STATEMENT OF THE INDEPENDENT CHAIR- SCR C

The Bracknell Forest Safeguarding Children Board (BFLSCB) is publishing the Overview Report of a Serious Case Review (SCR) undertaken during 2013 and 2014. The review concerned a 2 month old baby, born to young parents, who was seriously harmed as a result of abuse. Publication of the report has been significantly delayed by the criminal proceedings involving both parents and further attempts to undertake discussions with the family.

The incident, which led to the SCR occurred over two years ago. BFLSCB received and agreed the SCR report in June 2014 .It was written prior to the publication of statutory guidance Working Together 2015 and has been amended to reflect the outcomes of the proceedings in both the criminal and civil court jurisdictions. All partner agencies involved in this case engaged positively in developing the Action Plan in response to the recommendations in the SCR Overview Report and those of the individual organisations. There was clearly learning for all partner organisations. These Action Plans have been subject to regular monitoring and challenge and the key areas of learning have been disseminated through partner agencies, discussed in a series of workshops for front line practitioners and fully integrated into the LSCB training programme.

Overall, it was felt that a key issue in this review was the opportunity to raise awareness and ensure understanding of the risk to non independently mobile babies. The evidence is clear that babies are unlikely to be bruised before they are mobile and everyone should therefore be alert to this and to ensure appropriate action is taken. The LSCB has developed a document to explain this to parents/carers, reviewed procedures and supported training to all practitioners to continue to raise awareness. In addition this review has highlighted the need to ensure all agencies “think family” and that information held around adults is shared and considered pro-actively. The LSCB has reinforced this through its training programme and has been reassured by the improved operational arrangements between children’s and adults services where there is now regular liaison and discussion.

The Overview Report highlighted a number of areas of good single agency and interagency practice and also identified issues for partner organisations where it was felt that practice could be improved and made 10 overarching recommendations for the LSCB.

Each organisation has made good progress to address the recommendations and examples of progress include:

Acute Hospital - reviewed training and undertook learning events resulting in increased numbers of appropriate referrals and the hospital now receives information on all children subject to child protection plans.

Schools - significant effort has been made to raise awareness of safeguarding, and through the revision of existing procedures increased support and improvements have been made to professional communication and the recording of concerns.

Primary Care - undertook focused training and devised a new procedure/template to record information and strengthened arrangements to enable receipt of domestic abuse notifications.

Children's Social Care - provided significant professional development opportunities in relation to the importance of family history and involvement of fathers. They reviewed case transfer and decision making processes, and improved arrangements for Children's Social Care and adult services to discuss cases and regular case file audits are undertaken to monitor progress.

Bracknell Forest LSCB has ensured the key learning from this Serious Case Review has been addressed and encourage ongoing discussion and challenge between partner organisations and the use of audit activity to continually monitor progress against areas for improvement.

Alex Walters
LSCB Independent Chair

February 2016

Bracknell Forest Local Safeguarding Children Board

BRACKNELL FOREST SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW USING THE

SIGNIFICANT INCIDENT LEARNING PROCESS

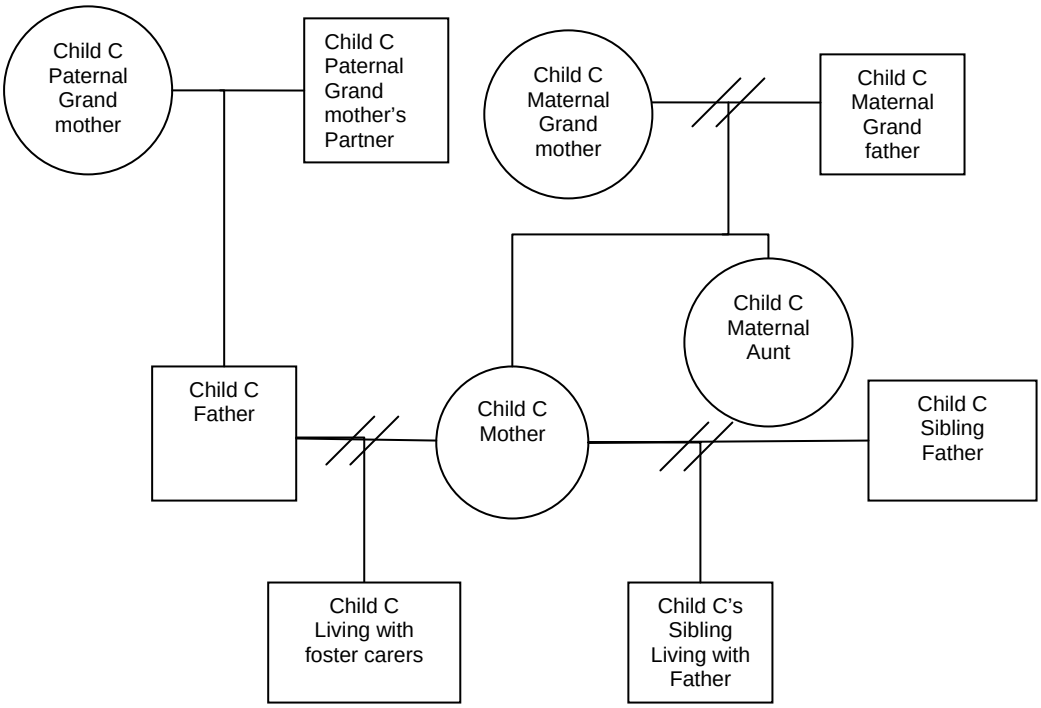
CHILD C (Born 2013)

CHILD C Sibling (Born 2010)

CONTENTS

1. Introduction

1.1. Genogram



1.2. Introduction to the Children

Child C

1.2.1. Child C is now 2 ½ Years. Following proceedings held in the family court an adoption order was granted in September 2015. It is understood that he settled in well with his adoptive parents. Although initially observed to be slightly small for his age he developed well and was described as having a very happy disposition and as being a cheerful and playful young child.

1.2.2. The review was informed that C was meeting his developmental milestones and even exceeding them in some areas.

1.2.3. C was reported to be an active little boy who swims regularly and this appeared to aid his gross motor development. As a baby C was fascinated by lights and mirrors although this had lessened and as he became more interested in toy cars and balls.

1.2.4. It was reported that C had developed a secure attachment following his placement and was able to demonstrate his cheerful and happy personality.

1.2.5. Regular contact had been supported with his sibling, supervised by Children's Social Care. He demonstrates neither enjoyment nor aversion in this relationship; instead showing a mixture of passive and happy behaviours during this contact.

Child C's Sibling

1.2.6. Child C's sibling is now 5 ½ years old. As a result of the further investigations following C's injuries his sibling was cared for by his father and has remained living with him on a permanent basis. He was reported to have settled well and was described as generally being a happy and cheerful child, who can be shy and withdrawn around people he is less familiar with. C's sibling is beginning to form friendships at school.

1.2.7. However when first placed with his father C's sibling speech was said to have been significantly delayed and that he had a very limited vocabulary and was reluctant to communicate. C's sibling's father expressed concern about his son's speech and has been active in pursuing speech therapy. Following the support offered by speech and language therapists he was said to have been slowly making progress.

1.2.8. C's sibling has almost completely gained control over his bladder, an area he had also been slightly delayed in. However, overall C's sibling's development is in line with his other developmental milestones, having good command over his gross motor skills and enjoying play, particularly enjoying water play and making craft pictures.

1.3 Summary of Circumstances Leading to the Review

1.3.1 C was a child who had been known to services, including Children's Social Care, and he and his sibling were made subject to Child Protection Plans when C was around 8 weeks old.

1.3.2 C's sibling is 3 years older than C and was born to a different father. At the time of C's sibling's birth his mother was engaging with the Family Nurse Partnership (FNP) as she was a young mother who was expecting her first baby. The FNP worker conducted an assessment of C's mother and discovered she had witnessed multiple domestic abuse incidents between her parents as a child and that she was an elective mute until the age of 12. C's sibling's father was seen as supportive, although was not living with C's sibling and his mother at all times during their relationship.

1.3.3 The police hold records of 11 domestic incidents leading to them being called out during C's sibling's early years and prior to C's birth. C's sibling was present and witnessed some of these. This led to various assessments and investigations being undertaken by Children's Social Care as well as a period of working with the family under a Child in Need plan.

1.3.4 C lived in a home in which domestic disputes were a frequent feature and this, alongside the substance abuse and mental health issues experienced by those who cared for the children, were the issues around which agency assessments and intervention were based.

1.3.5 Agencies involved included the Family Nurse Partnership, with whom C's mother participated in an intensive parenting course; Children's Social Care, who had been aware of the family since October 2010; the police who responded to numerous callouts and engaged in multi-agency discussion; health visitors and general practitioners; domestic abuse workers; housing staff and education professionals.

1.3.6 C was admitted to hospital on 19 October 2013 with a displaced fractured right femur which was considered to be a non-accidental injury.

1.3.7 Although both parents were initially arrested for grievous bodily harm and lengthy criminal proceeding followed, no convictions have been made.

2.1 Introduction to SILP

2.1.1 Working Together 2013 states that SCRs and other 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.

2.1.2 This review has been undertaken in a way that ensures these principles have been followed. For this review the SILP model was used.

2.1.3 The key principle of a SILP is the engagement of frontline practitioners and first line managers, giving a much greater degree of ownership and a much greater commitment to learning and dissemination of lessons. SILP uses systems methodology, looking at how the actions of professionals are influenced by the organisations and systems in which they are working.

