Norfolk Safeguarding Children Partnership

Child Safeguarding Practice Review regarding Child AI

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1. Circumstances that led to this Child Safeguarding Review.

1.1 In August 2019 Child AI, then aged five and a half suffered significant burns to 26% of her body while in the care of her mother. At the time of the incident, the case was still open to Children's Services but a Social Work Assessment (SWA), completed two days before the incident, had recommended that the case should be stepped down to Early Help. Child AI had previously been managed under Section 47[1] of The Children Act (April – November 2018) and then for a short period of time managed under a Child in Need Plan (Section17). AI has one younger sibling, aged 10 months at the time of the incident.

1.2 AI was taken to the local Emergency department and was then transferred by air ambulance to the Regional Burn Centre, where AI underwent surgery. Following discharge from the Burn Centre the family were placed in a family assessment unit. This placement ceased and AI and her sibling were placed in foster care.

1.3 The case was considered by the Norfolk Safeguarding Practice Review Group (SPRG) on 02.09.19, where it was agreed that the case met the criteria for a Child Safeguarding Review (CSR), that is:

- Abuse or neglect of a child is known or suspected
- The child had been seriously harmed and 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
- The child sustained a potentially life-threatening injury
- The child is likely, i.e. on the balance of probability, to suffer serious and permanent impairment of physical and/or mental health and development.

1.4 The Safeguarding Practice Review Group formally recommended to the Independent Chair of Norfolk Safeguarding Children Board (NSCB), now the Norfolk Safeguarding Children Partnership (NSCP) that a CSPR is commissioned to review this case, in line with Chapter 4, Working Together.[2]

1.5 The Police investigation is ongoing with regard to the injury sustained by Child AI. The Care Proceedings have concluded.

1.6 At the time of Child AI's injury 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 NSCP Business Manager. The purpose of the CSPR 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 CSPR considered the work of the following agencies:

[1] The Local Authority have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or like to suffer significant harm.
[2] Working Together to Safeguard Children, HM Govt 2018.The CSPR was commissioned whilst arrangements were in transition.

- Local Authority Services (including: Children's Services, Early Years)
- Education
- Health agencies (including: Community Health Services, Midwifery Services, General Practice, Emergency Services at a local hospital)
- Ambulance Service
- Housing
- Norfolk Constabulary.

2.2 The timeframe for the review was from January 2018 when Child AI sustained her first burn injury to August 2019 when Child AI presented with 26% full thickness burns to the chest and abdomen. The possibility of Child Sexual Exploitation (CSE) relating to the household was initially identified however, it was agreed that the review should be appropriate, proportionate and that CSE was not explicit within the case and was not key to the case.

2.3 The Child Practice Review Panel identified specific lines of enquiry grouped against expected standards and procedures, and a particular focus on the management of cases of neglect and the impact on the lives of the children. The terms of reference were as follows:

- How well are parents' potential learning disabilities understood and their parenting capacity assessed in light of any cognitive limitations?
- Did the professionals have a view on the bonding between mother and child? How was this assessed?
- If a child is frequently arriving at a nursery/early year setting with bruises, scratches and other minor injuries how is this monitored and shared with other professionals working with the family?
- What does the use of A&E services tell us about the way families understand and access health provision? How does this impact on our safeguarding systems?
- Are staff desensitised to indicators of neglect and how does this impact on their ability to effectively assess risk?
- What are the similarities and differences between this case and other neglect cases in the local area? (Ref Case AF, AG and the local 'deep dive').

2.4 The CSPR was also asked to use the NSCP 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. The lead reviewer and NCSP Business Manager met with the maternal grandmother and mother separately. It was difficult to get engagement with both the maternal grandmother (MGM) and mother in order to elicit a meaningful dialogue. The family moved from London about twenty years ago and her three children had attended school locally with no identified problems. She reported that the mother and her younger brother fought like "cats and dogs" but she left them to sort it out between themselves. The mother and Child AI lived with the grandparents until they moved into their own property at the end of 2016. The MGM did not have any concerns about her daughter's ability to look after Child AI. She described her relationship with her daughter as close, however she was unaware of the ASB, alleged cannabis smoking and that there had been a risk to the mother's tenancy. Child AI was

described as an inquisitive child and was always “doing things she shouldn’t be doing, I was always right behind her.”

In the interview with the mother she was unable to articulate what the professionals working with her had concerns about and had not found any of the professionals/ agencies working with her helpful, she “didn’t get any support.” The mother told us that she had been bullied at school but could not remember about what, she described her time at college as being better. The mother had studied child care at college and when asked if this had been helpful in parenting her own children she replied “I don’t know where the paperwork is” (she hadn’t brought it with her when she moved). The mother struggled to tell us what Child AI was like or what she enjoyed doing. The only incident that both the mother and maternal grandmother described (and the mother showed us a photograph on her phone) was when Child AI had ‘flipped out and trashed her bedroom.” The mother thought that Child AI had autism or Attention Deficit Hyperactivity Disorder and wanted help to get a diagnosis, but “no one would give it to me.” The mother had asked her brother to help her look after her nieces and nephews (the children of her older brother) over a weekend and that she had been frightened of her brother at the time.
It was clear that neither the mother nor the maternal grandmother had a clear understanding of what the professionals were concerned about in relation to the mother’s ability to safely parent the children.

3 Practice Summary from the review period – Key Events.

At the end of each Key Event practice learning points have been captured, these are not recommendations but serve as a summary of where systems and practice can be improved.

Background prior to the review period: Child AI and her mother lived with her grandparents until December 2016 when the mother signed a tenancy agreement with a local housing provider for a two bedroomed flat, located in the local town. The mother reported that the father of AI lived in London and that there was no contact with him. From September 2017 there were reports from neighbours to the Housing Association that raised concerns about the level of rubbish and Anti- Social Behaviour (ASB) associated with the mother’s property including; a large number of teenagers visiting the flat. The mother’s 16-year-old brother was staying with her at the time and it was thought that it was his friends that were causing the disturbance and ASB. One of the callers to the Housing Association expressed concern for AI at this time. The mother was advised that ASB could have an impact on her tenancy and she was advised to stop her brother visiting or staying at the flat. AI attended the Emergency Department (ED) at the local hospital 16 times from birth to December 2017. The reasons for attending the ED were for minor accidents following trips and falls and seeking advice for minor illnesses such as fever and cold like symptoms.

3.2 An ambulance was called to the family home on two occasions between January and February 2018. Both visits by the Ambulance Service resulted in safeguarding referrals being made to Norfolk Children’s Services.

The ambulance service attended the family home in early January 2018 following a referral from the NHS 111 service[3] for a thermal burn to AI’s hand as mother was unable to take Child AI to the local Emergency Department. The burn consisted of

[3] NHS 111 is available on line or by telephone 24 hours a day, seven days a week for advice and management of cases.

small blisters to the palm and the pads on her fingers; she had no loss of sensation. It was reported that the injury had been sustained when AI reached up to the hob after it had been switched off. The ambulance crew noted that AI was just tall enough to reach up to the oven hob. The incident had happened some hours prior to the callout; the pharmacist had given the mother something to treat the burn with, but also advised her to contact 111. The ambulance crew made a safeguarding referral to Norfolk Children's Services due to the state of the flat, Child AI being described as unkempt, and that although the burn was possibly accidental it happened because of a lack of parental supervision. One month later an ambulance crew attended the flat, this time it was reported that AI had fallen and hit the back of her head, and had sustained some minor bruising. Another safeguarding referral (the second within a month) was made due to the state of the home environment: there was no light in AI's bedroom, broken toys scattered over the floor, and it was reported that AI had run her own bath that morning.

