies were clarified and further considered to see if the organisational systems and processes in place at the time were sufficiently robust to support professionals in their work. Supporting evidence from research has also been included where appropriate.

6.4.2 Some of the findings drawn from the analysis are attributable to a single agency, others are more generalised and/or thematic and apply to the whole partnership.

6.5 Recommendations

6.5.1 Only new findings emanating from this investigation have been formulated into recommendations for NSCB to consider. They will be added to the existing NSCB SCR action plan. A summary of the recommendations and associated rationale can be found at the end of the report.

7 Prologue to Serious Case Review Report for Child V

7.1 The Prologue

Established learning from NSCB SCR Child R (2017)

7.1.1 The NSCB Child R SCR published in January 2017 consists of an in depth study of a serious injury to an infant living in a context of domestic and alcohol abuse. The injuries occurred during a similar time-frame and in the same geographical location as this SCR. Several of the professionals, teams and practitioners involved were common to both cases.

7.1.2 The injuries to Child R and the death of Child V occurred within nine months of each other in July 2015 and March 2016. NSCB commissioned a SCR shortly after each of the incidents happened. The publication dates for each of the SCR reports however, have been subject to their own substantial delays due to parallel criminal justice proceedings and legal constraints.

7.1.3 Many of the findings in the Child R SCR apply exactly to this investigation. The reader will easily recognise the corresponding practice issues as they re-surface in Child V's story. The fact that findings in the Child R report are replicated in agency responses to Child V's family suggest they were general and systematic in nature rather than one-off failures.

7.1.4 To assist the reader, the common conclusions from the Child R SCR are summarised below under the 'key lines of enquiry' headings mentioned in 5.1.2 of this report. All of these conclusions have been accepted by NSCB as areas for improvement and are incorporated into the current NSCB multi-agency SCR action plan. This SCR, therefore only concentrates on new learning.

Opportunities for assessment

7.1.5 Child R and his family were subject to a range of assessments for various professional purposes. Most were service specific and task oriented rather than holistic or rooted in a 'Think Family' approach. There was very little cross-agency communication between partner organisations about their respective assessment findings, and subsequent actions and issues that required clarification were frequently not followed up.

7.1.6 Social care Initial and Core Assessments were mainly analysed on the limited basis of one-off visits with family members (usually the mother) rather than by utilising a combination of intelligence from family and professionals alike. Little effort was made by front line social workers to fully engage with, or comment on Child R's father's role

within the family, and it was apparent that staff had difficulties completing Initial Assessments within the required time-scale.

Application of thresholds

7.1.7 More than one referral was made to Children's Social Care. Each referral resulted in a Child in Need (Children Act 1989 section 17) response. Risk analysis and risk planning were vague. The rationale for applying the threshold below a child protection response was driven by the absence of injury or actual harm to Child R, rather than the likelihood of risk and harm occurring in the future. There was also a persistent optimistic belief that Child R's mother, a victim of abuse herself, would have the capacity to protect her baby.

7.1.8 The healthy child programme health visiting response to Child R was stepped down from a universal plus threshold to a universal care programme at a time of significant change to the family's circumstances. Information from the past did not influence the decision or trigger an enhanced single agency response, or a multi-agency discussion as to whether the threshold for a further statutory intervention had been met.

Services provided

7.1.9 Between 2010 and 2015, Child R and his family received attention from a range of qualified professionals from a number of organisations. However, for social care particularly, direct contact with family members was minimal.

7.1.10 There was a lack of provision with regards to bespoke domestic abuse advice and safety planning, as domestic abuse advocacy provision was only available for high risk and urgent need. Health and social care providers did not appear to undertake domestic abuse safety planning as an aspect of their service offer.

7.1.11 Structural and operational changes occurring with health and social care were found to have adversely affected the morale of front line practitioners delivering care to Child R's family. Capacity to meet the demand was a concern for health and social care practitioners, and social care managers in particular concentrated on managing the throughput of cases rather than the quality of service, leading to premature closure of Child R's case on more than one occasion.

Inter-agency collaboration and participation

7.1.12 Information sharing between agencies before, during and after contacts with Child R's family was generally poor. Decisions remained uninformed, unchallenged and sometimes not communicated at all.

7.1.13 Evidence showed a general tendency for practitioners to defer to social care decisions, believing that once made they could not be challenged. The analysis also concluded that many professionals in the partnership worked in isolation and were contented to work within professional silos. There was an overall assumption by partners that once social care was involved, other agencies had no part to play.

7.1.14 NHS operational systems did not facilitate face to face meetings or inter-

disciplinary discussion (for example between health visitors, GPs and midwives) about cases of concern.

Supervision and oversight

7.1.15 Supervision across the partnership did not promote systematic professional reflection, scrutiny and challenge. Managerial oversight systems in health and social care were also found to be narrowly focussed and poorly recorded.

Family engagement

7.1.16 Meaningful engagement with Child R's father about his parenting role and capacity to parent safely was negligible despite a number of professionals knowing about his troubled past and concerning behaviours.

Policies and procedures

7.1.17 Single and multi-agency operational procedures and safeguarding guidance were available but were not always adhered to in practice. Notably, the forwarding of c39d forms (coming to police attention notifications) was inconsistent.

7.1.18 Safeguarding procedures designed for office working hours were not effective at weekends, particularly in the hospital setting, and a maternity protocol for undertaking antenatal routine enquiry for domestic abuse was not effective in practice.

The impact of alcohol and domestic abuse

7.1.19 Domestic and alcohol abuse risk factors were not given sufficient weighting in risk and needs assessments. Assumptions were made that Child R would and could be adequately protected by extended family members and by his mother in particular, in spite of evidence that suggested that this might not be so.

7.1.20 Safety planning assumed a low priority in care plans and the risks associated with domestic and alcohol abuse were minimised. The report articulated a need to improve the knowledge, skills and confidence of the workforce in relation to children living in an abusive environment.

8 Serious Case Review Investigation and Report for Child V

8.1 Background and Context

8.1.1 Child V's parents are migrants from Eastern Europe. Her father was Lithuanian and her mother a Russian national residing in Latvia prior to her move to the UK. They initially registered for universal health care services in 2005. Their first languages were Lithuanian/Russian, although they are able to understand and communicate in English to a limited degree. They met in their workplace and entered into a relationship in 2006. They are not married. The couple's first child, Sibling V, was born in 2011 by which stage they were residing in a two bedroomed property, managing a joint mortgage arrangement.

8.1.2 Extended family members for both parents lived nearby and offered support to

the couple and their children including sharing accommodation when necessary and at times of crisis.

8.1.3 The couple first became known to safeguarding services after Norfolk police responded to two domestic abuse incidents in January and April 2013, when Child V's father tried to make contact with his partner after their relationship had broken down and they were living separately. Alcohol abuse played a part in both incidents. The first consisted of aggressively banging on the front door and the second involved abusive text messages. On each occasion a c39d form (child coming to police notice) was completed and sent to social care, who forwarded a copy to the health visiting team. Child V's father does not appear to have a history of similar offences in Lithuania.

8.2 Narrative Summary

8.2.1 In April 2013, police were called to the family home. Sibling V's father was arrested following an allegation of a serious sexual assault on his partner whilst under the influence of alcohol. Sibling V, aged 18 months was present when the assault took place and was considerably distressed. The police informed the Multi Agency Safeguarding Hub (MASH) by telephone and a c39d form was completed and sent to the MASH for review. After the assault, Sibling V's mother relocated temporarily to live with her brother and his wife.

8.2.2 The MASH decision in relation to the alleged assault was to take no further action other than to record the incident as 'for information only'. The c39d form was not forwarded to any other services, although a telephone call was made to inform the family health visitor about the incident the next day.

8.2.3 The health visitor sought practice advice from the deputy named nurse for child protection as she was unclear how to respond to the information. The deputy named nurse suggested she waited for the c39d form to arrive. On receipt of the copied document, the case would be discussed formally at the health visitor allocation meeting.

8.2.4 The police were concerned about the nature of the allegation and charged Sibling V's father with the assault. He was bailed for a period of eight weeks. A Computer Aided Dispatch (CAD) marker to alert officers to a potential risk was placed on the home address and an alarm was installed in the house.

8.2.5 Sibling V's mother withdrew her cooperation to assist the police as a witness several weeks after the assault charges were laid. A senior police officer in the Rape Investigation Unit (RIU) remained sufficiently concerned to request advice from the CPS about proceeding to a victimless prosecution. This was not supported and the case was dropped. Eventually a penalty notice was issued to Sibling V's father for being drunk and disorderly.

8.2.6 Early in January 2014, after a separation of approximately nine months and within two weeks of the couple reconciling, the police were again called to the family home. Sibling V's father had attempted to hang himself in the garden following a heated and alcohol fuelled argument with his partner. Sibling V, aged three was present at the address when the incident occurred. A form c39d was completed and

sent to the MASH for an initial child protection risk assessment. A copy of the c39d was forwarded to the child's health visitor.

8.2.7 Sibling V's father was taken to hospital from the scene of the incident, admitted for treatment and subsequently discharged two days later. He was not considered to be suffering from a mental illness. A discharge summary of the incident and medical treatment was sent to the GP and a GP consultation to discuss the issue of alcohol abuse followed within a fortnight. The medical opinion was that he abused alcohol episodically but was not alcohol dependent. The GP noted that a child was present in the household.

8.2.8 The case was immediately referred to social care for an Initial Assessment of Sibling V's safety and welfare, and a joint Initial Assessment visit by a social worker and the family health visitor was undertaken shortly afterwards. This was in accordance with a County-wide joint visiting agreement. This was the only visit made to the family during the Initial Assessment phase.