2.2 Process

2.2.1. After discussion in the LSCB Serious Case Review Sub-group on 19th November 2013, a recommendation was made to the Independent Chair of Bracknell Forest Safeguarding Children Board that the circumstances did meet the threshold for a serious case review. On the same day the Independent Chair accepted this recommendation. The Independent Chair undertook a peer challenge discussion with another experienced LSCB chair on 22nd November 2013 who agreed the criteria for a serious case review were met. The Independent Chair confirmed agreement to undertake a serious case review on 25th November 2013.

2.2.2. From a scoping meeting comprising representatives of the agencies (the same membership as the Reference Group) on 12th December 2013 agencies were commissioned to provide written reports and were issued with a template requiring factual reporting and analysis. Learning points and recommendations were also addressed in the document and all agencies followed the same format.

2.2.3. It was decided that C and his sibling would be within scope and the time period was set from 1st January 2010 to 25th October 2013. An opportunity was provided for authors to report on any significant information outside this scope. Case-specific terms of reference were issued covering 13 broad domains and requiring authors to provide details of the case in relation to 4 additional areas of focus for some authors to address.

2.2.4. A Learning Event was convened for 13th March 2014 and was largely well attended by representatives from:

Children's Social Care

Mental Health

Midwifery

Health Visitor

Police

Domestic Abuse Perpetrator Service

Housing

GP

Education

Early Years

These representatives were at practitioner, manager and Safeguarding Lead levels. The attendees also included members of the Serious Case Review Subgroup.

2.2.5 A first draft of this report was circulated to all attendees prior to the Recall Day on 7th May 2014.

2.2.6 On the basis of that discussion a second draft was sent out for the Reference Group to consider. A third draft was further consulted upon with the Reference Group and accommodated suggestions which have been incorporated into this final draft which was presented to the Board on 19th June 2014.

2.2.7 The process has been efficiently administered by the Democratic Services Officer, to whom I would extend my thanks.

2.3 Independence

2.3.1 To ensure transparency, and to enhance public and family confidence in the process, the Local Safeguarding Children Board (LSCB) appointed an independent person to lead the process.

2.3.2 The Lead Reviewer who has acted as Chair and Overview Report Author for this review is Donna Ohdedar, an independent safeguarding consultant with no links to Bracknell Forest Safeguarding Children Board (BFSCB) or any of its partner agencies.

2.3.3 The Independent Chair of Bracknell Forest Safeguarding Children Board was appointed to chair the Reference Group. This group was made up of members of relevant agencies who had not had contact with the case. It became apparent at the first meeting of the Reference Group that one of the members present had provided an additional view of the decision not to take the case to conference in May 2012, alongside the Assistant Team Manager and Child Protection Conference Chair. It was decided that within a small authority with only 3 Heads of Service such minor contact is inevitable. This decision has been considered by this review at the practitioner events and was debated at the Reference Group. It was discussed in some of the agency reports, including that commissioned by Children's Social Care from an independent consultant. It is dealt with in the overview report in section 5.2.

2.4 Voice of the Family

2.4.1 At the outset of the process a commitment was agreed to providing the opportunity for the family to participate as fully as possible. It was agreed that Child C's mother, the fathers of both siblings and the maternal grandparents should be approached.

2.4.2 The independent lead reviewer wrote to the mother, the fathers of both siblings and the maternal grandmother on 12th January 2014 offering a meeting to explain the process and making it clear that they would be welcome to contribute. C's mother indicated over the telephone that she did not wish to be involved in the review. The door was left open for further contact should she change her mind. C's sibling's father indicated he would think about the review and he would initiate contact with the Lead Reviewer if he decided he wanted to contribute. This never happened. The Lead Reviewer also contacted C's father who said he preferred not to get involved.

2.4.3 After explaining the process by letter, on 10th April 2014 the lead reviewer telephoned the maternal grandfather. He wanted to express his view that he felt he had not been involved by Children's Social Care during the time he had spent with C's mother and C's sibling living with him during the early part of the scoping period. He stated that C's mother does not always open up but that he knew what was going on 'behind the scenes'. He wanted to say he was conscious he should have got involved sooner but he has only got involved now the children have been taken away.

2.4.4 Child C and his sibling were considered to be too young to contribute to the case review.

2.4.5 The LSCB Chair wrote again to mother and both fathers at the conclusion of the criminal proceedings offering a further opportunity to meet to share the report and discuss the learning for agencies, but unfortunately there was no response.

3. THE FACTS - Summary of Agency Involvement

3.1 This section is designed to summarise the key relevant information that was known to the agencies and professionals involved about the parents, and the circumstances of the children.

3.2 Child C's family has been known to a number of agencies for a number of years; certainly in the last two generations. Children's Social Care was involved with Child C's mother as she was growing up. Her parents were in a violent relationship and she and her sister spent time moving between the two parents during their teenage years. She has convictions for offences of violence, disorderly conduct, possession of a class A drug and driving with excess alcohol.

3.3 Child C's maternal grandmother has a history of severe mental health problems and serious drug and alcohol addictions. Child C's maternal grandfather has a history of depression and one conviction for a serious offence committed when he was a young man.

3.4 Children's Social Care first had contact with Child C's sibling and his family in October 2010 when the maternal grandmother alleged Child C's mother had assaulted her.

3.5 Domestic disputes were then reported throughout 2011 and 2012; the police have records of 8 such disputes during this period. They occurred between Child C's mother and her partner, her sister and her mother. On some occasions Child C's sibling was present and on some he was not. It was a regular feature at this time for the mother to move between homes, e.g. moving from the home of maternal grandmother to maternal grandfather following a dispute or sometimes moving to her partner's home with Child C's sibling.

3.6 A significant point in the 2011/12 period was in October 2011 when the police were called to the home of the maternal grandmother. They found her caring for Child C's sibling whilst under the influence of drugs and alcohol. Child C's sibling was then aged 14 months and had been left there all day by his mother. He was unsuitably dressed, unfed and his nappy had not been changed. The police called his mother who was out with his father. She failed to return for over an hour and asked the police officers to feed him and put him to bed. This incident prompted a section 47 investigation as part of a core assessment. A monitoring period followed during which Child C's mother engaged with services and signed a letter of agreement acknowledging the importance of not leaving the child with her mother or other unreliable baby sitters. The case was closed in December 2011.

3.7 Also of note during this period was an incident in May 2012 when Child C's mother was alleged to have hit her sister twice in the face and swung a vodka bottle at her. The child was present during the altercation. He was 21 months old. The response to this incident was a telephone strategy discussion which led to a single agency investigation by Children's Social Care. The outcome was that Child C's sibling was to be treated as a Child in Need rather than deciding to take the case to a child protection conference.

3.8 2013 saw not only the birth of Child C, but also 9 incidents which led to the police being called out to the family home. 6 of these incidents were treated as domestic incidents and were appropriately shared with Children's Social Care. The 5th incident of the 9 was not recognised as a domestic incident by the police officers and was therefore not shared with Children's Social Care. The 6th incident of the 9 did not warrant a referral in the opinion of police. The 9th incident was the alleged grievous bodily harm to Child C which was appropriately shared. The 3rd and 4th incident resulted in the case being taken to a Child Protection Conference on 17th September 2013. Child C and his sibling were made subject to a child protection plan under the category of emotional abuse.

3.9 Two days after the conference, the Deputy Head of the school attached to the nursery which Child C's sibling was due to start attending called to ask about the outcome of the conference. The school and nursery had not been invited to the conference as the child had changed setting but Children's Social Care had not been notified. She reported that bruising had been seen on Child C's cheek a week before on 12th September when she had seen Child C's sibling and his mother at the school for an introductory visit. The Duty Social Worker had visited the family home on 16th September and had not seen any bruising on Child C. It was decided there would be no benefit from a medical examination.

3.10 In October 2013 agencies were alerted on 3 occasions leading up to the incident which triggered the children being taken into care. The situations giving rise to these alerts were a domestic violence incident between C's parents; the health visitor voicing concerns that C's mother had friends in her flat who she thought were drinking alcohol early in the morning; and a further domestic dispute involving the police being called to verbal disputes.

3.11 On 19th October Child C's mother called 111, the out of hours number for medical advice and signposting. C was 14 weeks old. The mother reported his right leg had gone floppy. Advice was given to seek advice from a GP or other local service within 12 hours. Child C was admitted to hospital four and a half hours later. He had a displaced fractured right femur and was reported to be in considerable distress.

The mechanism of his injury raised safeguarding concerns to the staff very quickly and through questioning of parents the involvement of Children's Social Care was identified.

3.12 C was admitted to the paediatric ward for treatment and assessment of his injury which was considered to be non-accidental injury (NAI). Police arrested C's mother and father the next day for grievous bodily harm with intent. Child C was made the subject of police protection and arrangements were made for C's sibling to remain with his father.

4. Key Practice Episodes

4.1 This review will now focus on the key practice issues during the period in question. There were 4 key practice episodes, and these are :

- Domestic Incidents January 2010 to October 2011;
- Child C's Sibling found in the care of Maternal Grandmother (October 2011);

- Domestic Incident of 9th May 2012 through to closure of case on 22nd October 2012
- Escalation of risk May to October 2013

4.2 Domestic Incidents January 2010 to October 2011

4.2.1 Police have records of 6 domestic incidents during this period, although Children's Social Care have records of only 4. There is one incident regarding which police have records of a referral but Children's Social Care do not have records of this being received. The incident that was not referred was not recognised as a domestic incident. Whilst incidents are referred automatically where a child is present on the scene, they are not automatically referred in other cases e.g. there is a child in the family who is not present at the time of the incident.