Learning points:

- **At the time of the review the Safeguarding Team within East of England Ambulance Service NHS Trust (EEAST) did not have the capacity to feedback to crews following safeguarding referrals. Crews are always able to contact the safeguarding team if they wish to receive feedback to a specific incident.**

- **Whilst some agencies are routinely included in social work assessments, not all referrers have the same experience. This is particularly true of those that are not routinely involved in every case for example some housing providers, the Ambulance service amongst others. It is clear that CADS ensure all professionals are informed of the outcome of their contact, if it has been referred to a locality for a SWA. However, at this point not all referrers are contacted or included to contribute to the social work assessment. This is a missed opportunity for both the completeness and accuracy of the assessment and also ongoing learning of all agencies involved in the safeguarding of children.**

- **Currently all NHS111 Services are live with CP-IS and it is hoped that all Ambulance Services will be live before March 2021.**

- **Staff need to consider when families use the Emergency Departments is it because they do not want professionals to visit the family home?**

3.3 The behaviour of young people associated with the family escalated, leading to complaints being made to the housing provider and the police being called. (Housing and Anti-Social Behaviour).

At the end of January 2018, the police were called by neighbours due to Anti-Social Behaviour (ASB) by associates of the family including: setting the fire alarms off, smoking cannabis, leaving condoms in the lifts and making lots of noise. The Housing Officer visited the property to advise the mother that this behaviour needed to stop as the future tenancy of the flat was at risk. The police were called again in early February by a neighbour as they were concerned about the number of youths smoking 'weed' and drinking at the family address and were concerned about the impact of this on Child AI. The police visited the property and found Child AI in the care of two males

(the uncle and a friend). The mother was called back to the property and spoken to. The Housing Association served a Section 21 notice[4] on 26.02.18. In March another Section 21 was served and a plan was put in place which would allow the mother to remain in her home, take steps to alter her behaviour which would help her to keep the tenancy of the flat. The agreed plan allowed more options to be put in place and was seen as a positive action. At the time ASB housing officers were looking at the level of compliance with the tenancy agreement; it was more about enforcement rather than taking an holistic approach[5]. The police visited the family home on 11.03.18 as it was believed that the flat was being used for Child Sexual Exploitation (CSE) and drug use. When the police visited the address, it was found to be in an "atrocious state, with rotting food, used nappies and clothing items strewn across the floor." The police made a referral to Children's Services that described the home conditions as extremely poor, with very little food in the home, and that Child AI was seen wearing only a dirty long-sleeved T-shirt.

Learning points:

- **ASB officers should consider the impact of the ASB in a safeguarding context when a child is present and share with appropriate agencies.**
- **To review membership of the Anti-Social Behaviour Action Group (ASBAG) and to strengthen the safeguarding response within the local community.**

3.4 **Following the police referral, the case proceeded to an Initial Child Protection Conference in April 2018 and AI was made subject to a Child Protection Plan under the category of neglect.**

Following a strategy discussion on 21.03.18 it was agreed that the case should proceed to an Initial Child Protection Conference (ICPC). The concerns were:

- risk of CSE;
- unknown males attending property (police intelligence);
- poor home conditions;
- lack of parental supervision for AI; and
- the possible eviction of the family due to anti-social behaviour at the address.

The mother disclosed that she was pregnant due to deliver in October 2018; the father of the unborn child was unknown. Child AI was made subject to a Child Protection Plan under the category of neglect. The mother was to be referred to the Adult Learning Disability Services as there was concern about whether the mother had learning difficulties and lacked the capacity to parent effectively. There is no record of this referral being made. The statutory child protection visits (fortnightly) and the core meetings took place monthly from April to October 2018. The professionals continued to be concerned about the mother's level of supervision and keeping AI safe. It was reported that Child AI had no 'stranger danger awareness'[6] In late August 2018 an

[4] A 'Section 21 Notice of Possession' operates under section 21 of the Housing Act 1988, is the legal eviction notice template notice a landlord can give to a tenant to regain possession of a property at the end of an Assured Shorthold Tenancy (AST

[5] The role of ASB Officer is currently being reviewed and is likely to be called something different moving forward to more accurately reflect the safeguarding work these members of staff undertake.

[6] '**Stranger Danger**' is better referred to as a small part of teaching children protective behaviours as 85 per cent of **danger** or abuse to children occurs with someone known to the child or trusted by the child. The aim is to teach children to be safe, to be aware of predatory **strangers**, and to be self- protective.

ICPC was convened for the unborn baby; the decision was that the unborn child would be managed under a Child In Need Plan.

3.5 AI attended Nursery prior to commencing at the local Primary school in September 2018.

Following the burn that AI had sustained in January (2018) the nursery staff noticed that AI's behaviour changed and it was observed that she was taking additional snacks and food from other children's plates, had repeated head lice infestations and would come to nursery with minor cuts and bruises. The mother was always up-front about the injuries. There were 19 pre-setting forms completed[7] between January 2018 – July 2018. AI was described as a child who found it difficult to relate and play with her peers, and the other children were fearful of AI at times. AI sought out her key workers and would play more with adults than the other children. The nursery had put in place a Target Support Plan[8] which was regularly reviewed. AI started in the reception class of a local primary school in September 2018. It was reported that AI settled well into school, however AI was not good at reading social cues from the other children and was "in other children's faces." The records from the nursery were transferred to the school but although there was a copy of the CPP included in the records, it was unclear whether the plan was still in place or whether there were any future meetings planned. The Designated Safeguarding Lead (DSL) at the primary school developed a good working relationship with the mother. The DSL described the mother as" needy, vulnerable and more like a teenager" The mother frequently talked to staff at the beginning and end of the school day to seek basic parenting advice and to report any concerns.

Learning Points:

The safeguarding guidance for Early Years settings should be reviewed to inform practice in the following ways:

- **By keeping chronologies of injuries to children in Early Years and schools, staff understand the importance of using them to analyse patterns and identify the cumulative risk and where appropriate consult with CADS in order to ensure the needs of the child are being met. The number of perceived minor injuries to a child should be viewed in relation to parenting capacity and the ability to keep children safe**
- **Early Years Settings are supported to explore different methods of providing support and management oversight of the safeguarding function so that Safeguarding Lead Practitioners (SLPs)have dedicated time to reflect on and analyse case records in an non-reactive way to build an understanding of children's needs and respond accordingly. This will support settings to create safe cultures for everyone in the setting's community.**

3.6 A Review Child Protection Conference was held the day before the birth of AI's sibling; the decision was to manage the case under a Child In Need plan.

[7] These forms mark any injuries on a child when they arrive at the nursery, including a body map and description of the injury.
[8] Plan identifying key areas of child's development that required additional support.

