



Norfolk Safeguarding Children Partnership

Report of the Serious Case Review regarding Child AG.

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1. Circumstances that led to this Serious Case Review

- 1.1. In September 2018 Child AG¹, then aged two and a half, presented at hospital severely malnourished and neglected. At the time of this presentation AG was in the care of his mother and father. Child AG is the fourth child in a sibling group of six. The case had been managed under a Section 47² of the Children Act but had recently been stepped down to be managed under a Child In Need Plan (Section 17). There had been previous concerns about the family including neglect and domestic abuse. A skeletal survey was completed on the 02.10.18 to investigate possible bone disease. As a result of this it was identified that there were bi-lateral humerus³ fractures of varying ages; there was no evidence of bone disease. The X-rays also confirmed malnutrition over time.
- 1.2. AG's siblings were taken in to Police Protection on the 03.10.18 and placed in foster care. Police investigations and Care proceedings were still in progress at the time of writing this report.
- 1.3. The case was considered by the Serious Case Review Group (SCRG) on the 08.10.18 and it was agreed that the case met the criteria for a Serious Case Review (SCR), that is:
 - A child has suffered significant harm
 - Abuse or neglect of a child is known or suspected
 - There is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.
- 1.4. The independent chair of Norfolk Safeguarding Children Board (NSCB) accepted the recommendation to conduct a SCR on the 10.10.18, in line with Chapter 4, Working Together⁴

¹ To protect children's anonymity all the children are referred to using the male pronoun.

² The Local Authority have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm,

³ The humerus is a long bone in the upper arm. It is located between the shoulder and the elbow.

⁴ Working Together to Safeguard Children, HM GOVT 2015. This SCR was commissioned while LSCB was still in statute.

- 1.5. At the time of Child AG's presentation and subsequent diagnosis of malnourishment over time, and healing fractures (of varying age) to the arms, there were a number of agencies involved with the family.

2. Methodology and Terms of Reference.

- 2.1. Full details of the review process are included in Appendix 1. In summary, an independent lead reviewer worked alongside a review team, composed of senior managers, and facilitated by the NSCB Business Manager. The purpose of the SCR was to review the involvement of the agencies involved with the family to understand how professionals had understood the cause and nature of the family's difficulties, and how effectively professionals had responded. The focus of the review was to learn about how the local safeguarding systems are operating and if any changes may be required as a result of the wider lessons from this case. The SCR considered the work of the following agencies:

- Local Authority Services (including: Children's Services, Early Years, Community and Environmental Services)
- Education
- Womans Refuge
- Health agencies (including: Community Services, Midwifery Services, Acute and Community Paediatric Services, General Practice)
- Housing
- Norfolk Constabulary
- Services provided by neighbouring county.

- 2.2. The timeframe for the review was from March 2016, when Child AG was born, to the 30 September 2018, after AG had presented at the hospital suffering from malnutrition and healing fractures to his upper arm.

- 2.3. The Serious Case Review Panel identified specific lines of enquiry grouped against: expected standards and procedures, and cultural competence in the context of working with families from a travelling community, with a particular focus on the recognition of neglect and malnutrition (see Appendix 1)

- 2.4. The SCR was also asked to use the NSCB's Thematic Learning Framework (see Appendix 2) and to consider learning that has already been identified within a number of recent Norfolk reviews.
- 2.5. **Contribution of Family members.** The involvement of key family members in a review can provide particularly helpful insight into the experience of receiving or seeking services. At the time of writing this report it has not been possible to meet with family members due to ongoing criminal proceedings.

3. Brief Summary of the Case.

- 3.1. **Background:** The family left their home in a neighbouring county citing that they no longer felt safe in their own home due to experiencing violence and intimidation from their neighbours which included reports of being shot at using a BB gun.⁵ The family felt victimised because 'they were from a traveller background'. The family had been provided with a travel warrant⁶ by the housing department and travelled to a town in Norfolk where it was reported that a maternal aunt lived. The family's application of homelessness was turned down by the borough council as the view from the police and housing department in the county they had left was that the family could safely return to their home. The family were deemed to have made themselves intentionally homeless.⁷ At the time the family moved they were receiving support from Early Help Services, General Practice and the Health Visiting service.⁸ AG had been born prematurely at 31 weeks' gestation and spent a period of time in Special Care Baby Unit (SCBU). Following discharge AG was not taken for any follow-up appointments with the consultant paediatrician despite re-referrals made by the GP. AG's younger sibling was also born prematurely at 35 weeks' gestation and again had failed to be brought for a consultant paediatric follow-up⁹.
- 3.2. The mother contacted a Womans Refuge from a local railway station stating that she was fleeing domestic violence with her five children and had nowhere to go. The mother and her five children were accommodated at the refuge on the same day. A

⁵ A type of air gun designed to shoot metallic projectiles called BB's.

⁶ With an explanation that the family were owed a duty of housing elsewhere- housing authorities must ensure that suitable accommodation is available for the applicant and their household, until the duty is brought to an end, usually through the offer of a settled home.

⁷ Section 119 of the 1996 Housing Act <https://www.gov.uk>Housing,local>

⁸ Universal plus service which meant that the family received a higher level of support from the service.

⁹ NICE guidance-developmental follow-up of children and young people born pre-term.

worker at the refuge noted that the mother presented as vulnerable, struggled to process information, had problems reading and writing and identified that she may have some level of learning difficulties. The mother left the refuge early in the morning with the children and arrived back late. It was discovered that not all of the children returned to the refuge each evening and when challenged the mother stated that they were at their aunt's house. We now know that the family were visiting the father in nearby woods where he was living in a tent and two of the children stayed with the father overnight to help and support the mother who found it difficult to look after five children under the age of five.

- 3.3. Following a referral to Children's Services (from the refuge and police) in early November 2017 a decision was made to undertake a Social Work Assessment (SWA) under Section 17¹⁰ - to explore areas of developmental need and parenting capacity. The parenting capacity assessment was never completed, the decision was taken that this would be completed when the family were permanently housed (it has not been possible to determine why this decision was made but will be reviewed under the quality of the CPP). During the assessment period the eldest sibling made a disclosure of physical abuse by the father to a teacher. A strategy discussion took place and it was agreed by all agencies that the threshold for an Initial Child Protection Conference (ICPC) had been met. All five children were made subject to a Child Protection Plan (CPP) under the category of neglect. The parents did not attend the ICPC. The assessment was completed by SW1 and then allocated to SW2 (male). At the time the Family Intervention and Social Work Assessment Team were separate but have since joined together.
- 3.4. Following the ICPC appointments were made for AG and his younger sibling to be seen by the community paediatrician for developmental assessments as there had been no follow up from the point of discharge from the SCBU where the children were born (nearly two years and one year respectively). The HV identified that the parents had failed to take AG and his sibling for five appointments during a six-week period (December 2017-January 2018). When AG was examined by a paediatrician in the middle of February 2018 following identification of bruises by the HV on a home visit, the doctor recorded:

¹⁰ Children Act 1989. States that it is the general duty of every local authority to safeguard and promote the welfare of children. An assessment is undertaken to decide whether the child is in need.