4.2.2 The first contact recorded with the police came just after the birth of C's sibling on 2nd October 2010. C's mother dialled 999 but abandoned the call before the call was picked up. When officers called back an unknown male answered and when the operator asked to speak to C's mother he said 'Yeah if you're going to come and arrest her'. Checks revealed the mother did not wish to be seen and she later could not recall phoning the police as she had been drunk. The agency report author was unable to establish whether Child C's sibling was present when his mother called the police.

4.2.3 The first recorded contact with Children's Social Care was on 16th October 2010. It arose when the maternal grandmother alleged Child C's mother had assaulted her. The grandmother was known to have a history of severe mental illness, alcohol and substance misuse, and her daughter and grandson were living with her at the time. When it was confirmed that Child C's mother and sibling were moving to the home of Child C's maternal grandfather the decision was made to close the case.

4.2.4 Police have a record of a call from C's mother on 5th February 2011, who reported her boyfriend had tried to strangle her and she was now locked in the bathroom. C's sibling's father also called the police alleging C's mother had attacked him in his sleep. Police responded by arresting C's sibling's father and interviewing him. However, neither of the adults wished to pursue a prosecution against the other. Whilst C's sibling was not present, the police record shows Children's Social Care were notified. Children's Social Care has no record of this incident.

4.2.5 Police have records of domestic disputes in March 2011, both of which were referred to Children's Social Care. The father of C's sibling had returned to live with his family following the couple separating and C's mother was living with the sibling as a single parent. Both incidents involved alleged harassment and threats by telephone in which C's mother was the aggressor. A referral was made for Children's Centre Outreach and when it was confirmed that the Family Nurse Partnership (FNP) was continuing to support C's mother, the case was closed.

4.3 Child C's Sibling found in the fare of Maternal Grandmother (October 2011)

4.3.1 On 30th October 2011 the police were called to the home of the maternal grandmother, who was saying she had not slept for 3 days and was very irritated. They found her caring for Child C's sibling whilst under the influence of drugs and alcohol. Child C's sibling was then aged 14 months and had been left there all day by his mother. He was unsuitably dressed, unfed and his nappy had not been changed. The police called his mother who was out with his father. Initially she told the officer she had no idea where she was and requested for her child to be fed and put to bed prior to her coming home. The officer explained the seriousness of the matter to C's mother and after a number of phone calls and approximately 1 or 2 hours later, she said she was on her way home.

4.3.2 Upon returning home at 8.20 pm C's mother told officers she had left her son with her mother the previous evening and on her return home the child was still up and her mother was intoxicated. Despite this, C's mother left C's sibling in the care of his grandmother again the following day.

4.3.2 This incident led to a strategy discussion between Children's Social Care and the police. The decision was made to conduct a section 47 investigation as part of a core assessment. A monitoring period followed during which Child C's mother engaged with services and C's sibling was observed to be healthy and confident with both parents. C's mother was still receiving support from the Family Nurse Partnership and it was concluded that the decision to leave C's sibling with the maternal grandmother was a lapse of judgement by his parents. C's mother signed a letter of agreement acknowledging the importance of not leaving the child with her mother or other unreliable baby sitters. The case was closed on 13th December 2011 after a two month monitoring period during which no further concerns had been identified from the assessment. A referral was made of C's mother to Talking Therapies.

4.4 Domestic Incident of 11th May 2012 through to closure of case in October 2012

4.4.1 This incident led to C's mother being arrested for violence towards her sister whilst under the influence of alcohol. The maternal aunt alleged C's mother had attacked her with a vodka bottle which had hit her on the hand. C's sibling was present during the altercation.

He was 21 months old. He and his mother were living at maternal grandfather's home but moving between the two grandparents. C's mother was interviewed in custody and was released without charge the same day, due to lack of evidence. An appropriate referral was made to Children's Social Care of this incident.

4.4.2 On 24th May 2012 a telephone strategy discussion was held with the police and a single agency investigation by Children's Social Care was agreed.

The 10 day delay occurred because an initial assessment had begun but as more information emerged this was escalated to a strategy discussion.

4.4.3 The Family Nurse Partnership shared information regarding the family's situation. C's sibling's parents were separated and his mother had a new boyfriend (C's father). She was struggling to find her own accommodation as her housing application had been put under review. The reason for this was it was unclear where she was living as she had specified she was living with the maternal grandfather but spending 'occasional overnight stays' with the maternal grandmother to provide support. Information shared by the Family Nurse Partnership with Housing Services suggested C's mother was splitting her time between the two homes, taking the opportunity to stay at her mother's home whilst she was in hospital.

4.4.4 The FNP worker described C's mother as 'a lovely mum' who does 'all that is expected of her'. A concern was flagged regarding C's sibling's delayed speech development and the FNP worker was encouraging attendance at the Speech and Language Clinic for him. C's mother signed a written agreement regarding engaging with the Children's Centre and the voluntary agency support worker, a self-referral to the Community Mental Health Team and no inappropriate carers for C's sibling.

4.4.5 The assessment identified no immediate risks and described the mother as providing a very good standard of care. Child C's sibling's father was not seen but was spoken to by telephone. C's father and his family were seen as a positive influence.

4.4.6 The case was transferred to the Under 11s Team as a Child in Need case and a family group conference was recommended due to the impact of other family members on outcomes for C's sibling. This did not take place as C's mother felt it was inappropriate for her mother to take part, she said she didn't like her sister and she had not had much help from her father. The decision that the case was under 'Child in Need' rather than proceeding to conference was arrived at following a 4-way discussion between the managers of the social worker who had conducted the risk assessment and a Child Protection Conference Chair. The Chair agreed with the plan once she had heard all the relevant factors had been taken into consideration. The case was allocated to a Family Support Worker; a Child in Need Plan had been drawn up by the social worker who conducted the risk assessment.

4.4.7 The period from June to September 2012 was characterised by regular visits from Family Support Workers and the Family Nurse Partnership. However, the FNP Programme had been completed in September 2012 and the handover to a health visitor took place. This took the form of a joint visit with the FNP worker and health visitor in September 2012.

4.4.8 The Child in Need plan was reviewed on 19th October 2012 within Children's Social Care without any other agency present. The health visitor, upon calling, was told the review meeting had been cancelled and the case was now closed.

The health visitor attempted a visit with the family the following day but did not gain access. No further visits were made by the health visitor until July 2013. The review of the Child in Need plan recorded that direct work had been carried out with C's mother in her home, she no longer lived with her sister and there had been no reported incidents.

4.4.9 Neither of the children's fathers were included in the work done. It was noted elsewhere on the record that not all agreed actions had been completed by C's mother. In addition to this, Children's Social Care had been notified of a police callout on 8th September 2012 during which C's mother alleged her mother and her partner were high on drugs and he was threatening to beat her up. C's sibling was present. C's mother and sibling were moved to C's Sibling's father's and planned to move in with the maternal grandfather thereafter. The Family Support Worker discussed this with her supervisor on 19th September 2012 when it was recorded that 'anger is not seen as a significant issue'.

4.5 Escalation of risk May to October 2013

4.5.1 On 21st May 2013 police referred a domestic violence incident to Children's Social Care. C's mother, who was 7 months pregnant, alleged C's father, who was drunk, was smashing glass in the living room. C's sibling was at that time 2 years old, was not present during the altercation. The couple were living with C's sibling in their own rented property.

4.5.2 This was the first notification to Children's Social Care that C's mother was pregnant. The GP had been aware of the pregnancy since January, but had not referred the pregnancy. The midwives were aware there had been previous social work involvement and thus would have been expected to refer the pregnancy. However, the midwife who was involved in C's case is no longer in post and it has not been possible to contact her to explain why this did not happen.

4.5.3 Duty social workers tried to make contact with C's mother, who was resistant to any support or intervention. Calls were made by the social worker to the health visitor and midwife regarding a domestic violence incident when C's mother was 7 months pregnant. As midwifery were continuing to support the family and health visiting services were going to initiate support and the mother refused support from Children's Social Care the case was closed on 13th June 2013. Child C was born just over a month later.

4.5.4 The police report records four incidents in the month of August 2013. Three of these incidents were treated as domestic incidents which were all appropriately shared with Children's Social Care. One was not treated as a domestic incident, although it should have been. Thus Health visitor recording and that held in Children's Social Care only reflect three domestic violence incidents in this period.

4.5.5 Two of the incidents of domestic violence in August took place within a 6- day period between C's mother and father. The first of these involved C's mother returning home after having been out drinking. C's father had locked her out and her 9 day old son was with him. C was found to be asleep in his Moses basket. C's father was requested to leave.

4.5.6 During the second of the two incidents C's mother alleged she was being attacked by C's father. Police recording suggests he had kicked her 5 times whilst she was on the floor and had tried to strangle her in front of her baby. However, the police report received by Children's Social Care relates that there was no sign of struggle and no injury.

4.5.7 A Child in Need assessment was under way when the second incident was reported. A strategy discussion was held between Children's Social Care and the Police on 13th August 2013. It was agreed that Children's Social Care would carry out a section 47 investigation as a single agency assessment. A third incident occurred in that month when C's mother returned home late after being at a festival which triggered a further dispute.

4.5.8 The assessment recognised an emerging pattern of acrimony and domestic violence. Whilst both parents denied physical violence, they did accept the verbal altercations had a negative impact on the children's emotional well-being. The assessment identified the changes needed and the evidence required to confirm those changes had been effected.

4.5.9 The assessment noted C's mother was receiving treatment from her GP for depression at the time. C's father called the duty social worker on 2nd September to report that he was worried that C's mother would 'do something stupid' if she did not get the help she needed. The social worker contacted the GP that day and C's mother and arranged an urgent GP visit for her. The GP records, however, do not reflect this. There is recording of a call from the social worker when C was 3 weeks old when information sharing took place (but the details of this are not recorded). They also record a consultation with C's mother about low mood, angry outburst and alcohol abuse when C was 5 weeks old. It is recorded that C's mother started antidepressants and contacted Talking Therapies but there is no mention of a threat of suicide. There is no record of the GP contacting Children's Social Care or the health visitor about this situation.