In September 2018 the mother attended her GP due to low mood, anxiety and reportedly finding it difficult to leave the house. An urgent referral was made to the local mental health trust but no further follow-up was deemed necessary after a telephone consultation. During this telephone consultation the mother divulged that she had a social worker and it would have been an ideal opportunity for the mental health practitioner to explore more about her current situation. The mother was offered Cognitive Behavioural Therapy[9] via her GP; it is unclear from the records whether this offer was ever taken up by the mother. A Pre-birth Initial Child Protection Conference concluded that the unborn baby would be supported via a Section 17 and that SW1 would recommend that Child AI would be also supported by a Section 17 at the Review Case Conference (scheduled for October 2018). The Headteacher became concerned about AI's behaviour and it became evident that AI required support on a 1:1 basis. A week later the Designated Safeguarding Lead at the school received a telephone call from SW1 and informed her that Child AI was on a Child In Need Plan. This information was incorrect as Child AI was still subject to a CPP. The review Child Protection Conference was brought forward and it was a unanimous decision by the professionals to step the case down to a Child In Need Plan (Child AI's sibling was born the following day.) The view expressed by the professionals was that the risks had been reduced although some concern about how the mother would manage after the birth of the baby but it was hoped that the family would have been rehoused and be closer to the maternal grandmother. The management overview was that the case would be referred to Early Help and then closed in 6 weeks. The intervention and support provided by family support teams (early help) is invaluable to many families if it is an accurate assessment then the case should be stepped down after any form of statutory intervention. This must only happen if the assessment is an accurate summary of presenting risk and robust management oversight has analysed all available information. Stepping down must not be used as a means of moving cases out of statutory social work team if it is evident that child protection or child in need planning is more appropriate to meet the assessed need.

At the first Child in Need home visit SW1 recorded that AI had a couple of bruises; there was no explanation of where the bruises were or how Child AI had hurt herself and therefore no consideration given to seeking medical advice. It was also recorded that AI did not want to talk about school and again there was no exploration as to why this might be, or any strategies used to engage with AI. This was the last visit made to the family by SW1. The HV made three home visits following the birth of AI's sibling and the mother was observed to be meeting the needs of the baby with support from the maternal grandmother and a friend.

A month after the birth of AI's sibling a cause for concern was reported to the Designated Safeguarding Lead (DSL) regarding AI hitting other children for no reason. It was noted that there had been a change in AI's behaviour over the past two weeks. This was raised at the CIN meeting a week later; but despite this, the case was closed and stepped down to Early Help (EH). At the point of managing the risks under a CIN plan a Family Network meeting[10] should have taken place - this did not happen. The Family Network approach was a new initiative and was not fully embedded in practice. However, it is now required practice that all workers across the Social Work and Family Support services embed the Family Networking Approach into their practice and offer to children and families, so that it becomes "business as usual" in underpinning all their

[9] Talking Therapy that can help manage problems by changing the way people think and behave.

[10] Family networking is an overarching approach to identifying and engaging with the whole family – immediate, extended and anyone important in a child's life. Family Network Meetings (FNM) should be offered to any family whatever the level of intervention, and whether children are living with their families, in care or leaving care.

interventions In December 2018, EH made a referral to the Children's Centre[11] to support the mother in getting out of the house and interacting with other adults due to low mood, anxiety and isolation. The Parental Mental Health (PMH) worker from the Children's Centre visited the family home on three occasions and put together a programme for the mother which included: baby massage, yoga and music. The mother attended a total of four sessions prior to the closure of the Children's Centre. It was reported by the PMH worker that the mother appeared to struggle with the sessions, she didn't know what she needed to do, and was anxious about being in a group. The second home visit was done jointly with the DSL, the home conditions had deteriorated, dirty clothes everywhere and mother appeared to be struggling. Child AI was described as "bouncing off the walls". The DSL reported the concerns to Early Help.

Learning points:

- **It is required practice that all workers across the Social Work and Family Support services embed the Family Networking Approach and as part of this Family Network Meetings, into their practice and offer to children and families, so that it becomes "business as usual" underpinning all interventions.**
- **FNMs [or Rapid Family Network Meetings] must be actively considered, promoted and implemented where possible in all stages of casework planning from initial referral, through the key stages of the assessment process, in Multi-Agency Strategy Discussions, in CP conferences and in all other statutory review processes – Family Support/Child in Need/Child Protection/ Looked After Children.**
- **Staff working within Adult Services must remember to "Think Family."**
- **The importance of robust systems of management oversight and supervision which will allow reflective analysis and development of outcome focused plans to evidence real change for the children.**

3.7 Following police intelligence that vulnerable young people may be at risk of CSE at the family home the police visit and made a referral to Children's Social Care (the second police referral)

The local frontline police visited the mother's flat in May 2019 following information received from the CSE team within Norfolk Constabulary. At the time of the visit there was an Object marker[12] on the address The police had been given information concerning missing persons (aged 17) who were believed to be at the family home. The missing persons were not found at the address but the flat was described as "untidy, food had not been cleared away, the bathroom was filthy" and Child AI's bedroom was "not great" with either no bed covers or a very dirty bed. There was also a screwdriver left lying around in the living room. There was no food in the house but the mother was expecting her benefits to come through the following day. The mother and her brother were described as "very drowsy" and AI was "overfamiliar' with the officers. The view of the officer was that there was a high level of concern and

[11] The Children's Centre was part of the Great Yarmouth Community Trust- the centre closed on 30.09.19.
[12] Key information is put on the IT system for particular addresses- at the time the information was that children at risk of potential drug use at the property and undesirable visitors.

submitted a Child Protection Investigation.[13] The referral was forwarded to Children's Social Care. Following this referral, a Social Work Assessment (SWA) was instigated. SW2 made a joint home visit with HV1. Child AI was at school but her sibling was seen at this visit. SW2 observed that the mother always stood by the window on her mobile phone and thought that this was a sign for her friends / visitors for them not to come to the flat. SW2 discussed with the mother that her brother should only visit the flat for a limited time (two hours) and no more than three times a week. SW2 advised the mother that "he must ring the bell and you provide access." SW2 made an evening visit to the flat when Child AI was at home, SW2 observed that AI was over familiar and sat on her lap and pulled her hair, the mother did not respond to AI's behaviour or try to get AI to sit with her. It was also reported that AI sometimes stayed overnight with a friend to help the mother out, SW2 advised mother to stop doing this.

On the 17.06.19 a rapid response meeting was held at the family home where it was identified that the mother required ongoing support to help her sustain the improvements that she had made whilst AI was subject to a CPP. It was suggested that a Graded Care Profile [14]should be undertaken (the previous one had been completed in 2016). It is unclear whether this took place as a copy of it cannot be located within the records however it is important that individuals do not decide to ignore a direction given to undertake a piece of work. The social work assessment was not completed within the timeframe[15] due to high numbers of assessments to be completed by SW2 in the same timeframe. The outcome of the social work assessment was to step the case down to Early Help with support from the Children's Centre. The last SWA gives a clear assessment of what needed to change for AI and her sibling, and what their mother needed to do to achieve this. Unfortunately, this was based on observation and discussion with their mother during visits and makes no mention of whether their mother had the mental capacity to make these changes or understand why they needed to happen.