- that the parents had clear explanations for the bruising and concluded that there was no evidence of non-accidental injury.
- The doctor described AG as a ‘sick little boy who is weak’ and to be followed up in the community due to developmental delay thought to be due to his prematurity.

At the time there was no CP alert on AG’s records as when the notification had been received from CS following the ICPC, Medical Records were unable to find a matching patient; they registered a new patient and the alert was not put on. This is a systems failure and the NSCP will require assurance that this has been rectified for any future cases.

- 3.5. The mother and her five children left the refuge in early February 2018 and moved into a caravan with their father on a traveller site. The issue of domestic abuse had been attributed as a false statement in order to be accepted into the refuge and the violence experienced was by their previous neighbours. There were concerns about the environment and cramped conditions. The three older siblings were not attending school or nursery (they had not been seen since the end of January). The mother was pregnant due to deliver in September 2018.
- 3.6. Child AG was seen by a paediatrician (the same paediatrician who had examined AG when bruises were identified by the HV) in February 2018 for examination and assessment (the outstanding assessment from ICPC and the first Paediatric assessment following discharge from the SCBU). The outcome of the medical examination was that AG was delayed in more than one area of development and that this was due to his prematurity and low birth weight. It is accepted that children who prematurely may present with developmental delays and an allowance is given to children up to the age of two years. AG’s weight and height were recorded as on the 0.4th centile.¹¹ The paediatrician recommended that the GP refer AG for Speech and Language, growth monitoring by the HV and referral to the Child Development Centre.
- 3.7. Team Manager 1(TM1) visited the family in early March 2018 on a pre-arranged visit because SW2 was unable to get to work due to the adverse weather. TM1 attempted to find Bed and Breakfast accommodation for the family over the weekend so that they could be in warmer surroundings - there was none available. TM1 recorded that “AG is clearly a very vulnerable child and his needs could become quickly lost in the

9. UK World Health Organisation growth charts: growthcharts@rcpch.ac.uk

home” The case was transferred back to SW1 following the departure of SW2. The review case conference on the 20.03.18 was held; the children remained subject to a plan. Over the next two months the professionals continued to work with the family. The records of the visits continued to describe the cramped and overcrowded caravan and ongoing concerns about AG’s development, particularly gross motor skills and fluctuating weight. The parents were also challenged by the HV about watching inappropriate films that the children might find frightening - the parents stated that the children were always asleep. The community midwife made a referral to the Multi-agency Safeguarding Hub (MASH) following the booking appointment.

- 3.8. At a home visit in early May by the HV it was recorded that AG still had visible marks on his spine and scratch marks on the left-hand side below the rib-cage. AG was reported to have gained some weight but was still on the 0.4th centile. AG was reviewed the next day by a community paediatrician, the outcome of the assessment was that AG’s development was progressing slowly and his weight was still on the 0.4th centile. A referral was made to the physiotherapy service due to stiffness in the legs and he was to be reviewed in six-months. This information was shared with GP but not with SW1. Three days later at the core meeting the mother stated that she felt that HV1 was always watching AG and questioning bruises and abrasions that had been sustained. The mother also stated that she should be able to watch her films when the children were asleep; the HV reiterated the importance of ensuring that the children were asleep. SW1 stated that the children had not voiced that they had been frightened by any films that they might have seen (it is not known how this information was obtained by SW1)
- 3.9. The Eden Team¹² conducted their initial risk assessment on mother’s sixth pregnancy using Signs of Safety and a plan was put in place. A joint visit was to be conducted by HV1 and the Community Midwife (CM) by 28 weeks’ gestation and a pre-birth risk assessment to be completed. HV made a home visit; AG’s weight had dropped by 1kg from when he was seen by paediatrician. The HV discussed this with the team leader and was advised to weigh again in two weeks. At the core meeting held in early June AG’s fluctuating weight was shared. The view from professionals was that good progress had been made with the child protection process, the parents had engaged well with professionals to significantly reduce the risks to the children. The outcome of this meeting was that SW1 was to consider whether the review child protection

¹² Specialist team of midwives working with vulnerable women during pregnancy.

conference could be brought forward and step the children down to a Child In Need Plan (CIN). The HV weighed AG in the middle of June in three different parts of the caravan - the range was 8.1- 8.5 Kg; the plan was to weigh again in a further two weeks. The HV weighed AG again in early July and it was recorded as 8.8Kg. AG was observed eating a packet of crisps (this was the third time). Both parents reported that AG eats well, mother enquired whether she should give AG 'build up' drinks, HV advised mother to discuss with GP.

- 3.10. A pre-birth meeting between Children's Services and health took place in the middle of July, it was confirmed that CS had rejected the proposal of obtaining the family a new trailer but were supportive of providing a deposit. Due to the size of the family many of the landlords were unwilling to take them on. There had been a suggestion that the family may have to be split up in order to obtain housing an option that the family quite rightly did not want. All professionals in attendance at this meeting were aware that the housing issue would need to be rectified prior to the birth of the baby (due in September).
- 3.11. AG was seen by the physiotherapist; the assessment was recorded in hand held notes only. It was noted that AG had a bruise on his left cheek (he had been crawling near the caravan door and had fallen) and sores around the nappy line. The mother stated that AG had been seen by the GP for the severe nappy rash and had been given cream. SW1 was informed about the presentation and explanations given by AG's mother. (over the next two months AG missed four physiotherapy appointments and a hip X-ray).
- 3.12. At the Core meeting held on 23.07.18 it was noted that the attendance of the three older siblings at school and nursery, had fallen from the middle of June. (The children do not return to school after the summer holidays) AG's fluctuation in weight was discussed and mother was advised to take AG to the GP.
- 3.13. In mid-August 2018 the sixth baby was born prematurely at 34 weeks' gestation; the baby was fit for discharge on the same day. Over the next few days the midwives became increasingly concerned about the sleeping arrangements for the new baby in the caravan and specifically about the risks posed in the over-crowded caravan. Housing were unable to provide any temporary accommodation over the Bank Holiday weekend but SW1 was confident that the family would be offered something on Tuesday. The Safety Plan was not supported by the Eden Team Midwife; she had

discussed with her line manager who supported the challenge made to CS. There continued to be disagreement between the midwifery service and CS about the safety and suitability of the home environment. SW1 disagreed with the midwifery view and the HV felt that the home conditions were as safe as they could be. The case was now being managed by TM3 who discussed with Head of Social Work (HoSW). TM3 sent SW1 and an Early Help Family Focus Practitioner who was experienced in using The Graded Care Profile (GCP) to have 'a fresh pair of eyes' on the living conditions. The outcome of the visit was that the living conditions were suitable although the GCP was not completed. A written copy of the Safety Plan was given to the parents.