4.5.10 C's sibling's father had not been included in this assessment. He was made aware that a Child Protection Conference was taking place at a late stage in the investigation. C's parents did not want him to be invited to the conference but their wishes were overruled and he did attend, as did they.

4.5.11 The conference took place on 17th September 2013, about a month after the two August domestic violence incidents. Apologies were received from the GP, the Health Visitor and the manager of the nursery recently attended by C's sibling. Representatives from the nursery C's sibling was due to attend were not invited due to him having moved settings over the school holidays and Children's Social Care not having been notified. The invitation was sent to the previous setting. The invitation to the core group was sent to the wrong setting, with confusion surrounding the fact that two nurseries are located on one site. Reports were received from C's mother's GP, the health visitor and Children's Social Care. The decision of the conference was that C and C's sibling should be made subject to a child protection plan under the category of Emotional Abuse. A newly qualified social worker in the Long Term Team was allocated to jointly work the case with an Assistant Team Manager.

4.5.12 On 19th September the Deputy Head of the nursery C's sibling was due to start attending called to ask about the conference and to report an incident that had taken place a week earlier. On 12th September C's mother had been for an introductory visit at the school to view the nursery facilities with an application for a place in mind for C's sibling. Both Child C and his paternal grandmother were present for the visit. C's sibling was not present. No record was made of this information and it was not passed on to Children's Social Care. However, the school was not aware C and his sibling were open cases to Children's Social Care since Children's Social Care did not know the child had moved setting.

4.5.13 On 19th September 2013 the pre-school contacted the Head teacher of the school to report she had been receiving messages regarding C's sibling, but that he was not known to that setting. When the Head teacher shared this information with the Deputy Head, the Deputy Head disclosed that she had seen 3 small bruises on the left side of C's face.

No record had been made of this observation, it had not been addressed with C's mother at the time and the information had not been passed to Children's Social Care. The Deputy Head was unaware of the bruising protocol which required such sightings to be reported in non-mobile babies. She considered at the time that the facial bruising may have been caused by a feeding tube, which was something she had seen before. Whilst she had received child protection training, this training had been delivered prior to the bruising protocol having been established.

4.5.14 The social worker from the Long Term Team spoke to the Duty Social Worker who had visited the home on 16th September 2013. The Duty Social Worker had not seen any bruising on C. The Team Manager from the Long Term team decided it was too late to pursue a medical examination of C and that instead the matter should be taken up with the parent and with the school in relation to late reporting and non-compliance with the Bruising Protocol relating to a non-mobile child.

4.5.15 Issues in the parental relationship were once again evident to agencies in the weeks which followed as C's mother told the social worker during a visit on 25th September that she and C's father had separated. Then two domestic incidents were reported to the police within a period of 8 days at the beginning of October, both of which occurred with the children present. The two incidents were interspersed with the health visitor reporting concerning information about the situation in the family home.

4.5.16 On 2nd October C's mother called the police to report C's father had pulled a chunk out of her hair and had smacked her head against the floor. She said her two children were with her, one of whom was her 3 year old son who had seen what had happened and tried to pull them apart. C's father received a caution. He admitted he had assaulted C's mother when she returned late from a night out. The police referred this incident to Children's Social Care, but Children's Social Care records suggest that this was not done until 4th October. The Ambulance Service did not raise a safeguarding alert.

4.5.17 The health visitor called the social worker on 7th October to report she had visited the family home that morning and had observed C's mother to be under the influence of substances or alcohol. She had asked C's mother directly and she denied it. She also observed young people present in the flat who were drinking from cans. The observation had been made at 10.30am and Children's Social Care were notified at 4.30pm. The social worker made an unannounced visit the following morning. A visit that afternoon was not considered as the smell had been detected early that morning and it was considered unlikely any smells would be detected by the late afternoon. The social worker found C's mother was up and ready and had taken C's sibling to school. There was no evidence of alcohol and C's mother stated the cans seen by the health visitor the previous day contained Red Bull.

4.5.18 On 10th October C's father called the police to report C's mother had thrown his belongings off the balcony. Both parents said the two children were present but were asleep in bed. The call had been made at 7.33pm.

4.5.19 Children's Social Care was notified of a domestic incident on 4th October. They responded by speaking to C's sibling's nursery and the domestic abuse project which was being attended by father and by visiting the family the next day. Talking Therapies were approached, who were willing to consider joint work to include C's father.

The social worker discussed the case during supervision on 17th October and the notes reflect increasing concern about the use of alcohol and arguments and assaults between the parents. A joint visit was discussed, whose purpose would have been to lay down boundaries by way of a written agreement with a view to seeking legal advice if concerns increased. This plan was not recorded. The practitioners at the Recall Day explained the rationale for this approach was that previous written agreements had been short term whereas this one would have a longer term remit and would be used to assemble evidence to support a discussion with legal advisers. The two previous written agreements had been largely adhered to and thus at the time this appeared to be an appropriate plan. A joint visit between the health visitor and social worker was agreed the same day, but no agreed date was recorded.

4.5.20 On 19th October C's mother dialled 111, the out of hours number for medical advice. C was 14 weeks old and C's mother was reporting his right leg had gone floppy. C's mother was advised to see a GP within 12 hours. C's mother attended the Accident and Emergency department and C was admitted to hospital four and a half hours later. Whilst the hospital had no record of Children's Social Care involvement with the family, they had established this via questioning with the family who had been open and honest about this.

4.5.21 The hospital informed the Emergency Duty Service (EDS) that day that C was in hospital with a broken femur. A strategy meeting was held on 20th October with police and hospital representatives including the consultant paediatrician as well as an emergency duty social worker. The decision of the meeting was that the police would arrest both parents and that C would be made subject to police protection. The basis for C's sibling not being included was that C's sibling was to remain with his father. C's sibling was not visited to check these arrangements, but the account of the adults was relied upon.

4.5.22 On 21st October the parents agreed to C being accommodated and C's sibling remaining with his father. C's parents were to have supervised contact with C's sibling.

5. Themed Analysis

The analysis section of this review will consider the information above, which was gained from the agency reports and from the practitioner events, thematically. These themes, which link to the terms of reference agreed at the start of the process, are:

- Inter-Agency Notifications
- Following Safeguarding Procedures
- The Quality of Assessment
- The Response
- Inter-Agency Working

5.1 Inter-Agency Notifications

(a) Police

5.1.1 Police were called out by C's family on 18 occasions during the scoping period and on a 19th occasion when C was admitted to hospital.

They were called upon to respond in a variety of ways, including agreeing the arrangements for who should remain at which address following a dispute; to remaining at the property to ensure the safety of the children until parents returned home; to considering what criminal action should be taken in response to a situation. Importantly for this review, however, the police had a role in grading risk, recording information and sharing it appropriately with other agencies with responsibilities for safeguarding children.

The police can hold important information about children who may be suffering, or likely to suffer, significant harm, as well as those who cause such harm. They should always share this information with other organisations where this is necessary to protect children.

(Working Together to Safeguard Children 2013)

5.1.2 The information they held about the 19 calls they had received helped to paint a picture for other agencies about what was going on in the home. However, the police are required to filter this information in line with what they believe at the time is relevant to safeguarding children. They are required to include in reports of every domestic incident details of a child living at the address or with whom the suspect(s) have contact and this includes unborn children.

5.1.3 Some callouts were made prior to the police establishing their 3 referral centres in October 2011 which has streamlined the notification process. For these callouts, officers were required to automatically notify Children's Social Care where a dispute occurs with children present. In other situations, such as where there is a child in the family who is not present, this notification would not be automatic i.e. some such calls would result in a notification and others would not. In the period since October 2011, the referral centres receive all internal and external referrals regarding child protection and domestic abuse and their child protection referral managers make the appropriate risk assessments and share information.

5.1.4 Since October 2011 the referral centres receive all internal and external referrals regarding child protection and domestic abuse. The Risk Assessments of the domestic incidents are managed by the risk assessors as opposed to the Child Protection Referral Managers. The child protection referral managers review child protection referrals and liaise with Children's Social Care to agree an appropriate course of action and also notify child protection reports to the local authority which have been created by officers. Currently high risk domestic incidents are graded as such where:

(1) children are subject to a child protection plan

(2) unborn baby

(3) children listed

These are referred by the child protection manager on the day of the report. Alll other domestic reports where children are listed are referred by a 'crystal' report. Occasionally, domestic reports are referred which do not fit this criteria but which did reveal a child protection concern. These are also reviewed by the child protection referral manager and referred to Children's Social Care.

5.1.5 The police report states 13 of the 18 callouts resulted in Children's Social Care being notified although Children's Social Care have recording of only 12 being notified.

Of the 5 that were not notified, this happened for a range of reasons. Two were not recognised as a domestic incident, although they should have been. Three were not domestic incidents and did not need to be notified.