Learning points:

- **The importance of including the family history in the assessment to include the parent's own childhood experience and the impact it may have on their current parenting ability.**

3.8 An ambulance attended the family home due to a significant burn Injury to Child AI.

The Social Work Assessment was completed and the decision was that the case would be managed under Early Help and Family Support. Two days later the ambulance service was called to the family flat. The call handler had advised the mother to "douse Child AI with water and await the arrival of the ambulance". On arrival the mother was described as "deadpan" with very little emotional response. It was reported that the mother had been in the kitchen when she had heard AI scream from the living room. The mother did not respond immediately to the scream so AI made her way from the living room to the kitchen, whilst on fire. It was reported that AI had found a cigarette lighter in the living room and had started playing with it. The mother had scooped AI

[13] Child Protection Investigation notices are submitted on any police call out where there is a safeguarding concern; the CPIs are then populated on Athena, the central police data base.
[14] Graded Care Profile. A practice tool that gives an objective measure of the care of children across a range of needs.
[15] Social Work Assessment should be completed within 45 working days of the referral being received by the Local Authority.

up and put her in the shower and removed any remaining clothing before the ambulance crew had arrived. The crew found AI in the bath and that they could see that the burn was serious and covered a large body area. AI was transferred to the Emergency department at the local hospital and later transferred by air ambulance to the regional burn centre.

4.0. Analysis of Practice

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 CSPR is seeking to achieve a greater depth of learning about safeguarding systems within Norfolk, and beyond the individual case. The review has been conducted and written with the benefit of hindsight, which often distorts the reader's view of the predictability of events, which may not have been evident at the time. Despite robust systems being in place, there were some gaps in practice which need to be considered in order to learn from them.

4.2 How well are parents' potential learning disabilities understood and their parenting capacity assessed in light of any cognitive limitations?

Much has been written about the negative professional conceptualisations and stereotypes of parents with learning difficulties and even the 'system abuse' they face when they come into contact with child protection processes.[16]
There is also substantial evidence concerning the range of problems that can impair parental capacity to meet the needs of children[17] including: mental illness, problem drug and alcohol misuse, learning disability and intimate partner violence. It is also well documented that children may be at increased risk where a parent/carer has a learning 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, and the ability to sustain the change is an additional level of concern.

The professionals working with the mother had different professional opinions as to whether the mother had a learning disability/need, and lacked the capacity to parent effectively. The mother's behaviours were also associated with depression, low mood and anxiety and she found it difficult to leave the family home at times. The Mental Capacity Act [18] (MCA) is routinely used in Adult Social Care and across Health Services but not routinely in Children's Services. The MCA is designed to protect and empower people who may lack the mental capacity to make their own decisions about care and treatment. Part of the two-stage assessment is to determine whether the person understands the information relevant to the decisions, retain the information, and use the information to weigh up that information as part of the process of making the decision. In a safe child protection system obtaining agreement from parents means that professionals must appreciate the vulnerabilities of a parent, and ensure that consent is a process of appreciative enquiry and respectful enquiry. The view

[16] Aunos and Feldman2002; McConnell and Llewellyn2002. McConnell etal2006. Sigurjónsdóttir and Rice 2018).
[17] Cleaver et al,2011; Brown and Ward,2012
[18] Mental Capacity Act 2005 legislation.gov.uk

expressed at the learning event from frontline staff was that the label given to someone often sticks, but the narrative does not always support the label. The professionals working in the nursery and school settings told the lead reviewer that they had developed a relationship with the mother and she would seek the key workers out at the start and end of each day. The mother found it difficult to make decisions and sought reassurance on a daily basis. It would appear that the mother found it difficult to firstly make decisions and then lacked the ability to execute the decision.[19] The mother was able to follow clear instructions when given and the lead reviewer was told that story boards and picture boards were used when working with the mother.[20] The mother did not attend a special school and told the lead reviewer that she did not remember having any problems with school work or extra time when taking exams. A learning disability is defined as;

A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); with a reduced ability to cope independently (impaired social functioning); which started before adulthood, with a lasting effect on development.[21]

A learning disability is usually identified with an IQ score below 70, and this is typically the criterion against which eligibility for local authority adult learning disability services is assessed in England. We now know that the referral to the adult learning disability service was never made, however the view from the adult AD was that it they had received a referral it is unlikely that she would have met the criteria for an assessment or service. Parents with learning difficulties may have been assessed as having IQ scores above 70 overall, but often struggle with literacy, everyday practical tasks and abstract concepts such as time, as well as the wide range of social disadvantages common to adults with learning difficulties/disabilities such as poverty, poor housing and social exclusion and a lack of social support[22] When parents with LDs come to the attention of children's social care, concerns are typically and primarily in relation to neglect - which may include failure to offer appropriate protection or meet children's basic needs.[23]

During the care proceedings the mother underwent a Psychological Assessment[24] where she was found to be in the borderline range of adult intellectual ability, and therefore falls outside the range whereby the mother would be considered to have a learning disability. However, it was identified that the mother would find it difficult to process complex verbal information and would find it easier to understand when information was presented visually. Following the incident leading to the review the residential placement for the family broke down due to significant concerns about the mother's capacity to keep the children safe and sufficiently meet their needs. The mother struggled to provide the daily personal care of both children despite frequent prompts from staff.

Cognitive and parenting assessments are a fundamental part of any plan and should be completed at an early stage. Assessing the likelihood of a parent being able to make sufficient changes in their lives to ensure the child's safety and wellbeing is part of assessing whether the parent has the capacity to change. The importance of and the need to support social workers to determine how long to spend on individual cases

[19] Executive capacity-the ability to execute one's decisions.
[20] NSCP illustrated Threshold Guidance updated 2019.
[21] Department of Health 2001 page 14
[22] Cleaver and Nicholoson; McConnell and Llewellyn 2002.
[23] Understanding 'Successful Practice/s' with Parents with Learning Difficulties when there are Concerns about Child Neglect: the Contribution of Social Practice Theory 2019Beth Tarleton & Danielle Turney
[24] Psychological Report 2019

and to balance 'thoroughness and depth' and 'timeliness and proportionality' in the conduct of assessments becomes critical. When services are configured for adults and children separately there is a danger that the impact of risk within the whole family may not be fully understood. It is evident from this case that the professionals working with the mother never fully understood the possible implications and limitations of how successfully the mother was able to parent and keep her children safe on a daily basis.

4.3 Did the professionals have a view on the bonding between mother and child? How was this assessed?

Research[25] on attachment theory suggests that early intervention with care givers can dramatically affect your beliefs about yourself, your expectations of others, and the way you process information, cope with stress and regulate your emotions as adults.[26] What researchers call a child's attachment style develops in particular through the parent or other caregiver's response at times when the infant is distressed, for example when the child is ill, physically hurt or emotionally upset .