- 3.14. As well as concern about the sleeping arrangements the Eden Team Midwife was concerned about AG's condition and described him as 'malnourished'. The HV visited the following day after discussion with SW1 who informed the HV that midwifery had raised concerns about housing and the presentation of the other children. AG was weighed and had lost 1.2Kg from the last visit (05.07.18). The HV noted that AG looked "slender with ribs visible"; the mother reported that AG continued to eat well and had not been ill during this period. The mother was advised to take AG to the GP that day. The GP was aware of the concerns surrounding AG's health and development. The mother did take AG to see the GP- the outcome was that "baby was well in himself" and to be seen by the dietician next week. HV informed SW1 about the weight loss.
- 3.15. The relationship between the Eden Team midwife and SW1 continued to be strained and SW1 was accused by the midwife of colluding with the family. The planned meeting between Head of Social Work and Health Safeguarding did not take place but a telephone conversation did. This failed to resolve the difference of opinion between the midwife and SW1 in how the case was being managed and that the concerns about AG remained in that he was "malnourished".
- 3.16. During the first week in September 2018 the mother did not engage with the midwifery service in the same way. HV1 contacted the mother to arrange a joint visit with the midwife. Initially the mother refused as she stated that she thought that they were "judgemental" and had concerns about AG. The mother agreed to a joint visit on 10.09.18. At this point the family were accommodated into a larger trailer, for one week only.

- 3.17. The physiotherapist discussed safeguarding concerns with the Named Nurse during a supervision session on the 11.09.18. The concerns arose from the initial assessment in July 2018 when AG had sores around the top of the nappy area, a nappy rash and was reported to be dirty. The mother had failed to bring AG to subsequent appointments with the physiotherapist. The Named Nurse suggested that AG needed to have a planned paediatric medical. The Named Nurse and physiotherapist attended the review conference the following day.
- 3.18. The review child protection conference was held; the decision to step the children down to a Child In Need Plan was unanimous as they were no longer at risk of significant harm, however, Child AG was to have a child protection medical (see paragraph 3.17). The mother requested another health visitor as she was unhappy about the questioning about food in relation to AG. Four days after the conference the family moved into temporary accommodation.
- 3.19. AG attended for the booked Child Protection Medical, the medical problems were as follows:
- Marasmic Kwashiorkor (severe malnourishment with oedema)
 - faltering growth,
 - gross motor delay of unclear cause,
 - severe nappy rash,
 - severe constipation (faecal impaction),
 - de-pigmentation of unclear cause,
 - Vitamin D deficiency and
 - Iron deficiency anaemia.

AG was admitted on to the ward, the mother refused to allow photographs to be taken as “it is against her religion”; photographs were subsequently taken after the Strategy meeting. The mother signed the safety plan which stated that AG would remain in hospital until the doctors deemed him to be medically fit and if the parents attempted to remove AG then Police Protection (PP) would be obtained to keep AG safe.

A strategy discussion took place. The plan was for a joint Section 47 investigation to commence. All of AG’s siblings were to undergo child protection medicals. The family and all children were seen at the temporary housing by the police and CS - there

were no grounds for PP. The case was re-allocated to SW3. The child protection medicals carried out on AG's siblings did not identify any concerns.

- 3.20. The skeletal X-ray on AG identified healing fractures of varying ages to the upper arm. AG's five siblings were removed under Police Protection and placed with foster carers.

4. Areas of Practice Learning

4.1. Introduction

This section of the Review assesses the quality of multi-agency practice at the key points that are considered to provide the most significant learning. In doing so, the Review considers the information that was known, or could have been known, at the time of the events alongside the individual agency practice standards. Where there is information about why practice may not have met required standards, this is explained. By understanding why things happened in the way that they did, rather than simply what happened, the SCR is seeking to achieve a greater depth of learning about safeguarding systems within Norfolk, and beyond this individual case. The review focuses on six areas of practice learning; however, the areas overlap and impact on each other and demonstrate the complexity of what is happening at a given time.

Child AG and his siblings were being seen regularly as part of the child protection plan and the plan was being implemented. At the ICPC the areas of concern and risks were clearly identified and a plan put in place to reduce the risk of significant harm to the children. The CPP was realistic in meeting the needs of the children, the focus for the plan was to support the parents in meeting the needs of the children to include parenting and supervision, ensuring that AG and his sibling attended all medical appointments and assessments and that the children attended school and nursery on a daily basis. The plan also identified the need to support the family in gaining suitable accommodation that would provide a safe environment for the children to live in. The statutory visits both announced and unannounced took place and the core meetings were held monthly. What is evident over the nine months that the children were subject to a plan under the category of neglect, is that the entries become more descriptive with little analysis or impact on what this means for the lived experience of the children. The fact that the children were living and continued to live in over-crowded and challenging conditions seemed to be accepted by all professionals with the exception

of the midwife. The professionals appear to have been desensitised to the ongoing and chronic neglect of the children and the concerning weight loss of AG.

The child protection procedures that the NSCB and its member agencies had put in place, in adherence to Working Together 2015, had been implemented in the way they had envisaged throughout the involvement with the family. With some important exceptions, agencies coordinated their work, shared information and came together to implement the child protection plan. There was a systematic approach to evaluating risks using the Signs of Safety approach.

Despite generally robust systems being in place, there were some gaps in practice which need to be considered in order to learn from them. For the purpose of gaining a better understanding of how and why, the learning has been separated out into six areas, however, they do overlap with one another and should not be viewed in isolation.

4.2. How did the safeguarding network assess the risk and impact on the mother and children of the reported domestic abuse from: the father, extended family and neighbours?

4.2.1. Research¹³ shows that domestic abuse is a significant health issue for the Gypsy & Traveller community. A recent study estimated that between 60% – 80% of women from travelling communities experience domestic abuse during their lives, compared to 25% of the female population generally. While many incidents of domestic abuse are perpetrated by husbands and intimate partners, other family members may be perpetrators of domestic abuse. Domestic abuse is accepted as normal for many women. Trapped by culture, poor literacy and education, distrust of the police and social services, and fear of separation from family and friends, Gypsy and Travellers are far less likely to report an incident or to seek help. Domestic abuse, often physical violence, impacts upon the victim's mental health and upon their children.