Comment

Irrespective of whether the referrals were before or after the establishment of the referral centre, the system is solely reliant upon the attending officer relaying their concerns. With hindsight it is possible to see that it would have been helpful for agencies to have had access to information about some of the unreported incidents as they helped with building a picture of how life was in the family home. However, this information could have been requested as part of the information-gathering process for the assessment. Similarly, some of the softer information regarding these incidents that appears in the police record was not available within the police referral. Equally this information could have been requested or could have been shared during multi-agency discussions. ***Recommendation 1***

(b) Health Organisations

5.1.6 Information was held by some health organisations which was not known by all agencies who needed to be made aware. When C's mother first became pregnant the trainee GP consulted her trainer and appropriately made a referral to the health visitor by letter. However, when C's mother became pregnant with C, no such referral was sent by either the GP or the midwife. It was known to the GP and midwife in January 2013. However, the GP notes suggested the previous pregnancy had gone well and contained nothing about alcohol consumption between pregnancies. In terms of the midwife's perspective, the booking was not made in the GP surgery and thus the midwife did not have access to the GP notes. Also, the mother reported she consumed zero units of alcohol; the midwife perceived that no referral was necessary. The midwife therefore made a routine referral to the health visiting service but no referral for a targeted antenatal visit was received from either the midwife of the GP.

Comment

This was a crucial time in terms of the support the family was receiving. The support of the Family Nurse programme came to an end and there was a 9 month interval during which the health visitor did not undertake any visits. The relationship C's mother had made with the Family Nurse was considered to be a strong and trusting one and the intensive, focussed visiting was key in supporting C's mother to cope with parenting despite the many difficulties she was experiencing. These included lack of wider family support, relationship problems, being a carer for her mother and not having stable housing. Whilst the health visitor was notified of her pregnancy, no referral for a targeted antenatal visit was received. It is hoped that this would also have resulted in the health visitor notifying Children's Social Care, who had reviewed C's sibling's Child In Need plan 7 weeks earlier.

The maternal grandmother's mental health history was well known to the practice and C's sibling was being left in her care. There is now an expectation that midwives review GP records and health visitors review all booking paperwork. The separation of information technology systems exacerbated problems between these health organisations. Communication between GP, midwife and health visitor was recognised as a theme in the Child B Serious Case Review undertaken in September 2011.

5.1.7 When the ambulance service was called to the family home on 2nd October 2013 C's mother alleged she had been assaulted by her partner with her children present. However, no safeguarding alert was raised by the crew. The police were already present at the address, but there was a need to alert Children's Social Care.

Comment

This particular ambulance crew did not undertake safeguarding training until early 2014. The police notification did not reach Children's Social Care until 4th October.

5.2 Following Safeguarding Procedures

5.2(i) Strategy Discussion

Whenever there is a reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion involving local authority children's social care, the police, health and other bodies such as the referring agency.

(Working Together to Safeguard Children 2013)

5.2.1 The first strategy discussion which took place during the scoping period was held on 31st October 2011. This followed the two incidents during which C's mother left C's sibling in the maternal grandmother's care despite having found him up late at night in the care of his grandmother who was under the influence of alcohol on the first occasion. The agency with whom the family had had most contact at this stage was the Family Nurse Partnership, but also CMHT had been involved.

Comment

Whilst it may not always be possible to secure the attendance of health professionals at short notice, there was no reason why an invitation to this strategy discussion could not have been sent. The assessment which was decided upon during the discussion focussed on the support that was needed for C's mother, particularly in view of her depression, and the need for monitoring. This was a discussion within which health professionals had a key role to play.

5.2.2 The same comment applies to the second strategy discussion which was held in response to the incident on 14th May 2012. This was the incident witnessed by C's sibling at the age of 21 months. C's mother was alleged to have hit her sister twice in the face and swung a vodka bottle at her. An initial assessment had begun but as more information emerged this was escalated to a telephone strategy discussion between the police and Children's Social Care on 24th May.

Comment

There was a sense at this time from the agency report that the FNP worker was working in isolation with this family and taking a lot of responsibility for the case.

The FNP worker does not feel this was the case. However, when a crisis occurred, this worker failed to liaise across agencies or make referrals. This factor adds further weight to the need for health organisations to have been invited to strategy discussions.

A subsequent individual call to the FNP worker, as was undertaken in this case, is no substitute for full inter-agency working in the spirit of the statutory guidance.

5.2.3 On 2nd October 2013 C's mother dialled 999 and alleged C's father had beaten her up. She said he had pulled a chunk out of her hair and had smacked her head against the floor. She said she had her two children with her, one of whom was her three year old son who had attempted to pull them apart. This was a serious incident during which C's sibling could have been injured. Police, Children's Social Care and health visitors were aware of the incident, yet there is no evidence that the emotional impact of C's sibling witnessing domestic abuse was considered. It did not give rise to a strategy meeting to consider the immediate safety of the children. The rationale was that a tight written agreement should be drawn up with a view to legal planning.

Comment

The fact that the discussion itself was not triggered is raised as an issue by some of the agency report authors. It should be recognised that the function of the strategy discussion within the child protection system is to strengthen the inter-agency response and allow for objective consideration and professional debate. However, there is no evidence that the other agencies involved at the time were minded to challenge the lack of action. There is no evidence of escalation or advice being taken from named professionals at this point. Certainly this was available for health visitors at the time, yet not taken up.

5.2 (ii) Child in Need Plan and Review

5.2.4 What followed from the strategy discussion in May 2012 was a Child in Need Plan. The outcome of the section 47 investigation was that the concern had been substantiated, but that C's sibling was not considered to be at immediate risk of harm due to the measures that had been implemented.

Comment

This decision has been called into question during the process of this review, taking into account what was known at the time about C's sibling having witnessed the vodka bottle incident. However, recording suggests the decision was taken following a discussion between a senior practitioner, an Assistant Team Manager, a Team Manager and a Child Protection Chair who agreed upon hearing 'all the relevant factors had been taken into consideration'. The rationale in part was that there had been two section 47 investigations in the first two years of C's sibling's life, yet Child in Need services had not yet been offered to this family. The decision was taken in good faith after some deliberation. The process of decision making is offered as an example of good practice by the agency report author for Children's Social Care.

5.2.5 Also worthy of scrutiny was the decision which followed to allocate the case to a family support worker. The basis for the decision was the worker's extensive experience of working with domestic violence situations and was supervised by an Assistant Team Manager whose role was to take a full overview of the case.

Comment

The statutory guidance in Working Together to Safeguard Children 2010 required a qualified social worker to lead the completion of a core assessment (and undertake the necessary enquiries to satisfy the duties set out within section 47 Children Act 1989).However, the guidance was vague in respect of the required experience/qualification for staff undertaking the assessment/enquiry.

The interpretation of 'leading' the case was debated at the Recall Day. In spite of the ambiguity in the guidance it is important that following core assessments/section 47 enquiries complex cases are allocated to suitably qualified and experienced staff. The proposal from Children's Social Care to risk assess such cases, taking account of how cases can change, is welcomed.

5.2.6 When the time came to review the Child in Need plan in October that year, the FNP worker had completed her final visit with the family and had handed over the case to the health visitor. When the health visitor contacted Children's Social Care regarding the meeting scheduled for 19th October she was told that it had been cancelled and the case was now closed. Thus the Child in Need Plan review, like the discussions above, was not truly multi-agency and once again did not include health representatives, including CMHT who held relevant information.

Comment

The decision of the meeting was to step the case down at a time when the supportive relationship between C's mother and the Family Nurse had just ceased. The family did not receive a visit from the health visitor for a further 9 months, during which time C's mother had once again fallen pregnant.

5.2 (iii) Child Protection Conference

5.2.7 The conference took place on 17th September 2013, following domestic violence incidents in August of that year. The section 47 investigation revealed that the children's basic care needs were being met but that the altercations were having a negative impact on the children's emotional well-being.

Following section 47 enquiries, an initial child protection conference brings together family members (and the child where appropriate) with the supporters, advocates and professionals most involved with the child and family, to make decisions about the child's future safety, health and development.

(Working Together to Safeguard Children 2013)

5.2.8 Once again, key agencies were not present for this conference. The GP, the health visitor and the nursery which C's sibling had recently attended sent apologies. This was considered to be an exceptional departure by this particular health visitor given the priority health visitors were giving to conferences at this time. However, for GPs it is more common that they do not attend. A number of reasons have been cited for this, including the notice they receive when they have fully booked clinics and the length of meetings. Whilst the GP and the health visitor did produce reports, this is no substitute for attendance. The nursery C's mother was considering for C's sibling was not invited due to him having moved setting and Children's Social Care not having been notified.

Mental Health Services were not invited despite the impact of the mental health issues of both the maternal grandparents and C's mother being of significance to the case.

5.2.9 A significant development had arisen during the course of an introductory visit on 12th September to the nursery she was considering for C's sibling. Bruising had been noticed by the Deputy Head on C's cheek. This should have been reported earlier, which would hopefully have resulted in staff from this setting being invited which would have brought this development to the multi-agency arena sooner.

Comment

Some invitations were sent appropriately in this instance, other than the omission of the nursery C was due to attend. This was due to it not being known C's sibling had moved setting. Once again Mental Health Services were omitted on the basis that their involvement was with grandparents and with C's mother historically.

5.2.10 The conference made both children subject to a child protection plan under the category of Emotional Abuse. Whilst the category fitted well at the time, it has been considered that the learning from this case would be that in cases such as these the category of physical abuse should be favoured. The case was allocated to a newly qualified social worker, although the intention was for the case to be jointly worked by an Assistant Team Manager.

Comment

For the first week of the work the Assistant Team Manager in question had not yet arrived in post. 'Joint working' did not include joint visits, but the social worker was able to receive support when needed. Whilst the manager was clear she was directing the social worker's actions this arrangement is more akin to supervision than joint working. Furthermore, it is once again a departure from the local requirement for child protection cases to be worked by a social worker who is 3 months qualified and taken part in child protection training . At this point they would only be allocated a child protection case where it would be on a joint basis for a period of time. The decision was taken to allocate the case to this particular worker on the basis of his extensive experience as a mental health worker and knew the family history.