From around six months, infants are able to anticipate their parents' responses to their distress. They adapt their behaviour in turn, finding ways to manage their feelings. Researchers[27] also tend to agree that birth to three is a particularly crucial period of development, with attachment developing in particular from six months. Frontline staff stated that there was evidence that the mother did provide a level of care and love but there was a lack of intimacy and physical contact. There was little understanding of what the bond between the maternal grandmother was and how this may have an impact when the mother and AI moved to their new flat. There was an absence of fathers, the mother told the professionals that both the father of AI and the father of her sibling had left her when she was in the early stages of her pregnancy- they had moved to London and there was no contact. This was accepted with little challenge or further exploration of what this might mean.

From an early stage the professionals were concerned about the "bonding" between the mother and Child AI. AI had spent the first two years of her life living with her mother and maternal grandparents, who provided a level of support to them. The family were offered a two bedroomed flat in the local town, which they accepted. The mother continued to visit the grandparents' home on a daily basis either taking the bus or walking if she did not have the bus fare. When families are given accommodation away from the family (albeit a short distance away) does this have an impact on the family bonding and the level of support that is being provided? The mother's younger brother was seen as causing problems with ASB however, he may have provided a level of support that the network was not aware of. The mother had told us that she had asked her brother to come and help her when she was looking after her nieces and nephews over a weekend. The mother found it difficult to remember much about her own childhood apart from telling the lead reviewer that she had been "bullied" at school, although she could not remember about what. The psychological assessment identified that there was a disconnect between the mother and her early childhood years and described a "vagueness, cut off from any emotional connection when thinking about family and experiences." Professionals need to consider how the wider

[25] Baby Bonds
Parenting, attachment and a secure base for children
Research by Sophie Moullin, Jane Waldfogel and Elizabeth Washbrook
March 2014

[26] Benoit, 2004

[27] Benoit,2004

family network may offer some ongoing support to help sustain the changes that the family have started to make.

The importance of observing the mother child relationship is key to gaining a better understanding of their lived experience and emotional world. This work is often compromised when workloads are high and there is reduced capacity within the service. In this case the concerns were about the lack of supervision provided by the mother towards child AI in order to keep her safe. The use of the Signs of Safety[28] approach in child protection has led to improvements, however, in some cases there has been an over emphasis on the concept of safety and what works well resulting in the importance of good risk assessment being lost.[29] The child protection plan identified three danger or risk areas to help keep Child AI safe, including supervision. Progress on improvements to the supervision of Child AI were measured by a reduction of injuries sustained by AI within the family home. It was noted in the plan "that the mother was using the locks on the bathroom and kitchen doors to help keep her safe, and that she was being supervised at all times."

AI was described as a child that was "attention needing" and a very inquisitive child that was unaware of any risks or dangers. AI found it difficult to pick up on social cues, lacked social skills, and overwhelmed other children within the school setting. As previously noted AI had no awareness of "stranger danger," and the risks associated with that. It was noted that the mother did not have the capacity to understand the risks either. Although professionals identified the risk there was little evidence of understanding the impact on AI. The mother raised concerns with the school in February 2019 that she thought that AI was being bullied by another child and that AI no longer wanted to come to school. The response from the school was that they felt this was more about children learning to socialise with one another rather than bullying. The mother struggled with some of AI's behaviours, AI had a poor attention span and was not engaged with learning. It was reported that AI struggled to follow instructions and the view from the school was that AI demonstrated some traits associated with Attention Deficit Hyperactivity Disorder (ADHD) that needed to be explored. There is evidence that early and long-lasting severe and extreme neglect and deprivation, coupled with major disruptions of care, is associated with disinhibited attachments; quasi-autism; and inattentivity, overactivity and impulse control problems[30] This population of deprived children shows high rates of inattention/overactivity that share many features with ADHD.

A referral was made by the family GP to the Newberry Child Development Centre in June 2019. At the time the GP did not contact the school to discuss whether they had any ongoing concerns surrounding AI's behaviour. The referral was refused as AI was too young to undergo an ADHD assessment. A diagnosis of ADHD can be considered but will not usually be confirmed until a child is around six years old. The input of teachers as observers in a structured school environment is crucial and it is good practice for teachers' observations to be incorporated into an assessment.

The ambulance staff commented that there was very little emotional response from mum when they attended the incident in August 2019, and considered whether she might be under the influence of something as she was slow to react to things, if at all and only cried on one occasion. The mother did not appear to grasp the severity of

[28] The strengths-based and safety-focused approach to child protection work is grounded in partnership and collaboration. It expands the investigation of risk to encompass strengths and Signs of Safety that can be built upon to stabilise and strengthen a child's and family's situation.
[29] NSCB thematic Review Case AF, p31 Sept 2019
[30] Kreppner et al.2001

the situation asking 'will she be going into hospital." AI was described as quite calm, crying with the pain, and shivering. She was quite clingy towards the ambulance crew member who carried her to the ambulance and wanted to be held and hugged. AI only asked for her mum once. The ambulance crew had to ask the mum to hold AI's hand.

The way that the mother and extended family responded to the injury was seen as detached and lacking emotional response and was perceived by the professionals working with them at the time as "not necessarily how we would behave." The mother stated that she was scared to hold AI's hand or touch her as she didn't want to cause her more pain. Where there is an ambivalent relationship, or attachment difficulties between the primary care giver and the child, this has the potential of compromising the safety of a child from danger/risks posed by the environment in which they live or from other adults.

4.4 **If a child is frequently arriving at a nursery/early year setting with bruises, scratches, and other minor injuries how is this monitored and shared with other professionals working with the family?**

Staff working in Early Years settings use **Pre-setting Forms** to record any marks or injuries on a child when they come into the setting (on a daily basis). This includes using a body map to pinpoint the exact position of the mark and a description of the injury. **Pre-setting Welfare Forms** are used to report any safeguarding concerns and are shared with the Designated Safeguarding Lead (DSL) immediately.

The mother was reported to be open with the staff working in these settings and would alert them to various scratches and bruises on AI and give an explanation as to how they had occurred. It was also reported that Child AI had "lots of accidents at the nursery too" so AI was seen as a clumsy child. At the time the nursery had a number of low-level concerns but they didn't think it would meet the threshold for intervention and had experienced a number of Multi Agency Safeguarding Hub (MASH) referrals being 'bounced back." Since the introduction of Children's Advice and Duty Service (CADS) in October 2018 professionals reported that they feel empowered to contact the service and have a conversation about the children that they are worried about. The CADS service is made up of senior social workers who provide advice and support and talk through concerns and solutions, it allows early help and support to families.

The importance of keeping a chronology in order for staff to identify the frequency and nature of the reported and recorded injuries is essential. By keeping a log of injuries in date order it allows practitioners to identify any underlying patterns and the possible cumulative effect of these on the child. It also allows practitioners during supervision to explore that although the explanation given by the mother as to how the injuries happened may be plausible, does it identify that the level of supervision and possible neglect within the home setting requires more support to the family?
Early Years settings relationships with partner agencies is seen as positive but it is also dependent on individual working relationships and experience of working together. The lead reviewer was told that the staff working directly with Child AI did not have access to the records (they were kept in the office) and a verbal update was obtained by the safeguarding lead prior to the core group meeting. Attendance at core meetings is critical in developing an outline of the child protection plan, set out what needs to change and by how much and by when in order for the child to be safe, and have their needs met. Core groups must implement and refine the child protection plan and it is therefore important to ensure the key agencies involved with the child are present and feel equal partners in any decisions being made. It is critical that all of the agencies involved with the family are heard on an equal footing and feel that their contribution is as valid as any other partner agency. The importance of supervision

becomes key in allowing time and space to reflect on the case and emerging patterns in order to be able to articulate the current concerns as well as any improvements or family strength.