8.2.9 A further visit was made by the health visitor two weeks after the joint visit to complete a routine two year development check. Both parents were present and the assessment was deemed satisfactory.

8.2.10 The Initial Assessment notes made reference to several potential areas of risk, associated with domestic and alcohol abuse. On completion, a written agreement promising not to argue in front of their child was signed and left with the parents. This was a holding arrangement whilst the case was in transit to the safeguarding team for further work in the form of a Core Assessment, under level 3 of the NSCB Norfolk Threshold Guide 2013 (Children Act 1989 Section 17, Child in Need). The Initial Assessment had taken approximately four weeks to complete prior to transfer, somewhat longer than the expected timescale of completion within 10 days.

8.2.11 The case was allocated to a social worker in the safeguarding team for a Core Assessment at the end of February 2014, by which time Sibling V and his mother were once again residing at her brother's house, having left the family home because the abusive behaviour had continued despite the written agreement.

8.2.12 A Core Assessment interview occurred at the police station on 5th March 2014, at the request of Sibling V's mother. She had sought advice from the police Public Enquiry Desk earlier that week having received hostile text messages and suicide threats from her partner after suggesting their relationship should end. A second visit took place at her brother's home. Financial difficulties due to a joint mortgage arrangement were limiting her ability to find and pay for independent accommodation and her partner's refusal to cooperate was making a permanent separation difficult.

8.2.13 The recommendation of the Core Assessment was to keep the case open to the safeguarding children team whilst a multi-agency care-plan for ongoing support was formulated. Sibling V's father did not participate in the Core Assessment, apart from one meeting where he expressed a wish to resume and maintain the relationship with his partner.

8.2.14 A Domestic Abuse Stalking and Harassment (DASH) risk assessment was also

sent for consideration by the Norfolk Multi-Agency Risk Assessment Conference (MARAC), but it did not qualify for a standard high risk intervention, including ongoing support from an advocate.

8.2.15 The safeguarding team kept the case open for seven weeks to enable the local children's centre to engage fully with the family. The case was subsequently closed to the safeguarding team on the 12th April 2014. The rationale for closure was that no child protection concerns were evident, and Sibling V's mother seemed capable of protecting him. An instruction was given that, should the couple reconcile and move back into the family home, the child protection risks would need to be reassessed.

8.2.16 One month and four days following case closure, a Children's Centre Family Support Worker (FSW) discovered that the couple were once again living in the family home, albeit in separate rooms. This intelligence was immediately reported to the MASH for review. The MASH recommended that a second Initial Assessment should be undertaken.

8.2.17 The second Initial Assessment, which concluded that Sibling V had not suffered significant harm, did identify several potential risk areas that would require further work. The outcome was to recommend a further Core Assessment. This required a transfer to another team. Another written agreement was signed prior to transfer, promising that Sibling V's mother would remove Sibling V from the premises and contact the authorities should any domestic or alcohol abuse ensue.

8.2.18 The case was reallocated again within five days to another worker in the Child in Need (CIN) team. The plan was to complete the Core Assessment and provide ongoing support under Section 17 of the Children Act 1989 - level 3 in the Norfolk Threshold Guidance (2013).

8.2.19 A social care intervention designed to improve the couple's abusive relationship through a solution focussed restorative approach was proposed. The 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.

8.2.20 A booking for ante-natal and maternity services care was received in April 2015 and the first trimester passed without incident. However, Sibling V's mother went into early labour at 26 weeks gestation. Child V was rapidly transferred to a regional specialist neonatal unit for a review of her significant prematurity, however after three days she was stable enough to return to the Neonatal Intensive Care Unit (NICU) in the local hospital.

8.2.21 The health visitor undertook a new birth visit on the NICU. Some communication between the hospital and community health services was maintained throughout the baby's stay in the unit to update on clinical and developmental progress. No major or unusual concerns about the parents' interaction with their baby were identified. The infant was deemed fit for discharge early in November 2015 after a period of approximately three months as an in-patient.

8.2.22 The hospital neonatal community team (NCT) and the health visitor continued

to support the family at home until mid-January 2016, when the baby was discharged from the NCT into the sole care of the health visiting service. Child V was making satisfactory progress and was to follow a course of surveillance for growth and development designed for premature babies.

8.2.23 The family received two further home visits from the community health service. On February 1st 2016 the health visitor noted several concerns that were being expressed by Child V's father. They indicated an increasing level of parental anxiety. A further visit from a community nursery nurse two weeks later did not identify similar concerns.

8.2.24 Ten days after the nursery nurse contact, Child V was taken to hospital with injuries indicative of abusive head trauma (non-accidental head injury). She was admitted into the local Accident and Emergency department. Her condition required an emergency transfer to a regional Paediatric Intensive Care Unit (PICU) in a neighbouring county. This transfer was undertaken by the Children's Acute Transfer Service.

8.2.25 At the end of February 2016, Child V's father was arrested and interviewed on suspicion of having inflicted actual bodily harm. He was bailed to his brother's address on condition that he had no unsupervised contact with either of his two children and no unsupervised contact with any child under the age of 16.

8.2.26 An initial strategy discussion was held, involving the Social Care EDT manager, social worker and police officer to discuss the immediate management of the incident and the safeguarding implications for Sibling V. A decision was made that a police and social care joint investigation should commence.

8.2.27 An assessment was made as to the most appropriate placement for Sibling V whilst his sister was in hospital. A decision was made to place Sibling V in the care of his mother's brother and his wife. He had no contact with his father.

8.2.28 A statutory strategy meeting occurred four days later, involving several agencies in order to gather all relevant information and formulate a more robust multi-agency plan of action which included a plan to convene a child protection case conference to assess the risks to Sibling V.

8.2.29 As Child V's condition deteriorated over a period of three days, it became clear that she would not recover. Child V's father was rearrested for attempted murder (later changed to manslaughter). Child V died from her injuries on March 2nd 2016, by which time two police Family Liaison Officers (FLO's) had been assigned to support Child V's mother.

8.2.30 On 30th March 2016 social care contacted the police having been made aware that a 13 year child was resident at the bail address. This seemed to contravene bail conditions and could potentially be risky for the resident child. Children's Services expressed their concern and requested that the bail conditions were reviewed. They also asked that consideration was given to convening a Children Act 1989 Section 47 child protection conference for the child residing at the bail address.

8.2.31 Further discussions and risk assessment concluded that this older child (aged 13) was at a low risk of harm and a mutual agreement between police and children's services was made for the bail arrangement to continue. A child protection conference was therefore, not considered necessary.

9 Analysis and findings

9.1 Care Episode 1: Practice following the allegation of a serious sexual assault

9.1.1 The impact on children of witnessing domestic violence has long since been accepted as a safeguarding matter. A review of research evidence (Carpenter, G and Stacks, M. 2009) concluded that exposure to domestic abuse has a negative impact on the health and wellbeing of preverbal toddlers, with a profound effect on infant emotional regulation that lasts into adulthood. Witnessing domestic abuse is therefore harmful and significant. The interval between the onset of abuse to reporting domestic abuse incidents to the police, on average is 2.7 years after onset ('Getting it Right First Time: SafeLives, February 2015) meaning that for many cases, the act or reporting signifies a worsening and riskier situation.

9.1.2 Sibling V's mother reported an alleged sexual assault at the police station the morning after it happened. Comprehensive details of the alleged serious sexual assault witnessed by Sibling V were passed to the Multi Agency Safeguarding Hub (MASH) by the attending police officer. There is no evidence of a Child Protection Referral form being completed, although the attending police officer spoke directly to the MASH social worker and also recorded details of the incident on a Coming to Police Notice form (form c39d) which was copied to the MASH for the attention of social care. This followed standard police procedure.

9.1.3 Case files showed that an earlier form c39d had been dispatched the day before, relating to an episode of abusive but not violent behaviour. The report of another more serious incident occurring within 24 hours of the previous police notification should have served as an alert to the MASH partnership that the family situation was deteriorating and the abusive behaviour and associated risks were escalating. However the knowledge of the previous form c39d notification did not influence the response to the second more serious incident.

9.1.4 Information about the alleged sexual assault was reviewed by an experienced MASH social worker in a senior position. Full details of the incident were entered onto the Children's Services CareFirst recording system. Despite the fact that the incident was witnessed by Sibling V, it was not considered to be a child protection matter and a 'no further action' (NFA) decision was made. The incident was logged on the system as 'for information only'. There is no organisational memory or clear explanation recorded as to how or why that conclusion was reached. Equally unclear, is how professionals from other disciplines operating within the MASH contributed to the NFA decision, or indeed whether they were invited to do so. Evidence suggests partners had little to say or do in relation to the notification.

9.1.5 Based on sound evidence from research, the risk and harm to Sibling V from

witnessing a prolonged and distressing assault on his mother warranted a professional assessment by a trained social worker. It is the local authority social work department that is responsible in statute for assessing the safety and protection of children exposed to risk or harm from their carers. However, instead of a robust safeguarding response, the information was merely noted and left on file.

9.1.6 Established procedure would also expect that a copy of the coming to police notice form (c39d) relating to this event would be sent by social care to the community health team for the attention of the family's health visitor. This established procedure ensures that the community health service has an up to date, accurate record of police interventions to households where children are residing. The information is a vital indicator of how the family is functioning and important information for any subsequent health visitor activity.

9.1.7 A verbal report from the social worker was given to the health visitor by telephone after the decision for no further action was made. The police form c39d however was not copied to the community health team in the usual way. The telephone discussion would undoubtedly have been helpful, but should not have been used instead of, or interrupted the normal communication route of the form c39d to the community health service.