5.2 (iv) Referral to Emergency Duty Service

5.2.11 A referral was made by the hospital to the Emergency Duty Service when Child C was admitted to hospital on 20th October 2013. At that point it is required under local procedure to contact the on-call manager, undertake a records check and make a joint visit with the police to speak to C's parents and hospital professionals. The recording of the referral in C's case was very poor and contained little or no information. Some details were contradictory regarding decision making and the details of the consultant. The social worker did not enquire as to whether there were other children living in the family home.

Comment

When interviewed this social worker agreed that these actions should have been undertaken. These are required under the Berkshire Emergency Duty Service Local Safeguarding Boards Child Protection Procedures. However, due to excessive workload the social worker passed the case onto the overnight social worker to liaise with management and take forward the referral. Due to a social worker calling in at short notice the on-call manager who was notified of the case was acting up as a child care social worker. The Head of Service was contacted who instructed the social worker to undertake a joint visit with police and to contact C's sibling's father to ensure C's sibling's safety. This was not done and the social worker, when interviewed, explained this was due to the shift being extremely busy and explained that in her opinion Child C was safe. The third social worker who had contact with the case was described as thorough in her enquiries, she attended the strategy meeting and arrest. However, she did not visit C's sibling but did contact his father to check he would care for C's sibling and ensured he understood contact with C's mother and father should not be permitted. This was a busy weekend for this service, which received 259 phone calls and dealt with over 146 referrals. Extra staff were asked to work due to demand on the service and the complexity of some of the cases.

5.3 The Quality of Assessments

5.3 (i) Understanding of Family History

5.3.1 The family history was a significant factor in this case. This was not only because of the impact of this history on C's mother, but also because C's maternal grandmother was involved in the care of children. C's maternal grandmother has been known to Community Mental Health Services (CMHT) since 2003.

5.3.2 The FNP worker demonstrated good practice in terms of making a clear assessment of the history and the impact this would be likely to have on C's mother's ability to parent her child. A plan was formulated which took account of this combined with C's mother's current difficulties, including lack of wider family support, relationship problems, being a carer to her mother who was experiencing mental health issues and not having stable housing. The plan, discussed during management supervision, for the antenatal period included work around risk taking behaviours and on building self-esteem.

Comment

This was a robust plan.

5.3.4 This experience of pregnancy and babyhood for C's sibling was not mirrored during the second pregnancy. This became known to services in May 2013, during which time an opportunity was missed to provide targeted support during the antenatal period, assess risk in light of the family history and plan for the extra stress of a new baby within the family.

Comment

The family history and the recent history of domestic dispute was vital in assessing risk once the health visitor began work with the family. It did form part of the handover from FNP worker. The report from Berkshire Healthcare NHS Foundation Trust states that the records following this visit were very brief and the new birth assessment paperwork was not completed. It is not possible to ascertain from the record how long the visit took. The completion of the paperwork may have prompted the health visitor to have asked C's mother about domestic abuse when her partner was not present. This gap in knowledge was further exacerbated by the health visitor not attending the child protection conference or the first core group. Significantly, the failure to ask the question about domestic violence featured in the Child B serious case review in 2011.

5.3.5 Within Children's Social Care, the family history was well understood, with C's mother's own experience of childhood being considered in the context of her parenting within the Duty and Referral Team. However, this was not always evident in the Long Term Team as evidenced by their response to escalating concern and the way in which the Child in Need plan was implemented.

Comment

This raises questions as to whether the fullest information was adequately passed on by the transferring team and understood in the receiving team. It also raises questions about the decision to allocate the case to a family support worker in 2012 and a newly qualified social worker in 2013.

5.3.6 Police records relating to C's mother date back to 2003 and go back further in relation to the maternal grandmother. Police made risk assessments on each occasion based on previous risk assessments, and ensured officers were fully appraised of the history each time a domestic incident was recorded via access to live records. The hospital and education setting were not aware of the history. There was an exception to this in terms of one particular worker at the setting who knew some of the history due to a previous role she had worked in. She would have been required to bring this knowledge to the fore had child safeguarding issues been evident to her.

5.3.7 GP records contained notes regarding the family history of depression, drug and alcohol abuse as well as C's mother's history of elective mutism in her youth and being under CAMHS as a child. Thus there is no reason to believe this did not form part of assessments made within the GP practices. However, whilst the history prompted a referral of her first pregnancy, this was not the case for the second pregnancy.

Comment

In the Child B serious case review, a recommendation was made that GPs, health visitors and midwives should be encouraged to consider initiating the CAF (Common Assessment Framework) for pregnant women who present in pregnancy with complex social factors.

5.3 (ii) The Toxic Trio

5.3.8 When assessing risk for the children, how well understood was the impact of alcohol and substance misuse, domestic abuse and mental health issues for their carers? The health visiting records show no evidence of these factors being considered. There were 5 incidents of domestic abuse in the first 12 weeks of C's life, but the health visitor did not challenge the progress of the case or the lack of a strategy meeting. Many professionals involved in the case, unsurprisingly, were influenced by the Family's Nurse's views as she had been involved in a close and supportive relationship with C's mother. This may or may not have been a factor in the lack of challenge.

Comment

The Children's Centre did not feel minded to challenge on the basis of the good parenting they observed. However, they felt they may have taken a different view had they known the family history. The health visitor agency report author would have expected the health visitor to have challenged in these circumstances.

5.3.9 Whilst the FNP worker was clearly considering risk factors from the historical context to enable her to support C's mother, it is less clear the same approach was taken to considering the impact of these factors on C's sibling.

Comment

When discussions took place between the FNP worker and the social worker following domestic abuse notifications, the FNP worker felt she had no concerns about C's mother's ability to parent C's sibling. Following the fight between C's mother and his maternal aunt the underlying family problem of domestic abuse was not explored with C's mother and a referral to domestic abuse services or the freedom programme was not explored. When the FNP worker was consulted by C's mother due to her feeling low in mood, there is no evidence that she spoke to the GP to discuss C's mother's wellbeing or the likely impact of her low mood on C's sibling. **Recommendation 3, Recommendation 7**

5.3.10 In Children's Social Care, the impact of these factors did not seem to be taken into account at all stages. We did receive reassurance at the Learning Event from the agencies involved in the strategy discussion of October 2011 that the meeting took account of how difficult the combination of these three factors make it to work with families. In the summer of 2012, three sessions of direct work were offered to C's mother around issues of concern, including her anger. However, these sessions seemed to focus on C's mother's relationship with her sister and they ceased in October 2012 after a Child in Need meeting decided all necessary work had been done. Whilst a referral to Talking Therapies was made as early as 2011, there was no service offered to mother as a perpetrator of domestic violence. She was encouraged to contact the drug and alcohol service, although this was not taken up and it was not escalated. It was recognised that this service was reliant on self-reporting and would close the service for clients who did not attend for two appointments or more**.**

5.3.11 It is important to recognise that the worker identified to work with the family was seen as a match for this case due to his extensive experience as a mental health worker. However, the child protection plan was not implemented in such a way which reflected such an understanding. This may have been due to the joint working arrangement being more akin to supervision or it may have been due to inadequate transfer arrangements.

Comment

Whatever the cause, effective multi-agency safeguarding arrangements are needed to ensure cases involving these three issues receive the priority they deserve. The recommendations made by Children's Social Care are welcomed, see also **Recommendation 3.**

5.3.12 When a domestic incident was notified by the police in May 2013 Children's Social Care became aware of C's mother's second pregnancy and appropriately made enquiries of midwifery and health visiting services. This was an example of good inter-agency communication. The two agencies expressed 'no concerns' and this led to closure of the case. In the case of the health visiting service, it was not working with the family at the time, and this resulted in none being identified. This was an opportunity for any of the 3 agencies involved in this dialogue to consider:

- This case involved a child under 3 where there had been two section 47 investigations.
- The latest notification involved a new relationship provoking violence.
- Whether a pattern was emerging which may increase risks to the safety of C's sibling and unborn C.
- What significance should be attached to the violence occurring when C's mother was 7 months pregnant i.e. this not acting as a deterrent for either partner

Comment

The case was closed following this consultation. Children's Social Care felt at the time they were balancing risk factors against what they saw as reassuring information from the police about C's sibling's presentation. The decision to close the case and rely on other agencies to provide support suggests too much reliance was placed on these agencies. Overall, the response to the impact of the three issues coming into play at this time was lacking.

5.3.13 GPs were not aware of domestic dispute as an issue until October 2013. However, it was apparent from records that C's mother had been tagged for a criminal offence. Leaving this aspect aside, the combination of the alcohol and substance misuse issues presenting for this mother led to a referral to the health visitor in her first pregnancy but not her second. In the case of her second pregnancy a referral to Children's Social Care would have been appropriate.

Comment

Issues around alcohol generally were given insufficient prevalence. Alcohol was known to be an issue for C's mother from adolescence and was ongoing. Both fathers used alcohol but more latterly it seemed C's father was frequently using alcohol. What role was this or any other substance playing in the domestic disputes and what impact was it having on parenting the two children? Greater efforts could have been made to require the parents to engage with local drug and alcohol services. The health visitor discussed making a referral to drug and alcohol services with the perinatal health lead in September 2013 but this was not taken up. The recommendation for refresher training made by Children's Social Care is acknowledged here.

5.3 (iii) Involvement of Fathers and Extended Family

'*Every assessment should be informed by the views of the child as well as the family*'

(Working Together to Safeguard Children 2013)

5.3.14 The voice of the children is considered below, but the extent to which both fathers and both sets of grandparents were involved in assessments is relevant to this review.