4.5 What does the use of A & E services tell us about the way families understand and access health provision? How does this impact on our safeguarding systems?

Nationally the number of adults and children attending A&E services has risen dramatically over the past decade due to changing patient expectations and ease of access; it is perceived to be easier to attend an A&E department than obtaining a GP appointment. The NHS 111 telephone service is the NHS's non-emergency number and, in many areas, encompasses the GP Out of Hour Service. The number of people calling NHS111 that have been advised to attend their local emergency department, or been sent an ambulance, increased from around 150,000 a month to 200,000.[31] The reasons why parents bring their children can be split into five broad categories:

- Parental worry
- Perceived advantages of Paediatric Emergency Departments
- Perception of other healthcare services
- Social network influence, and
- Lack of confidence and low health literacy.

The mother did use the local emergency department for both Child AI and her sibling as well as attending her own GP. Each time a child is reviewed in the emergency department consideration will be given as to whether the presentation of the child raises any safeguarding concerns. For every attendance at the emergency department an electronic notification is sent to the family GP informing them about the attendance and treatment given. All correspondence for children under the age of 12 received by the GP surgery is sent directly to the lead GP for safeguarding who reviews and will act on the information accordingly.

The ambulance service and NHS 111 service also share information with the family GP about any call outs or treatment given where a safeguarding referral has been made. The health visiting service are reliant on receiving this information from the GPs. The GP Surgery work in a child centred and 'think family' way and work collaboratively with other agencies including the Healthy Child Programme (HCP) 0-19 service. The HCP practitioners, the safeguarding lead GP and the practice manager meet on a regular basis at a liaison meeting to discuss cases that they are worried about. The discussion around cases involves a reflective account of the situation and robust plans and actions are agreed, these meetings are formally documented. By working in this joined up way children and families of concern are able to be discussed in a transparent way and child centre decisions are made HCP has a robust system in place across the county which is supported by a care pathway to inform GP liaison meetings. The organisation also has clear escalation routes if the GP liaison meetings are not taking place so that this can be quickly resolved.

Information sharing both within organisations and between organisations is critical in keeping children better protected. The term information sharing may suggest that this is a passive action rather than an active exchange and dialogue between agencies and professionals within the multi-agency network. Information Technology (IT) systems are not uniform within health agencies or across the multi-agency

[31] Dyan, M. (2017) 'Winter Insight: NHS111?' Nuffield Trust briefing,22 February 2017. https://www.nuffieldtrust.org.uk/resource/winter-insight-nhs-111.

safeguarding network. This means that information sharing in 'real time' can become difficult as was demonstrated in this case.

Currently children who are subject to a Child Protection Plan and Looked After Children will be on the National Child Protection Information System (CP-IS) that is shared with A&E departments by Children's Social Care, so that when children are seen in this setting clinicians can check to see if they are subject to a plan. Those children who are subject to a CIN plan are not included on the CP-IS and staff are reliant on parents telling them. This system is not currently shared with the ambulance service (there are plans for this to be implemented by March 2021).

The current service landscape with fragmentation and outsourcing of services, service cuts and corresponding high caseloads and high staff turnover, has profound practical and emotional impacts on staff who are struggling to work effectively with families in complex circumstances.[32] Managers and commissioners need to recognise these impacts and put in place structures to provide support, time and guidance for front-line practitioners[33].

4.6. Are staff desensitised to indicators of neglect, and how does this impact on their ability to effectively assess risk?

Neglect remains a NSCP priority. The coexistence of issues such as: physical or mental ill-health, substance misuse, poverty, criminal behaviour, learning difficulties and domestic abuse can result in inconsistent and ineffective parenting and a disorganised lifestyle. It may mean parents have difficulty in controlling their emotions and experience apathy and disengagement, resulting in an inability to provide adequate emotional warmth to their children or essential supervision.[34] Complexity and cumulative harm was almost invariably a feature of families where children experience neglect.[35]

Emotional desensitisation means that with repeated exposure to the same sort of thing we tend to react less intensely. It is a normal response to become more tolerant to something that you are regularly exposed to. Familiarity with that experience often reduces (or alters) the emotional response to that experience. In the context of safeguarding it would not be unreasonable to accept that practitioners who are exposed regularly to a set of circumstances (poor home conditions, low level chronic neglect) will become familiar with the experience, and as a consequence, their emotional response may lessen. Continued exposure can lead to a state of no longer being shocked by what is in front of you as this becomes the 'norm.' By the nature of their work, safeguarding professionals are exposed to highly emotional and distressing material. Exposure to such material takes a psychological and emotional toll on the professionals and they are of increased risk of developing secondary traumatic stress. The steady 'drip, drip, drip' effect of seeing trauma on a daily basis can cause demoralisation, pessimism and apathy[36]. Professionals become defensive when the term 'desensitisation' is used rather than accepting that this is a possibility, and that critical thinking and reflective supervision will help to support and build resilience within the workforce. By building resilience and containment with frontline practitioners,

[32] Basarab-Horwath & Platt, 2019
[33] Complexity and challenge: a triennial analysis of serious case reviews 2014-2017, March 2020 DfE. https://assets.publishing.service..._SCR_REPORTS_2014_to_2017.pdf 2014- 2017,
[34] Cleaver, Unell & Aldgate,2011
[35] Complexity and challenge: a triennial analysis of serious case reviews 2014- 2017, March 2020 DfE.https://assets.publishing.service..._SCR_REPORTS_2014_to_2017.pdf
[36] What an Auschwitz survivor taught NHS safeguarding leads about resilience. Mike Drayton, Jessica memerzia and Sarah Robinson.

supporting them in acknowledging their own emotional response will lead to better assessments, identification of risks, and a better understanding of what the lived experience is for the child on a daily basis.

4.7. What are the similarities and differences between this case and other neglect cases in the local area? (Ref Case AF, AG and the local 'deep dive').

This Children Safeguarding Practice Review (CSPR) was conducted in the east of the county and was the second review that the lead reviewer had carried out in the area. The lead reviewer was struck by the strong narrative that was repeated and re-told about how difficult it was to work in the area with high levels of poverty and deprivation, coupled with high volumes/numbers of safeguarding cases, and a high level of vacancies in both health and social care services. The reputation of the area makes it difficult to recruit and the focus had been on recruiting rather than thinking about the effectiveness of how the services were working together. Problematic multi-agency working can result in lost opportunities for protecting children from harm.[37] "A respectful organisational culture is crucial to Safeguarding".[38] The challenge for the multi-agency safeguarding network is how the different mindsets of partner agencies can be broken down in order to work collectively. Organisational culture is often described as the personality of that organisation; "the way we do things around here". It encompasses the underlying values, beliefs and codes of practice that make an organisation what it is. It can be seen through behaviour, language, customs, rules, group interactions and habits. Handy[39]describes four types of culture which the organisations follow:

- Power - power remains in the hands of a few people
- Task - teams are formed to achieve the targets or solve critical problems
- Person – employees feel more important than their organisation, and
- Role – delegated roles and responsibilities according to specialisation.