9.1.8 An effective MASH should provide a fast systematic response to a safeguarding issue based on a robust risk assessment model. Decisions are made by analysing information from a range of multi-agency sources, gathered and interpreted by an integrated team of MASH professionals from different professional backgrounds.

9.1.9 The co-located and integrated MASH partnership system in Norfolk had been in place since 2011. It ought to have offered, at the very least, a robust means of two-way multi-agency information sharing to establish the nature and severity of the risk to Sibling V before the NFA decision was made, but there is no evidence of this happening.

9.1.10 The SCR panel learned that the Norfolk MASH operational protocols were in a state of flux in 2013. Many were described as 'underdeveloped' or not embedded into practice, and as a result were subject to frequent change. On interview, a MASH practitioner recalled that in 2013 a huge number of c39d forms were going into the MASH for review. To cope with the demand a very simplistic MASH recording system was adopted.

9.1.11 Another MASH practitioner commented that in all probability, because the incident had been verbally passed on to the health visitor, any further children's services involvement would have depended on the health visitor's assessment and opinion. This effectively redirected the task and responsibility for safeguarding and protecting Sibling V to the health visitor, a task outside of the health visitor's scope of practice.

9.1.12 Both of the above comments from the Norfolk MASH professionals suggest that the Norfolk MASH system was indeed experiencing operational difficulties and pressures due to the volume of cases passing through. Simplistic systems and ad hoc information sharing symptomatic of a service under strain appeared to replace the

robust multi-agency risk assessment process that a MASH system is designed to deliver.

9.1.13 The SCR panel has been assured that the MASH system for Norfolk has evolved and improved over the last three years and it continues to develop in line with County priorities. The current system consists of a fully functioning integrated and inter-professional team for domestic abuse incidents and involves health participation on site. This ensures that information and risk assessment decisions for safeguarding children and domestic abuse are informed from a wide professional base and reach the practitioners who need to know in a timely fashion.

9.1.14 The social worker telephoned the health visitor to alert her to the incident. On hearing the detail, the health visitor described feeling alarmed and concerned by the nature of incident and uncomfortable with the outcome, particularly as her case notes recorded two previous c39d notifications for the family, both relating to domestic abuse.

9.1.15 The health visitor assumed that the risks would have been properly assessed by the MASH professional, particularly as risk assessment was the primary task of the MASH system. Rather than challenge the decision, the health visitor deferred to the social worker and accepted the NFA decision without question.

9.1.16 It would have been reasonable for the health visitor to question the social worker during the conversation as to why no child protection activity was being pursued, but she chose to take another course of action. She chose to contact her own safeguarding children professional advisor for guidance on what to do next. The safeguarding advisor was employed to give front line practitioners expert safeguarding advice and support on casework matters, so this action was entirely appropriate.

9.1.17 The advice given by the safeguarding children advisor was to wait until a copy of the form c39d arrived in the office. Once the written account had been received, the case could be presented and discussed at the next health visitor professional allocation meeting. This would enable a suitable response to be formulated and planned.

9.1.18 At the time of the incident health visitors were managing large caseloads and supporting a number of complex families, allocation meetings were common and a way of managing the demand. Acting on the instruction she was given, the health visitor waited for the c39d form to arrive but it failed to appear. The failure to send the c39d form to the health visitor and the practice instruction to wait for it to arrive before formulating a plan, together resulted in the incident slipping from the organisational memory of the health visiting team. The opportunity therefore, for intervention and targeted early-help faded as new priorities took over.

9.1.19 Forwarding a c39d form to the community health team had been the accepted system in Norfolk for several years prior to any MASH system being adopted, but the belief by health professionals that the system would work on this occasion proved to be wrong. Any assumption that a system will work is inherently risky when complex safeguarding concerns are aroused.

9.1.20 An immediate and direct verbal challenge with regards to the NFA decision, followed by a proactive care-planning approach would have been a far safer and more

effective option. The learning from this series of events must be that professionals in all parts of the partnership, and particularly health visitors, must question and challenge decisions and concerns directly with colleagues, irrespective of their professional background or status, particularly if they feel that a child's safety might be compromised.

9.1.21 There seemed to be a generalised lack of urgency or focus on how witnessing an alleged assault on his mother might have affected Sibling V.

9.1.22 The SCR panel considered why relatively senior professionals within key health and social care settings did not support or command a more vigorous safeguarding response. No explanation has been forthcoming, other than a suggestion that there may be a generalised lack of knowledge and skills in relation to how to respond to domestic abuse and coercive control. Whilst this might have contributed, there are also questions to answer about why the partnership did not follow established systems and processes to support child centred practice. Agencies should therefore revisit their internal systems and competency frameworks to ensure practitioners understand the importance of compliance, commitment and the behaviour they need to exhibit to work in an inter-professional context.

9.1.23 Sibling V's father was arrested on suspicion of rape shortly after the alleged sexual assault took place. The investigation was managed by officers from the Police Rape Investigation Unit (RIU). The initial statement, taken from the Sibling V's mother immediately after the alleged assault, recorded a distressing and frightening situation. She described being afraid and being powerless and unable to assert any control over the events taking place. Sibling V's father gave a similar account of the incident, asserting that it was consensual. The incident occurred when Sibling V was in the room, causing him significant distress.

9.1.24 The officer in charge of the case recorded that Sibling V's mother had asked to withdraw her complaint several weeks into the investigation, stating she did not want to take any action against her partner. Further attempts by the police to encourage her to cooperate were hindered by her deliberate evasiveness and a persistent view that there was no need for them to be involved. Eventually a police recommendation was made that the case should not be prosecuted.

9.1.25 A senior officer in the RIU reviewed the decision and in light of the evidence sought advice from colleagues in the local Crown Prosecution Service (CPS), as to whether a victimless prosecution should or could be considered.

9.1.26 Two CPS professionals reviewed the evidence submitted by the police to clarify the substance of the case. The case files noted that Sibling V's mother had initially engaged with the investigation and had taken part in a forensic medical examination. She was also supported by the Sexual Assault Referral Centre (SARC) but, over a period of weeks, she withdrew her support for the investigation.

9.1.27 Whilst the CPS professionals acknowledged the serious nature of the offence, they concluded that there was insufficient independent evidence to proceed with a prosecution without the support of the victim. The CPS professionals advised the police that, in their opinion there was no realistic prospect of a conviction in this case

and in response to that advice the initial police recommendation for no further action (NFA) was upheld.

9.1.28 The child safeguarding risks linked to the alleged assault and further concerns about the adverse and unintended consequences for Sibling V and his mother should the case proceed, were both considerations in the CPS analysis. An assumption was made that as Sibling V had been notified by the police to the MASH on the day of the incident, measures to safeguard and protect him would be already be in place. The child safeguarding risks linked to the alleged assault and further concerns about the adverse and unintended consequences for Sibling V and his mother should the case proceed, were both considerations in the CPS analysis. An assumption was made that as Sibling V had been notified by the police to the MASH on the day of the incident, measures to safeguard and protect him would be already be in place.

9.1.29 At the time of writing this report a new system has been introduced in Norfolk that involves sending a summary report to the MASH of any 'No Further Action' decisions made by the police or the CPS which may have child safeguarding implications. This allows any risks, needs or plans to be reassessed in the light of the changed circumstances. This new system is to be welcomed and it is easy to see how this would have been of benefit had it been in place at the time of this episode of care.

New Learning

9.1.30 Over the last two decades, many researchers in the UK and the USA have explained why the victims of domestic violence and abuse frequently withdraw police statements or change their stories. Reasons are many and complex and are often driven by fear and self-protection. This non-engagement complicates and frustrates the prosecution process.

9.1.31 The challenges of working effectively with victims of domestic abuse have been extensively and continuously debated by the UK government for over a decade, the most recent 'Strategy to End Violence Against Women and Girls' (VAWG) being published in 2016. Multi-agency support for the fearful witness as a means of reducing attrition rates has been included in those strategic discussions for some while. Research by S. Edwards in 2000 highlighted the benefits of early support from professionals other than the police. Their interventions, particularly in the early weeks, help to empower a victim to feel safe and stay engaged in the criminal justice process.

9.1.32 CPS practice in Norfolk adheres to VAWG principles which inform the CPS national guidance (Code for Crown Prosecutors HM Gov 2013). The local statistics for Norfolk suggest that the Police and CPS systems are working well. Data shows that a high volume of domestic abuse cases in Norfolk are indeed successfully managed through to conviction when witnesses stay engaged.

9.1.33 Notwithstanding, the rarity of victimless criminal prosecutions in the County mirrors the national picture of attrition for both domestic abuse offences and rape, particularly when the evidence is thin or the victim is reluctant or too fearful to cooperate. The issue of non-engagement means that perpetrators remain at large and are not held accountable for their criminal activity.

1. Multi-agency Recommendation (Norfolk LSCB)

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.

9.2 Care Episode 2: Practice following the attempted suicide by Sibling V's father.

9.2.1 The next time the family came to the attention of the police was on Saturday 4th January 2014, when Sibling V's father attempted to hang himself in the garden following a domestic dispute. As two year old Sibling V was present in the house, another police c39d form was duly forwarded to the MASH to assess any potential safeguarding risks. The information was copied to the health visitor as required.

9.2.2 The condition of Sibling V's father on admission to the Accident and Emergency department was concerning. He was transferred to the intensive therapy unit (ITU) for monitoring as his injuries were described as potentially life-threatening or likely to lead to a lasting impairment. Recovery however, was much faster than anticipated and he was transferred to a hospital ward the next day, from where he was discharged home.