5.3.15 The assessment in Children's Social Care which followed included both parents, as did the work undertaken thereafter. However, C's sibling's father was not seen during the second investigation. The assessments of August 2013 involved both C's father and his family but not C's sibling's father, who continued to play an active role with C's sibling. The social workers stated they did want to involve C's sibling's father earlier but that C's mother refused to provide contact details. There is a sense overall that workers got to know C's father better than C's siblings father.

Comment

The varying levels of involvement of the children's fathers in assessments led to significant information being held about the mother's history and family background with relatively little being known about that of the fathers. For instance, both fathers work full time but it was not known what their occupations were. Work had an overall focus of work on C's mother as main care giver. However, both fathers remained involved in their children's lives, even when separated from the mother and were part of the relationships based on domestic abuse which had been ongoing throughout the children's early childhood. A similar theme was highlighted in the Child B serious case review in 2011, with limited assessment of the roles of males and others living within the household.

5.3.16 The grandparents were also key figures for the purposes of assessments of this family. A pattern was emerging which suggested many of the incidents triggered a move with C's mother and children to either the home of the maternal grandmother or the maternal grandfather. The maternal aunt was also living at the maternal grandfather's address but they were not successfully engaged.

5.3.17 The maternal grandparents were included in the first section 47 investigation. However, by the end of 2011 the maternal grandmother was clearly viewed as an unsuitable baby sitter. That view appears to have been formed following the incident when C's sibling was found in her care when she was under the influence of alcohol on 31st October of that year, rather than resulting from an assessment of her.

Comment

There is no evidence that C's mother's role as a young carer emerged and this may have been clearer had the maternal grandmother been involved in assessments and the impact of their complex relationship on the family dynamics been considered. **Recommendation 2.** In the Child B case of 2011 assessments were identified as having failed to address the broader social context and including the nature of the relationships between those caring for Child B.

5.3.18 There was an instance in response to the domestic incident in May 2012 when a suggestion of a Think Family approach emerged. The team manager who oversaw the work recommended a family group conference because of the impact of other family members on outcomes for C's sibling. However, this was not implemented as C's mother was not happy with family members participating.

Comment

Greater efforts could have been made to make this conference happen. Work has been undertaken to increase the number of Family Group Conferences with a 48% increase since 2012.

5.3.19 Latterly it is recorded that the paternal grandmother visited the pre-school with C and his mother and we heard at the Learning Event that she was seen as a supportive influence. However, it appears that it was not until the incidents in August 2013 that their involvement in assessments began and it is not known what their views were of what was happening for the family.

Comment

The reason given for the paternal grandparents not being consulted was that the case was not open to Children's Social Care when the relationship with C's father began. The case was opened in July.

5.3 (iii) Consideration of Mother's Circumstances

5.3.20 There were factors prevailing for the mother which were relevant to assessments during the scoping period. Her unstable housing situation was a factor which was taken up by the Long Term Team on mother's behalf. Housing Services were unaware until February 2012 that she was moving between homes. Her circumstances were investigated, which was very distressing to her.

Comment

These factors were well understood by social workers and the family nurse, including the impact on C's mother of the maternal grandmother refusing to have her in her home. In the Partnership Learning review undertaken in September 2013 a key message which emerged was that housing issues increase vulnerability.

5.3.21 Other factors have only been taken into account since the scoping period e.g. mother's acceptance of her dual heritage is only recently been the subject of direct work. Once again, the treatment of these factors was criticised in the 2011 serious case review.

5.4 The Response

5.4 (i) Children's Social Care

5.4.1 *Working Together to Safeguard Children 2013* sets out a clear process for how social workers as lead professionals are required to respond to a referral. Within one working day a decision must be made regarding which category of response is warranted, which services are required and whether further specialist assessments are needed.

5.4.2 In C's case some concerns came to the attention of Children's Social Care in the form of a referral. For instance, most of the police callouts to domestic incidents resulted in a referral to Children's Social Care. Other issues arose from assessments. For instance, issues arose during the process of the Child in Need plan in 2012. C's sibling was subject to disruption, instability and domestic aggravation as a result of the moves between C's mother's parents and then to the home of her new boyfriend's mother. A change of home was often triggered by a dispute, some of which he had witnessed. This was added to the change he was experiencing as a result of his mother's new relationship.

Comment

The Child in Need plan did not address these issues and the case was closed in October of that year with some actions identified in the plan outstanding. Contingencies were not expressed with identified consequences and this affected the response during this part of the scoping period.

5.4.3 Professionals spent time interacting with the adults in order to effect a positive change in parenting capacity. However, this resulted in this case in a loss of focus on C's sibling. There is no evidence that professionals could see what life was like for C's sibling.

Comment

The evidence was beginning to emerge at this stage, with police reports describing C's sibling as presenting as withdrawn and anxious and his speech had become significantly delayed.

5.4.4 The role of supervision is highly relevant in understanding why the response was not what it should have been. It was suggested by Lord Laming that supervision is the cornerstone of good social work practice, an opinion that was reiterated in the second Munro Review (May 2012). This section is concerned with supervision and management oversight across agencies, not purely that of social workers.

5.4.5 It was essential to step back from the case and reflect on the increasing pattern of police notifications and the escalation of domestic dispute, especially in the period before C's injury.

5.4.6 In Children's Social Care, whilst supervision was regular and recorded appropriately, it missed an opportunity to reflect on the patterns. Responding with written agreements had not been accompanied by monitoring and known consequences for default. A change of approach was needed.

5.4.7 Children's Social Care was notified of a police callout on 8th September 2012 involving alleged threats of violence from the maternal grandparents to C's mother during which the child was present. This was appropriately discussed between the family support worker and her supervisor during supervision a week later. The recording shows 'anger is not seen as a significant issue', but it transpires that this comment related to C's mother's anger. The decision was made during that session to close the case.

Comment

The rationale for case closure was that the identified work had been completed. However, this latest incident highlighted a key issue for mother and child, namely that of housing. Whilst the alleged threats were being made to beat C's mother up during this altercation she had locked herself and her boyfriend upstairs, leaving her son asleep in the next room. She had then left that address, moved to her boyfriend's accommodation for a short period before moving in with her father. This instability around housing was a key feature in the case and was by no means resolved at the time the case was closed.

5.4.8 A further example of supervision taking place yet not producing a robust plan is the session which took place on 17th October 2013. Two domestic incidents were discussed during one of which both children were present and these had been interspersed with a health visitor referral regarding alleged drinking of alcohol early in the morning. Whilst it is acknowledged as good practice that a joint visit was planned in October 2013 this was not recorded and no date was agreed for it.

Comment

This visit did not take place soon enough before C became injured. The reason for this was the number of cases being overseen by the Assistant Team Manager at the time as a result of staff having left with replacements not yet taking up post. Some supervision was being offered by new managers who had not yet gained the fullest awareness of their supervisees' caseloads.

A positive development has arisen in the form of an opportunity to reflect in a multi-agency context arising at CMHT and the SMART Drug Treatment Agency also offers this. Social workers have attended both of these. ***Recommendation 5.***

5.4 (ii) 111 Service

5.4.9 C's mother called the 111 service on 19th October 2013 to report that C's leg left leg was floppy. In these circumstances it would be expected that an investigation into how the injury had been caused would have been documented and likewise the rationale for ruling out non-accidental injury.

Comment

The call taker followed the national pathways triage system for the identification of potential non-accidental injury. However, there is a potential for a non-accidental injury to be missed which is inherent in the process. ***Recommendation 8***

5.4 (iii) Inter-agency Challenge

5.4.10 Children's Social Care was not the only agency who knew of the situation this family was in. Police officers and health visitors were receiving supervision during the scoping period, but there is no evidence they were discussing the possibility of challenging plans and/or responses. Upon de-brief the health visitor did not see why she would have challenged the decision making about the family at the time. Certainly at the time of closure of the Child in Need plan the situation may well have looked less concerning from the perspective of this service as the FNP programme had been working well.

Points at which challenge may have been considered were when:

(a) the Child in Need plan was closed when all actions had not been completed and this largely relates to C's mother's housing;

(b) the case was closed in June 2013 following a domestic incident when C's mother was heavily pregnant. The basis for case closure was the support being provided by midwifery and health visiting services. Whilst the decision was taken on balancing all factors there was an over-reliance on the other agencies at this stage;

(c) the response to the domestic violence incident in October 2013 in which C's sibling attempted to separate his parents was not to consider immediate risk in the context of a strategy discussion but to undertake further work and establish a tight written agreement;

(d) the school reported they had noticed bruising on C's cheek in September 2013 but the decision was taken not to proceed to a medical examination on the basis that the social worker had also seen the child yet had not noticed bruising;

Comment

The role that could have been played by specialist services cannot be underestimated in the context of the response. Whilst it is recognised that the family was not readily engaging, plans and agreements with contingencies which were followed through may have improved this. This included the drug and alcohol and domestic violence perpetrator services previously mentioned.

Importantly, when these were refused or not taken up the contingency plan should have kicked in and led to an appropriate response to safeguard the children. Greater follow up with children's centre and Talking Therapies regarding the level of the family's engagement would have helped to evidence how little input these entrenched issues were actually receiving.

5.4 (iii) Other agencies

5.4.11 Other agencies' responses to the family were lacking during the scoping period. Despite being told a 14 week old baby's right leg had gone floppy the response of the 111 out of hours service was not to go to the Accident and Emergency department. Instead they offered to call back within 12 hours, and did not involve a clinician to make a full assessment of the situation.