4.2.2. The refuge was concerned about the vulnerability of the mother and recognised that she had some learning difficulties. The mother also spoke about an incident whereby the father had thrown a puppy against a wall to kill it. The mother later denied the domestic abuse and stated that she had made it up, and that her partner was not and

¹³ Firstlight.org.uk

never had been violent towards her. Following the disclosure of physical abuse made by AG's eldest sibling, both parents denied this. They stated that they would never hit their children and the mother said she would never 'stay with someone who hit her or the children'. The parents expressed a view that AG's sibling was always making up stories. The workers in the refuge were concerned that the mother continued to visit the father with the children following the alleged incident even though she had been told not to do so. The mother stated that she would be unable to manage the care of all the children without his support.

- 4.2.3. At the Initial Child Protection Conference, the risks were clearly identified including: concern about how open the parents were being about their relationship, the reporting and then retraction of domestic abuse, the possible controlling (financial) and abusive behaviour of the father towards the mother, domestic violence within the extended family and the violence from the neighbours. One of AG's siblings described dad as 'angry' and mum and dad as 'sad'.
- 4.2.4. The professionals in the network seemed to either accept the explanation given by the parents that they had made domestic abuse up to secure a place of safety for the children, or minimise it. There had been no reported domestic abuse incidents to the police since the family's arrival in Norfolk, this does not mean that there weren't any.
- 4.2.5. Professional authority comes from a position of confidence and competency in their understanding of the situation and associated risks. The Signs of Safety¹⁴ is a strength based and safety focused approach to child protection work and is grounded in partnership and collaboration. Risks must be assessed from the perspective of the child in a dynamic and ongoing cycle; "Assessments are a continuing process and not an event."¹⁵ The professionals that worked with the family had a varying understanding of how to work with travellers, poor knowledge of cultural beliefs and lifestyle. For some professionals this was the first case that they had worked with traveller families. The visits and interaction with the family became overly focused on recording what they had observed rather than analysing and assessing the impact of the situation in relation to the safety of the children.

¹⁴ A solution focused, strength-based approach to social work practice which can be applied across the child protection system developed in Western Australia in the 1990's.

¹⁵ Working Together 2018.

- 4.2.6. In this case the professionals lost sight of the domestic abuse and violence that had been reported and became focused on the housing situation; the view being that if the family had secure and appropriate housing then “everything would be alright.”
- 4.2.7. We now know that there was a serious incident in January 2019 (outside the timeline) which resulted in a Multi- Agency Risk Assessment Conference (MARAC). This is a meeting where statutory and voluntary agency representatives share information about high risk victims of domestic abuse in order to produce a co-ordinated action plan to increase victim safety. The father had slapped the mother on the face using a combat / hunting knife before prodding her under the chin. The father then did this with a wheel brace.
- 4.2.8. The professionals working in the safeguarding network are reliant on there being an open and honest relationship with the family that they are working with. If this trust and partnership working breaks down the danger is that there is no clear understanding of what is happening within the family, the possible increased risks or the lived experience for the children.
- 4.2.9. The conclusion of the review team was: there was a confusing picture and understanding of the domestic abuse within the family. The challenge for professionals is to obtain a deeper understanding of relationship dynamics. Assessments which concentrate largely on the source of current risk can miss the more hidden latent and complex indicators that might place children at risk of emotional and physical harm. There was a lack of professional curiosity and domestic abuse was downplayed possibly due to their traveller background and an unconscious bias of cultural norms from the professionals working with the family. Staff require a better understanding of traveller culture in order to feel less threatened and scared about working with this community. (see section 4.7.)

4.3. How well was the impact of the parents’ learning difficulty understood in relation to how they parented their children?

- 4.3.1. It is well documented that children maybe at increased risk where a parent/ carer has a learning need/disability. Professionals need to carefully consider the implications of relying on individual parents to follow through on advice or recommendations, bearing in mind that they may be unwilling or unable to do so. Professionals should consider

whether the failure of the individual to follow through on advice or recommendations is an additional level of concern.

- 4.3.2. There is substantial evidence concerning the range of problems that can impair parental capacity to meet the needs of children¹⁶ including: mental illness, problem drug and alcohol misuse, learning disability and intimate partner violence. Research also indicates that where parents were themselves abused or neglected in childhood there is an increased risk of maltreating their own children.¹⁷ It has been suggested that the more severe abuse or neglect experienced by parents in childhood, the more difficult it is to resolve losses and traumas, and the greater risk that parents will maltreat their own children.¹⁸
- 4.3.3. The extent of both parents' learning disability/difficulty were never fully understood by the professional network. Although it was recognised that the parents found it difficult to understand what the professionals were concerned about, there was little evidence to demonstrate that professionals had considered any other means of communicating effectively with them. The parents left their home in a neighbouring county and moved to Norfolk without any housing provision; they had an expectation that they could turn up and a house would be provided. Both parents had literacy problems and yet there was an over reliance on giving the parents written instructions or copies of plans without checking whether they understood the content. The mother was very clear that when Children's Services had asked her not to have contact with the father following the disclosure of domestic abuse she would continue to meet with him as she could not manage the five children on her own. The parents also had trouble understanding the concerns of the professionals when it was discovered that the children were sleeping overnight in a tent in November and December.
- 4.3.4. Professionals, especially those in targeted services, routinely work with adults who are distressed and needy, who have been damaged by their trauma and history. Professionals have to strike a balance between being supportive and positive towards the family in the steps that they have taken, but must maintain "healthy scepticism" and "respectful uncertainty."¹⁹ In this case the mother continued to require a level of support in order to meet the needs of her children.

¹⁶ Cleaver et al, 2011; Brown and Ward, 2012.

¹⁷ Reder et al 2003; Dixon et al,2005.

¹⁸ Howe 2005

¹⁹ Laming 2003.

4.3.5. The conclusion of the review team was that it was unclear whether the multi-agency network fully understood the impact of the parents' literacy and learning needs in order to care for and meet the needs of their children. As a consequence of this the parents did not have a level of insight about the concerns that were being raised by the professionals working with them or have a clear understanding of the expectations and outcomes that were required. The importance of constructive challenge and clear and simple communication using a variety of methods is a key learning point from this SCR.

4.4. How is 'neglect' understood and particularly the ability of services to identify and recognise malnutrition?

4.4.1. Neglect is defined in [Working Together to Safeguard Children 2018²⁰](#) as "the persistent failure to meet a child's basic physical, emotional and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. When the child is born, neglect may involve the parents or carers failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- Protect the child from physical and emotional harm or danger;
- Ensure adequate supervision (including the use of inadequate care-givers); or
- Ensure access to appropriate medical care or treatment

Child AG and his siblings were all subject to a Child Protection Plan under the category of neglect. NSCB has endorsed the use of the Graded Care Profile (GCP) as the assessment tool that should be used at the earliest opportunity in all cases where neglect has been identified. The GCP was the tool identified and agreed as part of the Neglect Strategy that all partners working in the safeguarding arena in Norfolk signed up to. The tool should be used for assessment, planning, intervention and review. It provides a measure of the care of the child across all areas of need, showing both strengths and weaknesses. Improvement and/or deterioration can be tracked across the period of intervention. It allows professionals to target work as it

²⁰ SCR commissioned under Working Together 2015 but definition is the same.

highlights areas in which the child's needs are, and are not, being met. It may also help parents/carers who may have experienced neglect themselves to understand why such behaviours are harmful.²¹ The GCP was not used in this case, had it been it may have helped all the professionals to have an objective measure of what real progress was being made, if any. The Neglect Steering Group has identified this as an issue and has conducted focus groups and a small multiagency neglect audit.²² The sample in the audit was too small to draw meaningful conclusions but it is clear that more work needs to be done in promoting and using this tool across all agencies.