9.2.3 A mental health assessment undertaken prior to discharge by a qualified mental health liaison nurse concluded that Sibling V's father had acted on impulse and was not suffering from any serious mental health disorder.

9.2.4 Safeguarding risks were considered by hospital staff, but none were identified and Sibling V's father confirmed that he had never been in contact with social care before, for any reason. Being a Sunday, when local social care and children's community health offices were shut, sources of background information held by health and other colleagues in the community were unavailable. There was no reason to detain Sibling V's father in hospital, so he was discharged home. The routine hospital discharge process was completed, including posting a summary letter to the family GP.

9.2.5 Basic details relating to the incident and Sibling V were picked up and recorded on a MASH contact and referral form, although any reference to ethnicity and first language was omitted. On receiving the information on the Monday morning, the MASH worker attempted a mobile telephone contact with Sibling V's mother to check on the condition of her partner.

9.2.6 The social worker was somewhat surprised that the telephone was answered by Sibling V's father, who had returned home from hospital. Having enquired why he was in possession of his partner's telephone, an explanation was given that his own mobile device had been confiscated by the police. Sibling V's mother supported this explanation.

9.2.7 The social worker, sceptical of the explanation contacted the police constable who had completed the c39d and asked why the telephone had been confiscated. The

police officer was also puzzled as to why this would be so. However the matter of the confiscated telephone was never actively followed up to see if it was true. A police spokesperson and member of the SCR panel has since confirmed that there is no record that corroborates the account that the telephone was seized by the police.

9.2.8 The social worker was right to feel uncomfortable about Sibling V's father answering his partner's telephone, long since known to be an indicator of coercive control. Pursuing the explanation of 'confiscation' with the police, and confirming that this explanation was untrue, might have provided useful intelligence to inform any subsequent risk analysis.

9.2.9 With the information at hand, including previous domestic abuse incidents, the witnessing of an alleged serious sexual assault, hearing threats of suicide and being present during an actual suicide attempt, suggested that Sibling V's lived experience was set in a context of uncertainty, domestic abuse, coercion and control. The case was therefore considered to be of sufficient concern to allocate it for an Initial Assessment[1]. This was opened two days after the incident on Monday 6th January 2014. The GP, health visitor and police were contacted by the social worker and invited to contribute information in accordance with established procedure.

9.2.10 A home visit was undertaken on January 16th 2014 by a social worker and health visitor in line with a best practice joint visiting protocol approved by health and social care agencies. The family were described as Latvian and potential issues with regards to English as a second language were acknowledged. A relative acted as interpreter during the visit, despite the widely accepted principle that this was not best practice. The matter of using interpreters is mentioned later in this report.

9.2.11 The Initial Assessment was set out under the headings of the Assessment Framework for Children in Need and their families 2000. Several observations in relation to Sibling V and his development, health and interaction with his mother were included in the documentation. The mother-child relationship appeared to be warm and entirely appropriate, however there was little direct engagement during the initial visit with Sibling V's father, who kept very much in the background.

9.2.12 The Initial Assessment notes of the visit recorded several concerning aspects in relation to the parental relationship, including intense jealousy, alcohol and substance abuse and an apparent acceptance of previous sexual violence by Sibling V's mother on one hand, and a minimisation of the incident by his father on the other. An alarm system present in the house, fitted at the time of the reported sexual assault was noticed to have been deliberately dismantled by Sibling V's father. As the assessment progressed, considerable attention was paid to setting out a comprehensive list of actual and potential risks to Sibling V, albeit informed by a one-off conversation with Sibling V's mother.

9.2.13 The social worker concluded that the case needed a further Core

[1] An Initial Assessment is a 'brief assessment of each child referred to social services with a request for assistances to be provided (Department of Health, Assessment Framework Guidance 2000).

Assessment[2], emphasising that more had to be understood about Sibling V's father, his relationship with his son and his influence within the family. As a holding arrangement, each parent signed a written agreement that they would not argue in front of their child. In light of the history, the word 'argue' rather underestimated the nature of the relationship issues that were being described in the assessment document.

9.2.14 Contributions from the GP and the Health Visitor were noted, neither reported safeguarding concerns. However, before the Initial Assessment was completed, the Health Visitor undertook a two year check and recorded in the health visiting file that Sibling V's father was verbally shifting the responsibility for his suicide attempt onto his partner. This overt denial of responsibility, indicative of ongoing abuse and coercive control was significant and should have been shared with the social worker to factor into the Initial Assessment.

9.2.15 Similarly, a post hospital discharge consultation undertaken by the GP during the time the assessment was not communicated to the social worker, despite the GP being aware of the safeguarding concern, having contributed to the Initial Assessment a short time before. The outcome, if not the detail of the consultation would have been useful information for the social worker to contemplate as part of the assessment process. The responsibilities of the health agencies during this episode of care are discussed later on in this section.

9.2.16 A routine social work management meeting took place and a management overview was recorded in light of the findings of Initial Assessment. On reviewing and analysing the risks to Sibling V, a recommendation was made to 'step down' the case and transfer it to the children's services safeguarding team for a Core Assessment under the Section 17 (Children Act 1989). A request was issued for the Initial Assessment findings to be translated into the family's first language before they were posted to the family for their information. The rationale for the transfer was that Sibling V's mother seemed to be taking measures to protect her son and there was no evidence that he had suffered actual physical or emotional harm.

9.2.17 The rationale for the step down decision was based on the absence of harm to Sibling V rather than the likelihood of harm in the future. Repeated studies, the most recent being 'Pathways to harm, pathways to protection' (2016) continue to challenge the concept of a 'protective parent' for ensuring safety, warning that it may not apply in cases where the parent has experienced domestic abuse themselves. The evidence in this case suggests that the decision paid insufficient attention to the past behaviours and actions of Sibling V's parents, which, in light of more current events, supported the possibility that Sibling V's mother might not be able to sustain the level of commitment required to protect her son in the longer term.

9.2.18 Once the file had been prepared, the case transferred to the safeguarding team for a further Core Assessment activity. This was at the end of February 2014, more than a month after the last home visit and well outside of the 10 day Initial Assessment

[2] Core assessment is an in-depth assessment, which addresses the central or most important aspects of the needs of a child and the capacity of his or her parents as caregivers to respond appropriately to these needs within the wider family and community context'. (Department of Health Assessment Framework Guidance 2000).

completion timescale.

9.2.19 The SCR panel heard that a generalised delay in the movement of cases across teams was common during 2014 due to an increase in demand and an inefficient organisational structure. The children's services structure at the time consisted of three geographical divisions with a standard operational tiered structure for each. A delivery model of allocating work to separate teams (a) for receiving referrals, (b) for managing child protection cases and (c) for undertaking Child in Need Section 17 support casework, created unnecessary difficulties and/or delays particularly at the point of transfer. Adopting this 'step up and step down' approach also meant that families were subjected to a series of new social workers with an inevitable lack of continuity.

9.2.20 In addition, the three-way geographical split resulted in social workers spending inordinate amounts travelling, at a time when the overall demand for services was rising and a backlog of work was mounting. Furthermore, a management instruction to keep within initial and core assessment timescales, applied after a critical Ofsted inspection, was challenging in the extreme to practitioners who were struggling with the demand.

9.2.21 The children's services structure in place during the timeline for this SCR has been reformed. The structure now consists of six divisions instead of three. This enables increased contact with clients in smaller geographical areas. In addition, a social work delivery model has been implemented that doesn't differentiate between child protection and child in need teams and the children's services ethos and culture has transformed to prioritise quality over basic performance monitoring. Finally, switching to the Signs of Safety assessment model (Turnell and Edwards 1999) has provided a more positive and effective 'Think Family' approach in Norfolk based on balanced risk assessment and reflexive outcome focussed care planning.

9.2.22 A review of the safeguarding practice of key health professionals during this episode of care raised some important questions. All health practitioners delivering care directly to families receive regular high level safeguarding training to ensure they function competently and safely.

9.2.23 . GPs and health visitors in particular, know that they have a responsibility to promote the safety and wellbeing of the children they come into contact with. They are also taught that they have a duty in law to cooperate with the Local Authority when a child is being assessed for a child protection reason (Children Act 1989). In practice they are expected to be proactive practitioners and take full responsibility for passing pertinent information to safeguarding colleagues, including information involving significant adults, if this is relevant to the safety of a child.

9.2.24 The reason why the health visitor failed to share an important observation despite knowing that Sibling V was subject to an Initial Assessment was underway remains unexplained. It is extremely unlikely, given that child protection work is a substantial part of a health visitor's experience, that the health visitor was unclear of how to share information, or of when or to whom the information should go.

9.2.25 There might have been a lack of awareness of the significance of the information

in the context of coercive control and domestic abuse and this was certainly raised as a possible general concern during an SCR panel discussion regarding the previous episode of care concerning the sexual assault allegation.

9.2.26 The SCR panel also learnt that the health visiting service was in the process of being taken over by a new provider organisation in 2014 -15. It was considered highly likely that the ensuing uncertainty impacted negatively on some professionals in the team, at a time when demand was high.

9.2.27 In these circumstances good supervision and advice to support complex case management would have been essential to promote sound inter-professional practice and care planning. No evidence has been seen or heard which suggests extra measures were taken to support or supervise the workforce during this risky period of transition.

9.2.28 Large scale operational reform was also impacting on the ability of health professionals to interact with each other. For example, despite having been standard to practice in the past, face to face meetings between GPs and health visitors have decreased markedly since year 2000, as national models of delivery have moved away from GP attachment to centrally based health visiting services.

9.2.29 In January 2014, in common with many other areas in the Country, it appears that a system to enable GPs to meet regularly with their named health visitor to discuss cases of concern did not exist in Norfolk. This reinforced a rather separate and isolated approach to safeguarding practice for both sets of professionals.