Changing organisational cultures takes time and a commitment from all that change is required. Relationships are critical to build trust across the multiagency safeguarding network and a recognition and support from leaders that this is important. This becomes more difficult when there is a high staff turnover. It is not enough to co-locate agencies in the same building, there has to be a shared goal and a willingness to work collaboratively. This is sometimes helped with appointing a different operational manager who is seen to be independent and acts to bind agencies together towards a shared culture.[40] There are some early signs that professionals are starting to have courageous and positive dialogue in order to start building bridges and relationships. This needs to be supported so that healthy challenge and disagreements can take place in a safe environment at an early stage in cases which should then result in less cases being escalated. The term "escalation" can be perceived as negative and seen as going above someone in a hierarchy, resulting in a defensive reaction. In the Thematic Review[41] recently completed it was stated that, "relationships between professionals has an important impact on practice and service delivery, identifying the importance of this and establishing how relationships can be built and nurtured within the multi- agency safeguarding network [is crucial]."

[37] Complexity and challenge: a triennial analysis of serious case reviews 2014- 2017, March 2020 DfE.https://assets.publishing.service..._SCR_REPORTS_2014_to_2017.pdf
[38] Anneta Williams 2018.
[39] Charles Handy, Model of Organisation Culture 1999.
[40] Joint health and social care appointment for Stronger Families in Breckland
[41] NSCB Thematic Review Case AF- September 2019

Table comparing key features of cases: AF, AG and AI.

Case	Neglect	LD label	Substance Misuse	Domestic Abuse	Prematurity	Bruising
AF	X		X	X	X	X
AG	X	X	X	X	X	X
AI	X	X	X			X

The three local cases all involved children who had been subject to a child protection plan under the category of neglect and with poor attachment as a feature. The cases had been stepped down from a CPP to a CIN plan relatively quickly. Relationship and attachment are important in the understanding of neglect. Research shows that neglectful mothers are more likely to have a history of unstable, hostile and non-nurturing childhoods[42] to have a history of disrupted or discordant relationships in adulthood[43] and to be less responsive and sensitive to their own children.[44] Attachment theory is therefore a useful basis for understanding neglect, as it demonstrates linkages between a carer's own childhood and their adult mental health, their approach to relationships and their parenting style.

Neglect is often chronic in nature, involving a complex interplay of entrenched family difficulties. There is not likely to be a 'quick fix' remedy available. Therefore, services working with neglectful families must recognise the need to work with some families on a long-term basis. In all three cases the cases were stepped down from a CPP to CIN plan after a short period of intervention, "long-term working as an approach is 'out of favour' in the current climate of limited resources and a government preoccupation with short-term targets"[45]. However, services need to be aware of and make provision for a proportion of families for whom prolonged involvement with professional help is necessary for lasting solutions.

Despite the volume of work undertaken across Norfolk around neglect and the promotion of the Multi-Agency Neglect Strategy and the Graded Care Profile tool there is still much work to be done in ensuring that all professionals are aware of and competent in using the strategy and tools to enhance and evidence the work that they do in partnership with families. The Neglect Strategy (2017) is currently being revised and will be published over the next few months. An app is also being developed for families to enable them to monitor their own progress.

Norfolk Children Safeguarding Partnership are currently reviewing the Graded Care Profile (GCP) tool to make it easier for frontline staff to complete it. The feedback has been that the tool is cumbersome and time consuming to complete. The outcome of this is that only two domains are to be completed rather than all of the domains and identify: what are we most worried about, and what is working well

5. Learning Event for frontline staff and managers.

A Learning Event was held for key staff and managers in March 2020 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.

[42] Stevenson, 1998
[43] Horwath. 2007
[44] Crittenden, 1993
[45] Stevenson, 2005

The independent reviewer would like to acknowledge the honesty and contributions that all attendees made in difficult and emotional circumstances. Some staff attended in their own time and on their 'rest days' which would not be reimbursed. The learning that emerged was:

- The need for organisations to help and support staff dealing with trauma and build emotional resilience.
- To review sickness policy and ensure that the mental health of staff is managed appropriately and compassionately.
- Organisations need to be confident about permissions required in order to share information both internally and between partners.
- Use some of the key points discussed throughout the day as a basis for safeguarding supervision sessions.
- Raise discussions about family background and time to reflect on cases more - identify the missing information.

6. Conclusion and Recommendations

Neglect continues to be a serious and ongoing safeguarding issue in Norfolk as evidenced by recent reviews undertaken: for example, cases AF, AG and AI. These cases have highlighted that there is a strong commitment by the partner agencies to: reflect, learn and change practice to improve the lives and lived experience of children growing up in Norfolk. The systems in which professionals work are complicated. Over time, working practice has become reliant on Information Technology (IT) and all too often the IT systems have little or no inter-connectivity; the outcome of this is that the exchange of information becomes more challenging and is very much reliant on developing trusted working relationships with other partners. Building these relationships requires both time and a stable workforce. There should be a clear understanding of everyone's role and responsibilities to enable an optimum outcome for the children that they are working to protect. The aforementioned challenges are certainly not unique to Norfolk. However, the positive commitment and the willingness shown by the multi-agency safeguarding network to get things right and learn from the reviews conducted in Norfolk is a real positive going forwards.

NSCP is currently reviewing the Neglect Strategy and the Graded Care Profile tool so there will be no specific recommendation on neglect.

Recommendation 1.

NSCP as part of a workforce development plan, identify and equip frontline staff with the confidence and skills to work with clients who have, or may have a 'learning difficulty' including the use of visual aids in order to communicate effectively.

Recommendation 2.

NSCP requires assurance that social workers and frontline practitioners working with children are equipped to make full use of the Mental Capacity Act to test both an adult's understanding of the required changes, and probability of being able to successfully achieve these required changes.

Recommendation 3.

CSC and Cambridge Community Trust (Healthy Child Programme) should provide assurance to NSCP that working relationships within the east of the county continue to improve resulting in a positive outcome for children.

Recommendation 4.

NSCP to promote the Family Network programme, in order to identify and build relationships with the wider family to better support families when services are no longer needed.

Recommendation 5.

The NSCP should oversee the development of guidance for transferring safeguarding records from Early Years settings to schools to facilitate appropriate and timely information sharing at the point of transition.

Appendix 1: Methodology and Terms of Reference.

The Child Safeguarding Practice Review will be carried out in accordance with the requirements as set out in Working Together 2018.

The aim of this CSPR will be:

- To investigate what went wrong and why as well as what went well in the case
- To identify any learning and resulting recommendations for action
- To invest in providing opportunities for practitioners to learn from their own and others' experience, building confidence and empowering effective safeguarding practice for the future
- To provide a CSPR report for publication.