When working with cases of neglect it is important that professionals focus on the needs of the children and not the parents/carers. Neglect is cumulative and not a result of one single incident. Assessment is critical in identifying the risks and determining whether the parents have the ability to change and importantly sustain the change required to reduce the risk of significant harm over time. There is a danger when categorising children experiencing neglect, that less attention is directed to the neglect itself or the associated risks that children may face. Neglect does not always achieve the same priority as other forms of abuse.

4.4.2. In this case there was concern about:

- the three older siblings attending education (school and nursery) on a regular basis,
- the parents keeping the paediatric appointments for AG and his younger sibling,
- the developmental delay and faltering growth of AG,
- the cramped and overcrowded housing conditions.

AG was described as "a vulnerable child and his needs could become quickly lost in the home". The professionals did not seem to consider whether AG was parented differently to his siblings or if he was being 'scapegoated' – although in the initial assessment it was identified that "the mother found it difficult to show a high level of emotional warmth towards AG". The potential signs of abuse/neglect observed by the professionals who visited the family at home were largely left unchallenged, the view was that the parents were doing as well as expected in the circumstances that they

²¹ NSCB multiagency safeguarding arrangements, policies and procedures.

²² Audit conducted in March 2019 to act as a baseline to inform practice and develop a work plan for the Neglect Steering Group (limited to four cases and not all agencies were represented in the audit).

were living in and if some permanent accommodation could be found then this would help, especially in giving more space for the younger children to play in. What was absent from the plan was how the impact of the environment in which they lived was having a detrimental impact on their development and attainment, and how the cumulative effect was assessed and a contingency plan put in place to affect change. AG's younger sibling who was also born prematurely was reaching his milestones and weighed more than AG who was a year older. The urgency of AG being reviewed by a paediatrician seemed to diminish over time and then when reviewed, the doctor did not seem overly concerned, although AG was described as a "sick little boy who is weak" (see 4.5). This seemed to be accepted without challenge or curiosity about what this meant in relation to the care and management of AG.

- 4.4.3. AG was described as being a small, thin child who was often observed either sitting on his mother's lap covered in a blanket or in the bottom of a double buggy. AG was unable to fully weight bear or walk unaided and had reduced movements in the lower limbs. We now know that this was due to muscle wasting due to insufficient food being taken in to allow normal growth and development. There had been concern about AG's weight and his general development. The health visitor regularly weighed AG, the Parent Held Record (Red Book) was not always available to record on the centile chart, although the weight was plotted on the electronic records. His weight had crossed more than two major centile spaces downwards and this should have prompted further exploration as to the cause, and to investigate or rule out any organic cause for faltering growth as well as considering whether there were any difficulties in the interaction between the child and the parents. The professionals relied on what the mother told them about what food AG ate, he was not observed eating anything other than bags of crisps. It might have been helpful to have asked the parents to keep a simple food diary to review the daily intake of nutrients and the calorific value.
- 4.4.4. Despite the core meetings discussing AG's fluctuating weight it was difficult to get a sense of whether this was of concern to the wider network or if the significance and impact on AG's development and growth was fully understood. Poor growth in infancy is associated with high childhood morbidity and mortality. This means that a child's growth is an important indicator of health and wellbeing. The professionals were aware that AG was seen and weighed regularly, the weight went up and down and the explanation given was it was due to AG's prematurity and developmental delay. AG's centile chart was never brought to the meetings by the HV and the other professionals did not challenge as to why this was not available. This meant that there

was no visual overview of AG's weight, this would have provided a very concerning picture. The parent(s) attended the core meetings: there were no professional meetings without the parents. Professionals should consider meeting together without the family in certain circumstances in order to allow an opportunity for mutual challenge without the risk of displaying different views or opinions in front of the parents. The process whereby a client splits a network into friendly and helpful people and others who are rejected needs to be guarded against. The reluctance to meet as a professional group is possibly being driven by "nothing about me without me."²³ Professionals need to strike a balance between having an open and transparent working relationship with parents but have an opportunity to meet and discuss concerns before sharing with the parents.

- 4.4.5. The first professional to draw attention to AG's weight with the term 'malnourished' when describing AG was the Eden Team Midwife who reported her concerns along with the risk to the new baby in cramped and overcrowded housing. Was this because AG was being seen 'with a fresh pair of eyes' and without the history of fluctuating weight and the opinion of the paediatrician? This will be further discussed under supervision and management oversight (see 4.6)
- 4.4.6. One of the Social Work Team Managers (TM3) told the SCR that when she saw the photographs of AG it was obvious that "something was wrong". It is unclear why other professionals missed this (with the exception of the midwife). Was the network overly reassured by the fact that AG had been seen and examined by paediatricians and the family GP who did not seem worried? Research suggests that medical dominance in health care has resulted in the work of other healthcare professionals being largely requested and supervised by doctors through control of referral systems.²⁴ The paediatrician queried why the HV had requested an assessment for AG, and then when the HV requested to know the outcome was told to wait for the report (overlaps with 4.5). This is not acceptable in the MAS arena and needs to be addressed urgently.
- 4.4.7. The conclusion of the review team was that there needs to be robust use of centile charts particularly in cases where there has been ongoing concern about growth and

²³ Liberating the NHS: No decision about me, without me (DH 2012)

²⁴ Churchmann JJ, Doherty C (2010)

development over a period of time. Professionals need to be aware of the signs of under nutrition which include:

- weight loss
- loss of fat and muscle mass
- dry hair and skin.

Despite NSCB (now NSCP) sign up to the Neglect Strategy and neglect identified as a priority, the multiagency leadership has not been consistently demonstrated. It was disappointing that despite the children being subject to a plan under the category of neglect the GCP tool was not used in this case. The use of the GCP in Norfolk is low with practitioners stating that it is another layer of assessment and is time consuming to complete. At the Learning Event professionals identified that the GCP is not used as an intervention tool and at times is muddled up with the Signs of Safety model that was introduced at the same time. The compliance of using the GCP is an issue across the country and is not specific to Norfolk. Work has been carried out in other areas of the country that use the GCP as an empowering tool which focus the assessment of neglect in the relevant domain²⁵.