9.2.30 The National Health Visiting Service Specification 2014-15, which was published in March 2014, identified the need to restore the close working relationship between the GP and the health visitor. It stated that HVs and GPs must facilitate 'an agreed schedule of regular contact meetings for collaborative service delivery'. This has now been implemented in the County and health visitors are regularly meeting with GP colleagues. However, it is important that any new system ensures child safeguarding concerns always form part of the agenda for those professional meetings.

9.2.31 The recent NHSE requirement for Named GPs for safeguarding children to be part of the NHS safeguarding structure has been helpful. It has enabled the GP workforce to be more aware of safeguarding concerns and of when and to whom intelligence should be shared. Professional guidance for GPs is also available to improve the quality of information sharing in line with the Data Protection Act (1998).

9.2.32 Finally, the LSCB in Norfolk have identified that poor information sharing and silo working as an overarching theme in several recent SCRs. A programme of improvement is underway to ensure that all agencies are clear about their information sharing responsibilities.

9.2.33 During the interval between the Initial Assessment and the transfer of the case for further Core Assessment work, Sibling V's mother was already turning up at the police public enquiry office requesting advice about how to separate permanently from her partner. Further abuse and aggression had caused her once again to leave the

family home with her son and seek refuge in her brother's house.

9.2.34 The police facilitated the first Core Assessment meeting between Sibling V's mother and the new social worker at the police station five days later. During this visit it was apparent that alcohol abuse, coercive behaviour, including threats of suicide and abusive texts, were still features of the relationship. Verbal aggression and denying responsibility for the behaviour were also evident. Sibling V's mother wanted very much to separate permanently from her partner but housing and financial constraints were becoming a major disincentive to do so.

9.2.35 A Domestic Abuse Stalking and Harassment (DASH) risk assessment score of 11 points indicated areas of potential risk, so a referral to the Norfolk MARAC was prepared. Whilst the score indicated a considerable amount of risk, it fell below the Norfolk MARAC high risk threshold of 14 points, which entitled a victim to support from an Independent Domestic Violence Advocate (IDVA). No service was therefore offered. Subsequent referrals were made to two local providers for domestic abuse safety planning advice and housing support. However there is no evidence available that confirms the referrals were either sent or received.

9.2.36 Social care observations concluded that there were no overt signs that Sibling V had suffered physical or emotional harm from his parents. He seemed well attached to his mother who tried hard to protect him. Supervised contact between Sibling V and his father had been arranged by family members and was reported to be working well. Due to the high level of family cooperation, a child in need (CIN) response was developed, in line with the Norfolk Threshold Guide (Section 17 Children Act 1989).

9.2.37 The CIN plan included the allocation of a social worker and a family support worker (FSW) from the children's centre as a means of enhanced support. Partner agencies were invited to provide a professional opinion about Sibling V's welfare but there was little mention of how professional partners would or could engage with the plan to enable a truly multi-agency 'think family' response. Adopting a systematic way of recording a care plan against identified multi-agency outcomes might have given clarity, for example to health partners, about their specific role in improving the safety and welfare of Sibling V in both the short and longer term.

9.2.38 After six weeks, the case was deemed fit for closure by children's services on the proviso that Sibling V continued to receive additional support from a children's centre Family Support Worker. However, it was noted, on the basis of past behaviour, that the couple might choose to reconcile and live as a family again. The social worker therefore directed that should a reconciliation occur, an analysis of the risks and protective measures would need to be repeated. This was a reasonable and responsible recommendation.

9.2.39 With the benefit of hindsight, the social worker has told the SCR panel that the case could and possibly should have stayed open for a longer time to ensure Sibling V's mother had engaged fully with bespoke community resources for safety planning and domestic abuse and housing advice. This may have supported Sibling V's mother's effort to separate from her partner and sustain her independence.

New Learning

There is no new learning pertaining to this section of the review. Parallel issues are referenced in the Prologue of this report having been identified in the Child R SCR (2017).

9.3 Care Episode 3: Practice that occurred following Sibling V's parents' reconciliation.

9.3.1 One month after children's services closed the case, the FSW located in the children's centre discovered that Sibling V's mother had returned to the family home shared with her partner, not out of a desire to be together but due to unresolved housing and joint mortgage difficulties. Sibling V's mother assured the FSW that she and Sibling V had separate living accommodation in the house. However, the arrangement meant Sibling V would inevitably have unsupervised contact with his father. This change in circumstance was clearly risky, so the FSW triggered an immediate MASH referral; this was an entirely appropriate and timely decision. After initial enquiries, the decision maker in the MASH transferred the case for another Initial Assessment.

9.3.2 A second children's services Initial Assessment was commenced. Background information checks from the GP, health visitor and nursery gave brief summaries of Sibling V's health and development which were satisfactory. The notes continued to say that the family were of Latvian rather than Lithuanian origin. Sibling V's father did not actively engage in the assessment discussion, but it appeared that although the separate rooms arrangement was in place, the possibility of a full reconciliation was being considered by both parties, increasing the risk even further.

9.3.3 The Initial Assessment on this occasion was not jointly undertaken with a health visitor. The joint visiting arrangement was highly recommended at this time, but had not been formally adopted as standard procedure due to difficulties connected with staff availability in both agencies. There were no overt signs that Sibling V had suffered harm as a result of the move back to his home; however the insightful and thorough Initial Assessment that was undertaken by the social worker, identified a range of potential risks associated with the previous history and current change in circumstances.

9.3.4 Sibling V was clearly thriving and well attached to his mother, but there was concern about whether his mother could protect him. As a holding arrangement Sibling V's mother signed another written agreement stating she would return Sibling V immediately to the safety of her brother's home, should her partner become drunk or aggressive. The case was prepared for transfer to the safeguarding team for a more comprehensive Core Assessment.

9.3.5 The safeguarding team picked up the case and allocated a new social worker on 17th June 2014. The plan was to undertake further Core Assessment work with a view to a Child in Need plan under Section 17 of Children Act 1989 (Level 3 of the NSCB Threshold Guidance - 2013).

9.3.6 Unlike the first Initial Assessment, the case rapidly moved from one team to another. This inevitably meant that the family were subject to a different process and a change of social worker in a very short space of time. As mentioned elsewhere in this report, this 'separate team' delivery model, did not provide for continuity of care and placed unnecessary stress on the social workers and families alike. Practitioners and managers have articulated clearly that the model, introduced in good faith to improve efficiency, in practice had the opposite effect. In recognition of this unintended consequence, the delivery model was reviewed and restructured in September 2015.

9.3.7 The new social worker saw Sibling V at home with his parents at the end of June and again in early July 2014, once with a Russian interpreter. She became increasingly concerned when Sibling V's father openly blamed his partner for the sexual assault allegation and for getting the authorities involved in 2013, describing the event as 'no big deal'. She wrote in the social work case file that Sibling V's father was 'oppressive', and 'seemingly asserting influence' over his partner.

9.3.8 The social worker's concern was heightened to such a degree that a further DASH risk assessment was deemed necessary, but a score of 6 points indicated that although some risk existed within the relationship, it was not overly high. Reflecting on the result of the DASH score after the visit, the social worker wondered whether cultural factors or communication difficulties might have influenced the way in which Sibling V's mother answered the DASH risk assessment questions or may have increased the likelihood of abuse minimisation and denial. This is discussed later in this report.

9.3.9 The observations of Sibling V during the visit, judged him to be a well-nourished and cared-for child, living in good home conditions, unharmed by and attached to his parents. The social worker concluded that identified risks to Sibling V were entirely connected to his parents' relationship, in that he could be harmed by living in a context of coercive control or by witnessing or being injured in an act of domestic abuse.

9.3.10 The social worker recalled, during an SCR interview, that in her professional judgement, she thought that Sibling V should have been discussed at a strategy meeting and considered for child protection activity (section 47 Children Act 1989). She remembered that she was not entirely convinced that Child V's mother could protect him, or herself for that matter, should an abusive situation arise.

9.3.11 The notes of the social work management meeting, conducted by an experienced team manager relatively new to the County of Norfolk, summarised in writing the concerns that the social worker had identified. These included the apparent minimisation of violence by Sibling V's mother, and the candid assertion by Sibling V's father, that the relationship 'could be violent at any time'.

9.3.12 The request for a strategy meeting was both discussed and recorded. However, the manager's overview and opinion, noted as a result of the discussion, concluded that child protection activity could not be justified at that time. The decision was challenged by the social worker, who felt the threshold for child protection activity had been met, but further discussion did not change the outcome. The rationale for the decision was that no new incidents had been reported, and Sibling V's mother appeared to be aware of the risks and was cooperating with the assessment. Both practitioners however, were in agreement that the case was 'too fragile to close' at that

time, indicating that an element of risk remained.

9.3.13 A child in need (CIN) plan was formulated that included a multi-agency meeting to develop ongoing support. A programme of solution focussed restorative work to improve the parental relationship, and reduce the risk to Sibling V was a major part of the plan and it was to be delivered by the social worker. A management note required the solution focussed restorative work to be completed within six weeks.

9.3.14 A CIN multi-agency meeting took place as planned at the family home. The meeting involved both parents, the social worker, health visitor and FSW. The discussion centred mainly on reducing the risk of domestic abuse between the adults in the family. Both parents agreed to cooperate with the plan. Less attention was paid to monitoring the risks and needs of Sibling V who was fast approaching his third birthday. An assumption was made that the programme would be transformational for the parental relationship and that Sibling V would be safer as a result.