The case meets the criteria for a CSPR because:

- Abuse or neglect was known or suspected
- The child has been seriously harmed and 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
- The child sustained a potentially life-threatening injury
- The child is likely, i.e. on the balance of probability, to suffer serious and permanent impairment of physical and /or mental health and development as a result of neglect.

Terms of Reference

1. All Safeguarding Practice Reviews should consider themes and questions to provide an analysis of practice and to identify learning. The CSPR Lead Reviewer and Panel members are asked to consider why events occurred as they did, based on a clear account of what took place and the actions of the practitioners and others involved, including an analysis of any factors considered important.

2. Working Together 2018 sets out the criteria, purpose and process for conducting a child Safeguarding Practice Review.

3. The CSPR will be required to consider learning that has already been identified within a number of recent Norfolk reviews. Where this review identifies learning that had been previously identified in the earlier SCRs, the focus will be on how learning has been translated into practice in the intervening period.

General Terms
The CSPR will take into account the NSCB's Thematic Learning Framework as part of the general terms of reference. See Appendix 2

Specific issues to consider in the review of this case.

In this case the following have been identified as key issues for consideration that should be examined by each agency. However, the Lead Reviewer and agency authors should not limit their review to those issues already identified. There may be other more important themes for each agency which are different from these.

Consideration for specific focus on:

- How well are parents' potential learning disabilities understood and their parenting capacity assessed in light of any cognitive limitations?
- Why are staff desensitized to indicators of neglect and how does this impact on their

ability to effectively assess risk?
- What are the similarities and differences between this case and other neglect cases in the local area? (Ref AF, AG and the local 'deep dive")
- Neglect being overlooked in the context of other safeguarding concerns, i.e. Child Criminal Exploitation / Sexual Exploitation (CCE/CSE).

The Review Process and Framework

The review methodology will be proportionate to the scope of the review.

The investigation will include:

- Reviewing and collating detail of practitioner experience and explanation from interviews and document reading
- Specify 'why' questions when considering critical path events
- Revisiting the experience of staff locally – using single interviews and group discussions in each agency to ask 'why' questions and seek answers to any issues of concern identified, as well as detailing positive practice
- Seeking the views of the family on the services provided
- Collating and analyzing responses – contrast how it was at the time and how the service is now – use gap analysis to reach findings
- Considering any relevant research or other SCR evidence applicable to this review
- Writing up SCR report for publication
- Disseminating lessons / findings and actions required.

Methodology

The lead reviewer worked alongside a panel made up of senior managers from the agencies involved. The panel met on four occasions, two of the times were done using IT Team Meetings (due to Covid -19 pandemic). Ann Duncan was commissioned by NSCP to write the overview report and was independent of the case. The panel met with 17 frontline staff and one focus group.

The following documentation was made available to the lead reviewer:

- Integrated chronology
- NSCP Policies and Procedures
- Chairs reports of CP conferences
- Child Protection Plans
- Psychological Report
- Access to Liquid Logic records (Children Service)
- MASA Plan
- Thematic Review Case AF
- Family Safeguarding Networks

Members of the panel.

Job title / role	**Organisation**
Detective Inspector	Norfolk Constabulary
Head of Quality, Performance and Systems Manager	Norfolk Children's Service
Named Nurse Safeguarding	Cambridge Community Service
Deputy Designated Nurse	Clinical Commissioning Group
Improvement and Inclusion Officer	Early Years
Safeguarding Specialist Practitioner for Children and Young People	East of England NHS Ambulance Trust

Litigation and Anti -Social Behaviour	Flagship Housing
Safeguarding Advisor for schools	Norfolk Education
Named Nurse Safeguarding	James Pagett NHS Trust
Safeguarding Lead	Norfolk Suffolk Foundation Trust
Board Manager	Norfolk Safeguarding Children Partnership
Business Support Officer	Norfolk Safeguarding Children Partnership
Lead Reviewer	Ann Duncan

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Appendix 2: NSCP Thematic Learning Framework from SCRs

The NSCP 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.

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.

Norfolk Safeguarding Children Board

Case AI Practitioners Event

3 March 2020

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

The event was attended by 28 staff and managers including panel members and 25 evaluation forms were completed at the end of the event.

A total of 23 attendees found the day useful, comments included:

- Really useful to listen to different perspectives, points of view in a safe environment.
- I know very little about the processes of social care despite regularly referring into it, so it is very useful learning and I was personally affected by this opportunity to gain closure.
- Discussing questions with other professionals / services was very insightful and provided learning.

- Informed me of local services and pathways that I am not party to. Felt I was part of a solution, part of a whole rather than solo. Highlighted different aspects / indicators of neglect.
- Always useful to hear perspective of other agencies, very affirmative as most agencies are not too far away in agreement.
- It was good to understand other agencies barriers and challenges to multi-agency working.
- The conclusion and recommendations touched on the support for practitioners working with neglect – there needs to be more open discussion about the impact on workers and support to enable workers to continue to affect change with this work.

Key Learning from the day:

- Use of language when explaining situations to family, root causes, working with trauma
- How other services safeguard and communicate with others.
- Understanding cultural genograms of families, reason why the issue may occur
- Neglect – important to act on, keep low thresholds – refer even with symptoms. Holistic referrals instead of injury descriptions etc family dynamic etc
- To be able to involve other agencies such as housing and education in the planning for the child.
- The importance of working together and being open to challenge.
- Thoughts around desensitisation specifically with regard to neglect, also the discussions of learning disability.
- Culture of a family – the importance of looking into the family background and the benefit this can have.
- Systems approach – useful to be able to reflect on wider processes and how they impact on decision making (especially impact of service re-organisations etc on leadership of teams)
- Clarity of communication to parents how and in what form? Are key messages clear?

How will you implement learning in to your everyday practice?

- Be more aware of neglect when visiting and not become desensitised to neglect. Share information and be able to challenge decisions and accept challenge.
- To connect and communicate with other agencies to gain trust and consent of families to enable this to happen.
- Continue to support practitioners to identify neglect. Encourage reflection and clinical supervision.
- Re-visit with teams the value and importance of enough protected time for reflection and ‘slower thinking’ about cases.
- To ensure neglect interventions are robustly identified, not just a plan to assess.
- More awareness of the long-term impact of childhood trauma as parents and need to consider how to support this.

Appendix 4 Acronyms

AD	Assistant Director
ASB	Anti-Social Behaviour
ASBAG	Anti-Social Behaviour Action Group
CADS	Children's Advice and Duty Service
CSE	Child Sexual Exploitation
CIN	Child in Need
CPIS	Child Protection Information System
CPP	Child Protection Plan
CSPR	Child Safeguarding Practice Review
DSL	Designated Safeguarding Lead
EEAST	East of England Ambulance Service Trust
ED	Emergency Department
GCP	Graded Care Profile
GP	Family Doctor
HV	Health Visitor
HCP	Healthy Child Programme
ICPC	Initial Child Protection Conference
MGM	Maternal Grandmother
MASA	Multi Agency Safeguarding Arrangements
NSCP	Norfolk Safeguarding Children Partnership
PMH	Parental Mental Health Worker
SLP	Safeguarding Lead Practitioner
SPRG	Safeguarding Practice Review Group
SW	Social Worker
SWA	Social Work Assessment