4.5. When a paediatrician gives a positive medical view in relation to a child's presentation, as happened in this case, this should not necessarily override or take precedence over the concerns raised by the other professionals working in the safeguarding network.

4.5.1. Child AG had never been seen by a paediatrician following his birth at 31 weeks' gestation and subsequent discharge from the SCBU. The parents had consistently failed to bring the child for an assessment and review despite numerous appointments and confirmation that they would do so. The first consultation was a Child Protection Medical for a bruise on AG's cheek and at the base of the spine just above the nappy line. The view of the doctor was that the injuries were consistent with the history given by the mother. Although the doctor described AG as 'sick and weak' there was no further challenge of what this meant for AG. As a result of this a Strategy meeting that had been considered prior to the assessment was no longer required. At the next medical assessment, the view from the doctor was that AG was developmentally delayed and this was most likely due to prematurity. A referral was made for AG to be reviewed at The Child Development Centre in three months' time. Did this lead the

²⁵ Graded Care Profile Structured Judgement Tool developed by Jane Wiffin in Hertfordshire, May 2019.

professional network to be optimistic about AG's condition? There are many factors,²⁶ which lead professionals to adhere to a supportive and helpful plan, where there is sometimes unwarranted optimism about outcomes. As a consequence, professionals sometimes find it difficult to change course. Supervision becomes paramount to ensure that professionals are supported and challenged (see 4.7) In this case there was concern about AG's developmental delay and fluctuating weight (loss and gain) but after the examinations by the Paediatricians there was a subtle change in the urgency of the case. The HV was directed to continue weighing and monitoring AG's weight, which was done and recorded on the electronic system. It is difficult to understand why the sea-saw effect when the weight was plotted on the centile chart was not shared with the core group or escalated back to the paediatrician. The core meetings became an exchange of information, descriptive narratives and continuation of the plan with no evidence of challenge or analysis. This may be due in part to the fact that if a professional is reporting from a position of expertise and gives a rationale as to why this is happening it becomes more difficult for other professionals to feel able to seek further explanations. Training on providing skills to professionals to feel confident to challenge one another should be commissioned by NSCP.

4.5.2. The conclusion of the review team was that the significance of a medical opinion/ diagnosis appears to carry more weight within the safeguarding network. This was first highlighted in the Climbié²⁷ enquiry where professionals accepted a diagnosis despite a lack of evidence to support this. The fact that AG had been seen and examined by two paediatricians in a relatively short period of time may have falsely influenced the other professionals that AG's faltering growth was not as significant. The SCR was also told that there is generally a lack of challenge within meetings across agencies as there is a perception that other members of the team lack the knowledge and authority to challenge professionals speaking from a position of expertise. Clearly work needs to be undertaken by NSCP to ensure that all agencies feel that they can ask and challenge anyone within the network and that they will not be met with defensiveness.

²⁶ Reder et al (1993)

²⁷

<https://www.gov.uk/government/publications/the-Victoria-Climbié-inq...>

4.6. Supervision and management oversight are critical in managing and supporting professionals working with uncertainty; why did this not happen effectively in this case?

4.6.1. Much has been written on the benefits to both the individual and the organisation when regular supervision is given and received. Good supervision is fundamental to good practice in providing: support, challenge and reflection, particularly when practitioners are working with high levels of uncertainty and complex, chaotic and challenging circumstances. Whilst all of the agencies recognise the value of supervision and provide protected time for their staff it does not always take place.

4.6.2. The SCR was told that this case was well known within the different agencies as both SW1 and HV frequently discussed the case with colleagues and managers sometimes on a daily basis, using peer support and ad-hoc supervision which was not recorded. This discussion was helped by the co-location of Children's Services and health staff in the same building. The view was that because this case was well known that the case was being managed effectively and the management team had oversight. What became clear during the conversations with the frontline practitioners and managers was that this case did not benefit from regular protected supervision. At the time there were a number of changes within Children's Services in this locality which resulted in the case being overseen by three different team managers. The workloads were high and it was evident that it had been difficult to engage SW1 in structured supervision. This was also true for health and one of the supervisors described the daily exchange as "white noise" and reflected that maybe the full concerns about AG and his family had not been fully understood. Cambridge Community Services have identified the non-recording of ad-hoc supervision as a problem within the local area at the time and have subsequently introduced new guidance to capture and record these discussions.

4.6.3. The Eden Team Midwife was tenacious in her pursuit of raising her concerns about the sleeping arrangements for the new baby and her concern over AG. Through numerous telephone exchanges and written documentation outlying her concerns, nothing changed. The professional network split with the SW and HV on one side and midwifery on the other. The consequence of this was that the relationship that the midwives had with the mother changed and it became more difficult to work with the family. This was further exacerbated when the SW was accused by the Eden Team Midwife of colluding with the family.

- 4.6.4. The exchange happened over a bank holiday weekend, at the start of the next working week a telephone conversation took place between the Head of Social Work and Health Safeguarding Manager that did not resolve the difference of professional opinion. Problematic multi-agency working continues to result in lost opportunities for protecting children from harm; the ability to clearly identify the needs and risks within the family becomes more difficult²⁸
- 4.6.5. The physiotherapist raised concerns during Safeguarding supervision about AG. The physiotherapist had been concerned from the beginning of July 2018 due to sores around the nappy area and that AG was dirty. The mother had also failed to bring AG for the follow-up appointments, the mother stating that she “cannot get there.” Recent research²⁹ into health agency “Did not Attend” policies has shown inconsistency and that they can, at times, be a systemic defensive response by agencies to help manage large workloads. Non-compliance with appointments may be a parent’s choice but it may not be in the child’s best interest. Repeated cancellations and re-scheduling of appointments for children should be treated with curiosity. A shift away from using the term did not attend (DNA) to was not brought (WNB) would help maintain a focus on the child’s ongoing vulnerability and independence, and the carer’s responsibilities to prioritise the child’s needs. The concerns were shared with SW1 and they both attended the CPC the following day. The unanimous view of the professionals was that the risks could be safely managed under a Child In Need Plan but that AG was to have a Child Protection Medical. It is difficult to understand why the decision to ‘step down’ the case was not deferred until after the outcome of the CPM was known.
- 4.6.6. The SCR was told that the social work caseloads in this part of the county were higher than the recommended level and include a large volume of child protection work. At the time there were a number of agency workers employed in this area. The recruitment process was often carried out using the telephone. There was no formal induction or introduction to the values of the organisation. In this case SW1 was given a list of cases on the first day of working and some computer training and then “cracked on” with the work.

²⁸ Triennial Analysis of SCR Research in Practice/University of East Anglia/Warwick.