9.3.15 No significant partner agency contributions or actions were recorded, apart from the health visitor and FSW agreeing that there wasn't a role for them at that time. The GP was not made aware of the outcome of the visit. Instead of a multi-agency arrangement to enable a holistic approach for monitoring the lived experience of Sibling V, the social worker accepted all of the responsibility for the actions in the CIN plan.

9.3.16 After three sessions of restorative, solution focussed work, delivered by the social worker, the couple's relationship was deemed to have changed and improved sufficiently to recommend closure of the case. Both parents expressed how they were pleased with the outcome of the work, designed to rebuild their relationship.

9.3.17 Two further management meetings took place between the team manager and the social worker. The management overview, recorded after the meetings concluded that the relationship issues experienced by Sibling V's parents, (which had manifested as acts of domestic abuse) had been successfully addressed in the three restorative solution focussed sessions.

9.3.18 In the belief that the intervention had changed the abusive dynamic of the parent's relationship, Sibling V was considered to be safe. The case was subsequently closed with apparent partnership agreement. However, the extent of this partnership agreement is somewhat unclear, as the health visitor contacted social services three months later in December 2014 to enquire if the social care restorative solution focussed relationship work had been completed.

New Learning

9.3.19 The suggestion of a restorative solution focussed approach to mend the couple's relationship was discussed, approved and agreed by the team manager and the social worker at their management meeting. It became apparent during the SCR interviews however, that each of these professionals held very different perspectives about whether the child protection threshold had been met and whether the parents had capacity to change. Despite an initial challenge from the family social worker the

final decision to plan an intervention below the level of child protection activity remained in place without further question.

9.3.20 The team manager enthusiastically embraced a progressive and proactive approach that met with full parental cooperation, however the allocated social worker was sceptical about the decision and less confident that the plan would achieve sufficient change. In addition she was concerned about her own limited experience in delivering such a programme, particularly within a very short timescale.

9.3.21 What is of interest to this analysis is the apparent disconnect between the perspectives of the two professionals, and the fact that their conversation did not facilitate sufficient professional respect and reflection to enable their respective thoughts, aspirations and fears to be thoroughly aired. Being able to articulate challenge and acknowledge differences and concerns through a courageous conversation is key to safe and effective planning for children and families.

9.3.22 The very nature of any meeting which involves a front line practitioner and their more senior line manager inserts a power imbalance that can make open and forthright discourse difficult for some practitioners. However, if concerns and differences remain unsaid, unchallenged or misunderstood, the unintentional consequences result in a poor working relationship, work place anxiety and poor quality care for the service user.

9.3.23 Personality and style inevitably affect workplace culture and activity. Disputes and conflict between frontline workers and between frontline workers and their managers, particularly at time when staff and team changes occur, are both exceedingly common and stressful.

9.3.24 Employees who feel disempowered or unsafe, or who perceive there is a difficulty in their working relationship, particularly with more senior staff, have a responsibility, and should be encouraged to seek appropriate external support without feeling they have to resort to extreme measures such as triggering formal grievance procedures. Easily accessible support systems that promote discussion, mediation, feedback and advice on resolving workplace concerns can improve the delivery of care to service users by preventing worker distress and distrust from escalating (ACAS, Mediation: An approach to resolving workplace issues - 2013).

2. Multi-agency Recommendation (Norfolk LSCB)

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.

9.3.25 The use of restorative solution focussed brief therapy in this case was highly questionable. The British Psychological Society has cautioned against this methodology as a means of couples counselling for cases where domestic abuse and violence feature in the history. Its indiscriminate application for the purpose of improving relationships can result in an escalation of violence and abuse rather than reduce it (Harway and Hansen 1994). More effective interventions for relationships

known to be abusive have been found to be those that offer peer support, safety and separation planning, refuge and advice on housing and legal remedies.

9.3.26 A list of the pitfalls for professionals of adopting a restorative solution-focussed approach is well documented by Frank Thomas (2007) in a handbook for clinicians. He describes a tendency for 'Pollyanna thinking' which results from a sincere professional desire for the method to work and which leads to an over-optimistic spurious belief that the method has resulted in lasting change.

9.3.27 Where relationship work is indicated and violence and abuse features in the history, it should be delivered by highly trained and qualified psychotherapists, and incorporate the necessary supervision and formal risk assessment processes to evaluate the ability of the couple to change their behaviours and measure the likelihood of those changes being sustainable in the longer term.

9.3.28 With good intentions, and in good faith the plan was executed in the belief that the intervention, which consisted of three sessions, delivered by an inexperienced and untrained practitioner, would successfully change the couple's behaviour. The underlying history of abuse, minimisation and denial, coupled with evidence from research suggests that the chance of the short solution focussed intervention achieving a positive and lasting change was negligible. The intervention was inevitably adult focussed and the evaluation of the work was not clear about how the programme had improved the lived experience of Sibling V.

9.3.29 The interventions available for children and family work are many and various. They include solution focussed techniques where appropriate and they can be successful, providing that domestic abuse is not a family dynamic. It is important that the workforce understand the limitations of some of the intervention processes and tools available to them and that organisational systems facilitate both competent and confident delivery of interventions based on appropriate competencies, training and supervision.

3. Multi-agency Recommendation (Norfolk LSCB and Norfolk DASVB)

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

9.4 Care Episode 4: Agency activity from the antenatal booking until one month following Child V's death.

9.4.1 At the end of April 2015, Sibling V's mother had booked for antenatal care with the midwifery service. Documented ethnicity and first language information is slightly confusing in that Sibling V's mother replied 'yes' to having a good understanding of English and also 'yes' to needing an interpreter. These confused responses, given at the antenatal booking appointment, might have indicated that her understanding of English was rather less developed than supposed. Either way, there is no record of an interpreter being used for the booking or subsequent ante-natal appointments. The

reason was not explained.

9.4.2 Sibling V's mother attended all antenatal appointments as planned. The antenatal routine enquiry questions about domestic abuse remained unasked throughout the antenatal period. The midwife cannot recollect why the questions about domestic abuse were not asked, although it appears that at this time the routine enquiry departmental protocol was not considered as a practice requirement and its usage was rather ad hoc. A hospital policy to enable routine enquiry as a midwifery standard has since been developed. The midwife also told the SCR panel that the presence of the patient's partner might also have been the reason for the omission.

9.4.3 Maternity antenatal documentation does not include any reference to Child V's father. Given that no sources of historical information were available to the antenatal midwife during the pregnancy, and meetings between the health visitor and community midwife were not taking place, it is unsurprising that the history of abuse and previous safeguarding concerns remained unknown.

9.4.4 The pregnancy progressed without incident until spontaneous labour started early at 26 weeks. Child V was born at 26 weeks gestation and as such was an infant who would require intensive care in a Neonatal Intensive Care Unit (NICU) to support her immaturity. The neonatal notes recorded the ethnicity of the parents as Latvian for mother and Lithuanian for father. Both were identified as Russian speakers.

9.4.5 After a short admission to a regional unit, Child V was transferred back to the local hospital NICU. Neonatal staff confirmed during the SCR interview that the NICU admission process did not routinely enquire about domestic violence and abuse, which is common to most NICUs in the country. The working assumption was that as the question was asked in the antenatal period, domestic abuse would be picked up by means of the maternity notes. The issue however had not surfaced during the antenatal period, so remained hidden to neonatal staff.

9.4.6 A health visitor from the community children's centre visited the NICU, to undertake a standard new birth visit at 13 days post-delivery, within the national standard timescale. The assessment was undertaken by a practitioner standing in for the allocated family health visitor, who was absent at the time. The SCR learnt that the covering health visitor had not reviewed the family's history prior to the visit, so she too was unaware that domestic abuse had occurred in the past. An opportunity therefore to inform the NICU staff of the abuse history was missed. Further conversations that took place between the NICU and the family health visitor concentrated on the clinical and medical aspects of the baby's progress. The NICU did agree however, to inform the health visitor of any discharge plans in advance.

9.4.7 Neonatal staff recorded their observations about parental involvement, noting some initial reluctance on the part of Child V's mother to undertake caring tasks. This is not unusual. Many parents find the NICU environment overwhelming and some are understandably nervous about interacting with their babies who are so small and fragile. In the early weeks Child V's father was noted to be the more confident carer, although Child V's mother became equally confident in handling her daughter as time went on.

9.4.8 The baby progressed slowly, requiring some paediatric medical interventions for common neonatal complications, but at the beginning of November 2015, Child V was well enough to be discharged home with a naso-gastric tube in situ to augment her feeding. The Neonatal Community Team (NCT) was mobilised to offer neonatal care and support at home.

9.4.9 The hospital neonatal records indicated the appropriate use of an interpreter for complex paediatric medical discussions, although interpretation was not used when teaching the parents essential techniques such as passing a naso-gastric tube and infant resuscitation. These instructions, undertaken before discharge, require a high level of understanding. Failing to use an interpreter might have accounted for the rather substandard technique employed by the parents and observed by NCT staff, when they attempted to replace their daughter's nasogastric tube. The use of interpreters is discussed later in this report.

9.4.10 Despite the previous agreement, the health visitor was neither invited to the NICU pre-discharge meeting, nor notified when the infant went home. This did not follow the usual procedure which expected the Health Visitor to be contacted. No explanation has been given as to why this did not happen. The omission resulted in the health visitor learning of the discharge by chance when she telephoned to enquire about the baby's progress, one week after the family had gone. Routine discharge information was sent to the GP in a letter.

9.4.11 Throughout November and December 2015 there was reasonable joint working between the NCT and the health visiting service to support growth and development. Child V was formally handed over by the NCT to the care health visitor by means of a joint visit in mid-January 2016. Tube feeding had been discontinued by this time, as the baby was gaining weight.