²⁴ Munro, Eileen (2012) Review Children and young people’s missed health care appointments: reconceptualising ‘Did Not Attend’ to ‘Was Not Brought’ - a review of the evidence of practice *Journal of Research in Nursing*, 17(2). pp193-194. ISSN 1744-9871 and Lisa Arai, Terence Stephenson & Helen Roberts; the **unseen child and safeguarding**: ‘Did not attend’ guidelines in the NHS; *Archives of Disease in Childhood*. March 2015: <http://adc.bmi.com/content/2015/03/16/archdischild-2014-30729>

4.6.7. The conclusion of the review team was that this particular locality within Norfolk has a high level of deprivation and need. It can at times feel isolated from the rest of the county. The importance of restorative as well as safeguarding supervision becomes paramount in providing protected time and space to support the professionals working in this challenging environment. Ad-hoc supervision must be recorded and must not replace the rigour of planned supervision. Supervision should also explore and record what the lived experience is for the children. This case was the type that should have been taken to Joint Supervision project. The view of the panel was that there is an expectation that the current initiative for joint supervision will be reported back as part of the Multi Agency Safeguarding Arrangements (MASA) Plan by January 2020.

4.7. The family identified themselves as travellers; was the professional network competent in working and understanding the culture and beliefs of a traveller family?

4.7.1. For many professionals, working with Gypsies and Travellers for the first time means working within a new culture and context. This can be challenging and difficult to navigate and it is normal to have questions. For this reason, a level of cultural competence is important, or at very least, maintaining an open and inquisitive mind. Cultural competence is defined as the ability of providers and organisations to effectively deliver services that meet people's social, cultural and linguistic needs. "Professionals need to be aware of their own prejudices and bias and ensure that it does not influence the care they give."

4.7.2. The SCR was told that there was generally a lack of knowledge around travellers as well as some level of fear of traveller communities. Some of the professionals working with the family were unaware of services working with this community. Work is currently being carried out to look at upskilling workers around traveller communities and including knowledge of safeguarding practice.

4.7.3. The review team were curious as to why a male social worker had been allocated to work with the mother and children as Travellers may not accept male workers, as women and children should not be in the company of men that are not family. SW2 only worked with the family for a short period of time (about one month) and therefore the possible impact on this case was considered to be low. TM1 when asked about the allocation was clear that it was done because SW2 had capacity, that

consideration had not be given to whether this would pose a problem and it was not done with the view to work more closely with the father. It is surprising that SW2 had not considered whether there may be any impact or difficulties working with a family with six children. It was evident that there was no awareness from him that woman and female children should not be in the company of men who are not immediate family. This is of concern and needs to be addressed urgently.

- 4.7.4. The conclusion of the review team was that there was a gap in the knowledge and understanding of the culture and beliefs within the travelling community. At the same time, it must also be recognised that there are many interpretations and variations within the Roma Gypsy and Traveller community and that professionals need to be aware and confident in their knowledge and understanding in order to have a meaningful dialogue. The Gypsy and Traveller service should review their record keeping and safeguarding knowledge of the workers within the service. Specific training about working with the Gypsy and Traveller Community should be commissioned with immediate effect for the wider workforce and should consider working with One Voice³⁰ and the Gypsy and Traveller community to gain a better insight into their culture and beliefs.

5. Learning Event for frontline staff and managers

A Learning Event was held for key staff and managers at the end of September 2019 to share the key findings from the case and identify any additional learning. The full details of the event can be seen in Appendix 3. The Learning Event was an holistic process which allowed staff to reflect and challenge one another in both a positive and safe environment.

The independent reviewer would like to acknowledge the honesty and contributions that all attendees made in difficult and emotional circumstances. The learning that emerged was:

³⁰ Community based charity working with individuals, families and groups from the Gypsy, Traveller and Roma community across East Anglia in a supportive advocacy and community development role. onevoice4travellers@hotmail.com

- The significance of children not in education is not always acknowledged by the wider safeguarding network
- Understanding the significance of faltering growth and the use of centile charts
- Early Years and Education are in a unique position in that they see the child and parents on a daily basis however they are not always invited to meetings.
- The thresholds the police use to assess neglect are currently under review as it is felt that the accepted level is too low.
- The need to identify whether the refuge will provide safety for a woman from the traveller community fleeing violence. Checks need to be done that there are no other travellers within the refuge as information can be shared very quickly within the community. The children that accompany the woman may not always be their own.
- Recognising that professionals will have different conversations with men and women in the traveller community.
- There is a gap with adult service representation within the safeguarding network.
- A joint supervision pilot, the numbers attending are small and the reason for non-attendance is time constraints. The model of the sessions may need to be reviewed in order to get engagement from all the agencies involved.

6. Areas of Good Practice.

- The tenacity of the midwife in raising her concerns of the risks posed to the new baby and the identification of AG's condition. The midwife continued to do this on a daily basis and was not put off despite the concerns being downplayed. The record keeping was exemplary and provided a chronology of the unfolding events over a period of a few days.
- The physiotherapist brought the case to supervision because of the concerns about AG's condition at the first assessment and the fact that AG "was not brought" did not attend for five follow-up appointments. This supervision session resulted in the Named Nurse for Safeguarding (acute) and physiotherapist attending the case conference and identifying the need for AG to have a child protection medical.
- The work done by the Woman's Refuge in identifying the vulnerabilities of the mother and the complexity of the family. They worked to support as well as challenge the mother prior to the mother leaving the refuge.

7. Conclusion

It is difficult to understand how a child who was receiving services from a number of agencies in Norfolk was diagnosed with severe malnourishment in 2018. Whilst undertaking this SCR it became apparent that there was a superficial level of understanding of the family dynamics and relationships including domestic abuse, learning difficulties and whether the parents understood why the professionals working with them were concerned. Following the initial child protection conference, the risks and areas to focus on were clearly identified. Over time the focus shifted to housing with the belief that everything else would fall into place if the family were found suitable housing. Despite the fact that AG was weighed regularly and seen by paediatricians there was little evidence of consideration of faltering growth and the impact on the development of AG. In this case the view of the medical/ health professional was accepted, as they were perceived to be the experts. When clarification or explanation was sought it was re-buffed. This is clearly not a healthy environment in which to work and professionals and managers need to support and challenge one another in order to gain a better understanding of the situation and lived experience for the child. The importance of good supervision becomes paramount in ensuring that the focus of the case does not drift and that there are clear measurable outcomes to ensure that there is no case drift and that management has oversight of the case.

8. Recommendations.

The strategic leadership of NSCP should review the effectiveness and ability of all partners to deliver the neglect strategy and identify any barriers that may prevent this.

NSCP as part of workforce development plan, identify and equip all staff with the confidence and skills to enable them to work with clients from cultural and diverse backgrounds, including the Gypsy, Traveller and Roma communities, and the competency to challenge other professionals in a non- confrontational manner.

Health agencies to review the effectiveness of the management of faltering growth and how it is shared with all agencies.

Children's Social Care to provide assurance that Child Protection Plans are realistic and meeting the needs of children that reflect the current position of the risks to the children and are effectively reviewed over time.

Appendix:1

Terms of Reference

Methodology

Statutory guidance within Working Together requires Local Safeguarding Children Boards to have in place a framework for learning and improvement, which includes the completion of Serious Case Reviews. The guidance establishes the purpose as follows:

Reviews are not ends in themselves. The purpose of these reviews is to identify improvements, which are needed, and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action, which lead to sustainable improvements, and the prevention of death, serious injury or harm to children. (Working Together, 2013:66)

The statutory guidance requires reviews to consider: “what happened in a case, and why, and what action will be taken”. In particular, case reviews 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 data is collected and analysed; and,
- makes use of relevant research and case evidence to inform the findings

In order to meet these requirements, the model adopted in undertaking this review uses a ‘systems approach’, which draws significantly on the work undertaken by Professor Munro³¹ and SCIE [Social Care Institute for Excellence]. A ‘systems approach’ to learning recognises the limitations inherent in simply identifying what may have gone wrong and who might be ‘to blame’. Instead it is designed to identify which factors in the wider work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely. The purpose therefore is to move beyond the individual case to a greater understanding of safeguarding practice more widely.

The SCR was conducted in parallel with ongoing criminal investigations.

³¹ Social Care Institute for Excellence (Fish et al, 2008)

The Panel has worked with the police to agree meetings with individuals directly involved with the case. Police have been provided lists of individuals from the separate agencies and the outline of the conversations. Notes were taken but not shared with the individuals or Panel, but held centrally by the NSCB Business Unit and shared with the Lead Reviewer only.

Specific issues to consider in the review of this case.

- Expected standards and procedures
- Cultural competence in the context of working with families from the travelling community

Expected Standards and Procedures

- Were existing identified risks to AG and her siblings understood and managed at the correct threshold, and in the correct way?
- Was there a shared understanding of the CPP and CIN plan with clear contingency plans for stepping up, stepping down and /or escalation?
- How effective were the multi-agency CIN meetings and was there 'case drift'?
- How was the concerning presentation and overall deterioration in Child AG's welfare understood, in particular: faltering growth, malnutrition, developmental delay, physical injuries and neglect? Were the needs of all the children considered?
- Was the issue of domestic abuse sufficiently explored, including the impact on the children, and were the risks managed appropriately?

Cultural competence in the context of working with families from the travelling community

- To what extent did the cultural background of the family impact on the way that professionals managed this case, and responded to the family? Did professionals consider social isolation and transient lifestyle?
- To what degree did agencies have a shared understanding of the parents' non-compliance and was this acted on jointly?
- Was the possible impact of the mothers learning disability / literacy explored sufficiently? Was she able to understand what was required in order to meet the needs of her children, in particular AG, and how to protect the children?
- Due to the family's poor housing and cramped conditions did professionals (perhaps) apply different thresholds than the norm?

An independent lead reviewer worked alongside a review team (Panel), and composed of

senior managers, and facilitated by an independent chairperson. The review team met on 5 occasions and considered the following documentation:

- A merged chronology
- Child Protection Plans
- Core Group Minutes
- Child Protection Medical Report
- Access to records from Liquid Logic (Children’s Services)
- MARAC Minutes (post time line)
- Individual Conversations with 18 front-line clinicians and managers
- MASA Plan

The author of this SCR, Ann Duncan was commissioned by NSCB to write the overview report, she was independent of the case and all agencies involved.

The Review Team was comprised of the Independent Lead Reviewer, and the following senior managers/senior professional leads who were independent of the case:

Job title / Role	Organisation
Detective Inspector	Norfolk Constabulary
Head of Quality Assurance & Effectiveness	Norfolk County Council Children’s Services
Deputy Designated Nurse for Safeguarding Children	Great Yarmouth and Waveney Clinical Commissioning Group
Safeguarding Advisor for Schools	Norfolk County Council Education Services
Named Nurse for Safeguarding Children	Cambridge Community Services NHS Trust
Early Years Improvement & Inclusion Officer	Norfolk County Council Children’s Services
Head of Neonatal, Children and Young People Services	James Pagett University NHS Trust
Strategic Director	Great Yarmouth Borough Council
Head of Support and Development	Norfolk County Council Community and Environmental Services
Named Nurse Hertfordshire Community NHS Trust	Representing Hertfordshire Safeguarding Partnership
Business Manager	Norfolk Safeguarding Partnership Board
Ann Duncan	Independent Lead Reviewer

Appendix 2: NSCB Thematic Learning Framework from SCR

The NSCB Thematic Learning Framework has been developed to enable us to think about the recurring issues and barriers to effective working together. The framework was introduced to Board in December 2015 and has subsequently been tested with partners within Norfolk, through the Public Protection Forum (PPF), with the support of partnership board business managers, as well as nationally.

Learning from Serious Case Reviews: Emerging Themes



The thematic learning framework, focuses on four key learning areas:

1. **Professional curiosity** – how can the Board encourage and support appropriate curiosity with families, and between professionals?
2. **Information Sharing and Fora for discussion** – how can the Board ensure that we use opportunities for discussion effectively, include all relevant parties, act promptly and clearly; and share information well?
3. **Collaborative Working, Decision making and Planning** – how can the Board improve timely and collaborative planning and get strong and shared decisions?
4. **Leadership: Ownership, Accountability and Management Grip** – how does the Board give effective leadership and champion better safeguarding, locating clear accountability?

At the heart of all learning is the child or young person, and sitting underneath everything we do is the recognition that safeguarding requires people at all levels to manage risk and uncertainty.

Appendix 3: Learning Event.



Norfolk Safeguarding Children Board

Case AG Practitioners Event

26 September 2019

Registration at 9.00am – 4.00pm

Venue: Great Yarmouth Race Course, NR30 4AU

Agenda

Welcome and Introductions

Outline of Learning Event

Norfolk SCR activity and background

Outline of Serious Case Review Process

Whole group consideration of timeline

Whole group consideration of research questions

Identification of gaps/additional information required

Identification of learning & recommendations

Appendix 4: Acronyms

CIN	Child In Need
CPC	Child Protection Conference
CPP	Child Protection Plan
GP	Family Doctor/General Practitioner
GCP	Graded Care Profile
HV	Health Visitor
HoSW	Head of Social Work
ICPC	Initial Child Protection Conference
MARAC	Multi Agency Risk Assessment Conference
MASA	Multi Agency Safeguarding Arrangements
NSCB	Norfolk Safeguarding Children Board
NSCP	Norfolk Safeguarding Children Partnership
SCR	Serious Case Review
SCRG	Serious Case Review Group
SW	Social Worker
SWA	Social Work Assessment
TL	Team Leader
TM	Team Manager