9.4.12 The family health visitor raised the issue of domestic abuse with the family during the handover contact and was reassured by the parents that their relationship problems were 'in the distant past'. She therefore concluded that domestic abuse would be unlikely to happen again. This assumption was born out of an optimistic conversation with the parents and reinforced by the knowledge that successful 'couples counselling' had been delivered by means of a CIN plan many months before.

9.4.13 The health visitor made contact with the family again two weeks later. Child V was reported to be feeding well and gaining weight, although she had developed a habit of only falling asleep on her parents or in an infant chair. Child V's father described his daughter as being 'hard work'. He also disclosed that he was feeling very anxious about his unemployment and employment prospects which was impacting on his self-esteem as the 'bread-winner' for the family.

9.4.14 The conversation between the health visitor and Child V's parents, especially Child V's father was somewhat underestimated in its significance. The substantial change in family circumstances brought about by the arrival of Child V did not feature in the health visitor's assessment that failed to analyse or articulate how parental sleep deprivation and financial concerns might impact on the parent's ability to parent and attach to the new baby. Moreover the practitioner was of the opinion that abusive behaviours were firmly assigned to the past.

9.4.15 No specific actions to support Child V's father or mother featured in the plan although general ongoing support from a nursery nurse was recommended to monitor the new baby's health and weight. There was no mention in the notes of how Sibling V was adjusting to the new infant. At this time, Sibling V was attending a local pre-school nursery where he appeared to be thriving. The health visitor had decided therefore, shortly after Child V returned home from hospital, to discharge Sibling V from her caseload into the care of the school nursing service.

9.4.16 The health visitor's discharge summary indicated that there were no concerns about Sibling V's health or development. It did however, note that the family were caring for a premature infant, and also recorded that Sibling V's father had a history of domestic violence for which he had completed an anger management course. In light of the family's complex history and change of circumstances, it would have been appropriate to maintain continuity of service and delay Sibling V's discharge to school health until the family had settled and were requiring less intensive support.

9.4.17 With the benefit of hindsight, it is clear that serious stressors were emerging, with Child V's father being particularly affected and open about their impact. Encouraging a more holistic 'think family' approach with more attention placed on social factors including the engagement of fathers will enable health visitors to consider the wider context in which children are living.

9.4.18 The plan, based mainly on a narrow medical model, delegated the task of monitoring the baby's weight gain to a nursery nurse; this is common practice for babies who have identified feeding difficulties and it utilises an established skill-mix approach. However, whilst safeguarding knowledge and skills feature in nursery nurse training, as practitioners they are not sufficiently skilled or experienced to take a lead role for families with complex social histories or where safeguarding issues have been previously identified.

9.4.19 The description and behaviour of Child V was quite typical for a premature infant. It is common for premature babies to be anxious. They frequently present with sleep and feeding problems, which together result in a great deal of crying. Following Child V's collapse, it also came to light that Child V had experienced previous head trauma and a fracture to her arm; this too would have caused the baby pain and distress.

9.4.20 Taking a small and vulnerable infant home is a truly overwhelming experience, and many parents are totally unprepared for it. The extra physical and mental stamina required for caring for a premature infant are neatly set out in a publication by BLISS (2012), a charity for parents of premature and small for dates babies. What is clear is that a combination of parental anxiety, tiredness and the considerable needs and demands of a premature infant entirely dependent on its parents can be a challenging experience with little respite or reward. Caring for a new pre-term infant at home can indeed be 'hard work', emotionally and physically.

9.4.21 Abusive head trauma, defined by a collection of neurological symptoms, is accepted as a form of non-accidental injury and deliberate harm. It includes injuries caused by shaking. Parental exhaustion and perceived disruptive behaviour such as unremitting crying spells have been identified as precursors in cases where babies

have died following a shaking episode.

9.4.22 Picking up on the anxieties of parents who are caring for premature babies must be considered in a safeguarding context, particularly when persistent crying is reported. Premature infants are physiologically fragile due to their immaturity, particularly so for the circulatory system in the brain. It is important for health visitors in particular to realise the additional stresses that premature infants place on the whole family and any historical accounts of domestic abuse increase the need for vigilance.

9.4.23 At the very least, the family's situation was worthy of an in depth discussion with regards to how both parents and both children could be supported through tailored care and support plans. Had the risks been formally analysed and calculated by means of a risk assessment, utilising current and historical information, a different action resulting in a more robust safeguarding response might have occurred.

9.4.24 The lack of focus on the whole family, and particularly on Child V's father, in the health visiting care plan is reflected in a recent research study undertaken by Cowley et al 2013 (Why Health visiting? DH Policy Research Programme). It explained that health visitors nationally were not giving enough attention to holistic care, concentrating merely on mothers and children, this despite the 'Healthy Child Programme' (DH 2009) requiring health visitors to take fathers into account. There are now national drivers in place to improve this area of health visiting practice.

New Learning

9.4.25 When Child V was admitted for neonatal intensive care, the safeguarding component of the admission process comprised of asking the parents if they currently had a social worker. The NICU response therefore relied on that answer rather than on any proactive systematic enquiry from professional colleagues, for example the health visitor, who could appraise the staff of any relevant health or social information.

9.4.26 Specific enquiry about domestic abuse did not figure in the NICU admission procedure either, as it was assumed to have been covered in the antenatal period. In fact, NICU staff remained unaware of the domestic abuse history and of any previous social care involvement for the entire admission.

9.4.27 Ongoing Health Visitor and NICU professional discussions and assessments whilst Child V was in hospital centred on the clinical and physiological development of Child V. Parental behaviours were briefly documented in the NICU case files by nursing staff, but little effort was made with regards to seeking out or understanding emerging parental anxieties which could affect the lived experience of Child V and her older sibling in the future.

9.4.28 The inter-professional information sharing and discharge planning element of the hospital discharge routine failed, causing the family health visitor to be totally unaware that the baby had gone home. The SCR panel learned that the time of this failure coincided with the removal of the hospital Liaison Health Visitor posts that had hitherto communicated discharge plans to community colleagues.

9.4.29 Post discharge, NCT professionals clearly worked hard to monitor and support

Child V to feed and gain weight independently, but there is little reference in the documentation that alludes to the social and psychological wellbeing of the family as they adjusted to their new circumstances, including parenting a vulnerable preterm baby at home.

9.4.30 A literature review of studies by Audrey Saftlas (2016) indicates that parental tension, abuse and/or violence during pregnancy can contribute to, or trigger pre-term labour. Another study by Neggers et al 2004 concluded that pre-term labour and low birthweight were distinct historical factors in high numbers of cases where children had been physically abused by their carers.

9.4.31 Furthermore, researchers have found that pre-verbal infants subjected to stress and cortisol release (otherwise known as the stress hormone) in utero and during the perinatal period are both physically and psychologically disadvantaged before and after birth (RCM 2012).

9.4.32 Taking all of this research evidence into account, it is reasonable to suggest that safeguarding children practice should assume a high priority in neonatal intensive care work. The conclusion of this SCR with regards to the period of time that Child V received NICU and NCT services is that the safeguarding and promoting the welfare elements of practice seemed rather underdeveloped.

9.4.33 Increased effort and attention to social as well as clinical wellbeing is necessary to ensure patient safety, including for safeguarding neonates who are innately vulnerable. Professional awareness of social information will only come about however through the implementation of a system which enables a robust exchange of information from and between the GP, HV, midwife and neonatal practitioner. The evidence submitted for this SCR, demonstrated weaknesses in this regard.

9.4.34 NICU staff should widen their focus to adopt a 'Think Family' approach. Assessments for example should include information about family stressors such as domestic abuse and/or previous safeguarding concerns. NICU systems should also facilitate seeking out health and social information from other parts of the system.

9.4.35 Neonatal practitioners contributing to this SCR felt that the recent introduction of safeguarding supervision in the NICU would inevitably improve practice, but suggested that formal safeguarding training would also be beneficial in order to improve the safeguarding skills set of professionals delivering care in the neonatal setting. The Intercollegiate Document of 2014: 'Safeguarding children and young people: roles and competences for health care staff' specifies that all clinical staff working with children and families should train to level 3 and receive regular training updates. The hospital trust is responsible for compliance with this standard.

4. NHS Inter-agency Recommendation

Neonatal, maternity and NCT services should implement systems to routinely gather and/or share safeguarding and domestic abuse information, particularly during NICU admission and on transferring a baby to another hospital.

A system should also be implemented to ensure multi-disciplinary pre-discharge meetings take place which summarise health and social wellbeing and facilitate continuity of care.

9.4.36 Child V collapsed at home and was taken to hospital by her parents towards the end of February in 2016 within two days of a contact by the nursery nurse.

9.4.37 The multi-agency safeguarding systems on admission to A and E worked well and there was efficient communication between children's services, healthcare professionals and police at the time of the acute admission and transfer to the PICU in Cambridge.

9.4.38 Strategy discussions and meetings took place swiftly and partnership actions were agreed. Arrangements for Sibling V were part of those discussions, and he was placed with his maternal uncle and aunt, a couple with whom he was very familiar. His father was to have no contact with him unless agreed in advance by children's services.

9.4.39 After Child V had died from her injuries her father was rearrested on suspicion of her murder and bailed to a relative's address. At the end of March 2016, some confusion arose about the bail conditions. Children's services understood that Sibling V's father would have no contact with any child under the age of 16 years. However they learnt that he was in fact living in a household where a thirteen year old was resident. Social services challenged the police and asked for this to be reviewed as they were understandably concerned about the potential child protection aspects of this arrangement. Following a review, including a risk assessment, social care agreed that the bail arrangement could continue on the proviso that Sibling V's father had no unsupervised contact with the resident child.

9.4.40 There was, on this occasion, a clear systems failure with regards to effective and timely inter-agency communication about a bail arrangement pertaining to a child protection case. However, both police and children's social care services have considered this matter and have subsequently given robust assurance to the SCR panel that this was a 'one off' failure and was not typical of practice generally. It is therefore not included as a recommendation.

Cultural Awareness

9.4.41 The matter of how culture and ethnicity impacted on this family and the lived experiences of Child V and Sibling V have been considered for each episode of care in this SCR. The County hosts a large Eastern European migrant population. Most practitioners working in the locality where this family lived would therefore have delivered care to eastern European families on a frequent and regular basis.

9.4.42 It has been difficult to see how the issue of culture and ethnicity influenced the actions and decisions of the organisations involved in this case. For example, fields relating to culture and ethnicity in original documentation were frequently left blank and practitioner assessments and case notes seldom mentioned or considered cultural difference as a dynamic.

9.4.43 Similarly, much of the documentation which spanned several years and multi-agency involvement described the parents as Latvian rather than Lithuanian nationals. This was incorrect. This suggests that re-checking the detail and accuracy of culture and ethnicity for family members was seldom undertaken.

9.4.44 Practitioners need to appreciate that 'Eastern Europe' is a generalised geographical term. Latvia and Lithuania are indeed similar in respect of being Baltic States that achieved independence from the USSR, becoming members of the European Union in 2004. They are, however, two distinct and different countries with language and cultural differences that should be acknowledged and respected. The value of being vigilant and culturally competent is known to be an important factor for scoping the additional needs and vulnerabilities arising from being a migrant. This was vividly explained in the Victoria Climbie Enquiry Report (2003).

9.4.45 Cambridgeshire, Peterborough and Norfolk Local Safeguarding Children Boards were funded by the DfE in 2016 to undertake an innovative project to improve the effectiveness of community engagement and safeguarding practice for Eastern European families. The report for this project (Safeguarding and Community Inclusion: Final Project Report) was accepted by NSCB in 2016. The report provides a useful breakdown of the local Eastern European migrant population in Norfolk.

9.4.46 A key outcome for the DfE funded project, was to promote community engagement and cultural proficiency. However when reviewing evidence and during the SCR practitioner event it became apparent that the workforce in general was not aware of this NSCB document. Further work needs to be undertaken by NSCB to disseminate the findings of the report to ensure the workforce is both aware of and can apply the learning into their practice.

9.4.47 The question of whether alcohol misuse and/or domestic abuse was culturally significant was also raised within SCR panel and practitioner discussions. Anecdotal evidence was put forward by the police specifically, that suggested two thirds of their 'call outs' for domestic disputes seemed to be from the Eastern European community.

9.4.48 It is true that both the Latvian and Lithuanian governments are concerned about high levels of alcohol consumption, describing it as a serious social and public health problem for each country (McKee M et al 2017). Similarly, both Governments have identified that much work needs to be done in relation to gender violence and domestic abuse which continue to cause concern and which are outlined in a mapping exercise undertaken by the European Commission Directorate - Justice, Freedom and Security in 2012.

9.4.49 However, domestic violence is found in all societies and surpasses all geographical, cultural and socio-economic boundaries. To conclude that domestic violence and alcohol abuse were generally culturally significant for the Eastern European population in Norfolk, or that one particular community of children is at increased risk in the County would require hard statistical evidence, and no such evidence was produced to suggest this is so. Furthermore, alcohol consumption is not always a factor in domestic abuse, being cited as a disinhibitor for, rather than cause of violent behaviour. (Galvini 2004).

9.4.50 Two studies by Brandon et al (2012 and 2016) have concluded that when any child's family context includes a combination of parental alcohol consumption and domestic abuse, the child could be at increased risk. The significance in practice therefore, is for professionals to be extra vigilant and alert to the impact of a combination of parental alcohol and domestic abuse on any child's individual lived experience, safety and wellbeing, irrespective of their culture and ethnicity.

9.4.51 Lastly the matter of language difficulties and the consistent use of interpreters has been highlighted as an area for improvement. The family's ability to communicate in English was judged to be both problematic and not problematic in equal measure. Practitioners and professionals contributing to the practitioner event came to the conclusion that whilst the family could communicate well enough in English about day to day eventualities, they were probably unable to achieve a full understanding when conversations became complex, technical or stressful.

9.4.52 Practitioners also discussed their concerns about the quality of the interpretation services open to them in Norfolk. The police in particular found interpreters' lack of knowledge and skill in safeguarding matters frustrating, describing how at times they would need to translate the meaning of technical or complicated questions for the interpreters before they, in turn could relay the question to the user of the service.

9.4.53 In addition, the telephone interpretation service was described as problematic. The artificial nature of interacting with another person through a third party and a telephone device was considered to cause rather than alleviate communication difficulties. The frequent unavailability of an appropriate translator, plus issues of connectivity also prevented a meaningful conversation taking place. A combination of the above resulted in the likely, and inherently risky use of relatives to translate sensitive conversations, or practitioners trying to make themselves understood without using an interpreter at all.

5. Multi-agency Recommendation (Norfolk LSCB)

Norfolk LSCB 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.

6. Multi-agency Recommendation (Norfolk LSCB)

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.

10 Conclusion

10.1 This review concentrated on the single and multiagency practice that was delivered to Sibling V and Child V over a three year period between 2013 and 2016, a time when many services were in a state of transition and responding to service reorganisation resulting from a change of Government in 2010.

10.2 It became apparent that many features in the history mirrored exactly those found in an earlier SCR (Norfolk SCR Case R January 2017) which occurred within a parallel time-scale and within a similar family context of domestic and alcohol abuse. The case also occurred in the same locality of Norfolk, and many of the teams and professionals were common to both cases.

10.3 The fact that identical poor practice points were found in both cases supports an overall conclusion that some single and multi-agency safeguarding systems and processes in place at the time were generally in urgent need of review and improvement.

10.4 This SCR has concentrated on new areas of learning that did not appear in the Child R SCR. There is ample evidence in the NSCB SCR improvement plan that the findings from the Child R SCR have been prioritised as areas for improvement. To enable and reassure the reader that practice points raised in this report have been accounted for, the themes and issues from the Child R SCR have been cross-referenced in the prologue of this document, ahead of the analysis for this report.

11 Assurance and monitoring

11.1 Norfolk Safeguarding Children Board, has responded positively to the Child R SCR recommendations and is in the process of implementing a comprehensive action plan to improve several areas practice. New recommendations from this SCR will be added to the existing plan.

11.2 NSCB has an assurance function with regards to the progress and implementation of the SCR recommendations for this SCR, including those recommendations requiring a more single agency approach. Full implementation of any recommendations that apply to an individual agency, are primarily the responsibility of the agency concerned.

11.3 Norfolk Safeguarding Children Board will take sole responsibility for implementing recommendations that are thematic in nature, i.e. generalised to one or more agencies in the partnership, and also for disseminating the new learning from this SCR to all of the partner agencies in Norfolk.

11.4 Finally, NSCB will formulate a formal response to the findings of this SCR to explain how the recommendations from this review will be considered in the current NSCB work plan. This will be available to agencies and will be posted on the NSCB web-site.

12 Summary of Recommendations

No	Recommendation	Rationale	NSCB Thematic Learning Framework Category
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.	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	Theme: Collaborative working and decision making; <u>Associated Lines of Enquiry</u> • Inter-agency collaboration and participation • Services provided • The impact of alcohol and domestic abuse
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.	A professional difference of opinion about a risk assessment, managerial decision and care plan remained unresolved due to hidden tensions within the team dynamics.	Theme: Ownership and accountability. <u>Associated Lines of Enquiry</u> • Services provided • Supervision and oversight
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.	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.	Theme: Ownership and accountability. <u>Associated Lines of Enquiry</u> • Services provided • The impact of alcohol and domestic abuse

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.	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.	Theme : Discussion and Information Sharing; <u>Associated Lines of Enquiry</u> • Policies and procedures • The impact of alcohol and domestic abuse
5	Norfolk LSCB 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.	Practitioners were unaware of the final report designed to improve cultural awareness and competency in the County.	Theme: Collaborative Working and Decision making; <u>Associated Lines of Enquiry</u> • Services provided • Family engagement
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	The use of interpreters across the partnership was inconsistent and did not always follow best practice guidelines.	Theme: Discussion and Information Sharing <u>Associated Lines of Enquiry</u> • Services provided • Family engagement • Policies and procedures

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14 GLOSSARY

A&E	Accident and Emergency Department
CAD	Computer Aided Dispatch
CIN	Child in Need
CPS	Crown Prosecution Service
DASH	Domestic Abuse Stalking and Harassment
DASVB	Domestic Abuse and Sexual Violence Board
DFE	Department for Education
DH	Department of Health
FSW	Family Support Worker
GP	General Practitioner
HV	Health Visitor
IDVA	Independent Domestic Violence Advocate
LSCB	Local Safeguarding Children Board
MARAC	Multi-Agency Risk Assessment Conference
NCHC	Norfolk Community Health and Care Trust
NCT	Neonatal Community Team
NFA	No Further Action
NICU	Neonatal Intensive Care Unit
NHS	National Health Service
NHSE	National Health Service England
NSCB	Norfolk Safeguarding Children Board
PICU	Paediatric Intensive Care Unit
QEH	Queen Elizabeth Hospital
RCM	Royal College of Midwives
RIU	Rape Investigation Unit
SARC	Sexual Abuse Referral Centre
SCR	Serious Case Review
SMT	Senior Management Team