5.4.12 When the health visitor was concerned during a home visit in October 2013 about C's mother and possibly her friends drinking alcohol she did not investigate precisely what was in the cans whilst she was present and her referral to Children's Social Care came six hours later. She simply did not realise the significance of sharing this information earlier. This presented a major barrier to evidence gathering.

5.4.13 When the school saw bruising on C's cheek they did not refer this to Children's Social Care until later when they made the link between C and the family who had been to the Child Protection Conference. They did not follow the bruising protocol as it had not been cascaded. This protocol was introduced in the 2011 serious case review and which also featured in the 2013 partnership learning review, which resulted in reminders being issued. The Bracknell Forest Safeguarding Children Board should take this opportunity to consider carefully the way in which its messages are being disseminated and how it will disseminate the messages from this serious case review.

5.5 Interagency Working

5.5.1 It is very pleasing to report some examples of timely and effective inter-agency communication :

- The trainee GP referred C's mother's first pregnancy to the health visitor. This would have been improved by also informing Children's Social Care given C's mother's past history of drug and alcohol abuse.

- There is evidence of calls from Children's Social Care to the GP surgery in the early part of the scoping period. Unfortunately the calls were not recorded fully enough to enable the information shared to be used appropriately at further consultations with primary care.

- The housing service was proactive in making timely referrals of domestic disputes to Children's Social Care.

- Attending police officers were vigilant in grading risk and returning paperwork. Information regarding how the children presented during callouts was apparent in the recording made by attending officers. For instance, on 30th October 2011 officers' concerns regarding C's sibling not being fed, watered or changed were thoroughly recorded.

5.5.2 However, there is fundamental learning from this case for Bracknell Forest from examples of inter-agency and intra-agency working which were less than effective:

- The GP did not refer C's mother's second pregnancy to Children's Social Care. The hospital sent a routine notification to the health visiting service, but no request for a targeted antenatal visit. The GP did not later refer C's mother when she was presenting with low mood.

- The Family Nurse and CMHT were not invited to strategy meetings.

- The child protection conference did not take place until one month after the incident when C's mother alleged she had been attacked by her partner in August 2013. It received a report from the GP, but the GP did not attend. If the GP had attended, primary care would have been alerted to the domestic violence issues. The children's fathers' GPs were not invited to the conference and did not produce reports.

- The health visitor did not attend either the conference or the first core group meeting. An opportunity was missed here for the health visitor to understand the concerns and commence intervention earlier.

- The transition between family nurse and health visitor was not effected, resulting in a 9 month gap in which the family did not receive support.

- In May 2013 hospital midwives did not refer the police callout to Children's Social Care.

- The ambulance service did not raise a safeguarding alert when they were called out to a domestic violence incident on 2nd October 2013 during which children had been present.

- When C was admitted to hospital in October 2013 they were alerted to Children's Social Care involvement with the family as a result of questioning of the parents, who were very honest**.** This hospital had not received a list of children subject to a plan as they had not requested one.

5.5.3 These omissions resulted in pockets of information being held in certain agencies which were not clear to others until revealed during the process of this review. Examples would be that the GP knew C's mother had been an elective mute, but Children's Social Care did not know. However, the GP was not aware of domestic violence issues.

- Children's Social Care incorrectly identified the nursery setting, although confusion arose due to two settings being co-located on the same site. However, Children's Social care was informed of its mistake on two occasions yet failed to rectify its mistake.

- The lack of a strategy meeting in response to the incident on 2nd October resulted in agencies other than Children's Social Care not being able to contribute to the decision making at this crucial time.

- The Deputy Head did not inform Children's Social Care when she first saw the bruising on C's cheek. This affected the options open to Children's Social Care when they were informed.

- Information was not shared with the Children's Centre by PACT, the health visitor, the family nurse or Children's Social Care.

5.5.4 An integral part of effective inter-agency working is ensuring information shared is accurately recorded. Recording was deficient in this sense in GP practices and education settings linked with C's case. Similarly, recording made by the ambulance service did not show how non-accidental injury had been ruled out, either at the time of the 111 call or when the ambulance attended at the family home. An example of what resulted in the education context was that when C's sibling moved settings in haste this was a risk factor in the light of his circumstances. Social workers were heavily involved in his life, yet no alert was raised with them. Similarly, recording in the Emergency Duty Service was poor, leaving staff taking up the case on subsequent shifts with a very unclear picture of the situation the two children found themselves in following C's admission to hospital.

6. Voice of the Children

6.1 C and his sibling were very young during the scoping period and largely unable to speak. C was an infant and, other than the distress he would have displayed following his injury, any non-verbal signs of abuse he may have shown at other times would have been difficult to observe. However, C's sibling was clearly communicating his wishes and feelings through gestures and expression.

6.2 Police officers who did not know him recognised he had not been fed, watered or changed back in October 2011. Then in May 2012 he was observed to be upset when officers arrived and very quiet. He was a child who initially had been exceeding milestones and then was later seen to be anxious and delayed in his speech.

6.3 Professional curiosity may have led to questions being asked such as how the number of house moves were impacting on C's sibling. These moves tended to come immediately after an incident. Another relevant question was around how well he was managing the adjustment to changes such as his mother's new relationship and the birth of his sibling or his change of nursery.

6.4 C's sibling's daily lived experience did not come through in assessment and he was not seen holistically, with little direct observation of him. He was not observed with all his care givers and decision making was incident focussed rather than child focussed. Even in the earlier days when the case was being worked under Child in Need, there seemed to be a focus on C's mother's anger rather than C's sibling. These issues arose in the serious case review of 2011. In the partnership learning review of 2013, the good physical care provided to the child masked the underlying issue of domestic violence. It is relevant to question the extent to which this factor repeated itself in Child C's case.

7. Good Practice

A SILP review seeks to learn from good practice as much as from shortcomings. The following areas of good practice are identified:

7.1 The role of the family nurse worked well; this is an example of early intervention. The FNP worker engaged C's mother to begin with and went on to develop a close relationship with her. There was a skill in sustaining this relationship and this was achieved until the programme ended.

7.2 In Children's Social Care the duty social worker and senior social work practitioner demonstrated skill and persistence in engaging with C's mother. On one occasion it was necessary for them to sit for a long period of time in silence until she would speak to them.

7.3 The Duty and Assessment team researched the complex family history and made good use of it in assessments to understand how patterns can repeat themselves in later generations. This team shared concerns about the impact of the maternal grandmother's mental health on mother and child with mental health services.

7.4 There were positive interventions with C's father. The Domestic Abuse Perpetrator Service was viewed as a positive intervention by agencies involved and undertook valuable work. Evening visits were made by social workers in an effort to engage with C's father, who worked full time.

7.5 The duty social worker obtained C's mother's permission to share the Children's Social Care Assessment with the Housing Service to reinforce the urgency of the housing situation.

7.6 When Child C was in hospital a local agency was engaged to facilitate and supervise contact with the parents. Only two agency staff were used to promote consistency. The arrangement ensured that parents' wishes around contact were accommodated.

7.7 There is evidence that supervision was provided on a regular basis across agencies including Children's Social Care, health visiting service and the police. There is evidence of the health visitor discussing the case with the perinatal health lead.

7.8 Police officers were often called out to emergencies to find C's mother had disappeared. They were proactive in finding her and assessing her situation on these occasions, and would stay or come back during the night to check on her.

7.9 The Children's Centre went to visit C's mother, even after they recognised it was clear she would not engage. They provided information and informed her of courses she may wish to take up, leaving the door open if she changed her mind.

8. Developments Since the Scoping Period

8.1 The police now have 3-county based Protecting Vulnerable People Referral Centres. When an officer identifies a child protection concern they should create a record on the database (CEDAR). The child protection referral managers in the centre then conduct research, make risk assessments and share information as appropriate.

8.2 A new domestic abuse (DOM 5) form has been developed, referred to as 'Incident DASH'. It is shorter, sharper and more focussed on the officer attending, resulting in an improvement of the quality of information obtained following an incident. It includes an information sheet which can be detached and left with the victim. This contains information about support organisations and charities.

8.3 The police have introduced new measures to ensure low level domestic abuse is fully scrutinised, such as:

- If 3 domestic abuse incidents occur which are graded as 'standard' during a 6 month period a review is triggered by the domestic abuse risk assessor.

- If the grading was raised to medium or high the case would receive a risk assessment by the DAIU.

- If the grading was high risk a referral to the Multi Agency Risk Assessment Conference (MARAC).

- Single Incident Reviews are being conducted to better understand 'standard' domestic incidents where children are present.

8.4 The police have undertaken an audit to check the quality of completion of 100 domestic abuse incident forms.

8.5 The Domestic Abuse Service Coordination Project was started by the council and the police in April 2011. It is aimed to address a gap in service to standard and medium risk victims and perpetrators. One strand is a visit to the victim, often with a Women's Aid worker, after the initial police response

8.6 Health visitors now operate a colour coding system to enable families to be targeted for support. When a family transfers from the FNP to health visiting support they are coded pink as a vulnerable family and targeted to receive monthly visits for a minimum of 6 months. Targeted families are reviewed monthly by the health visitor manager.

8.7 Mental Health workers must now contact the health visitor if the patient is the parent or carer of a child under 5 to discuss the case and the possible impact on the mental health of the child.

8.8 Health visitor training now includes a safeguarding scenario which includes grandparents within risk training. Level 2 internal training is mandatory which covers considering risk from grandparents.

8.9 Since 2013 family nurses receive specific child protection supervision 3 times per year with a named professional for child protection in addition to the supervision they receive from their supervisor.

8.10 Health visitors involved when a domestic abuse incident occurs where a child is directly involved must seek advice from a named professional where they have concerns about actions taken following the incident.

8.11 The health visitors' children's safeguarding team screen police domestic violence reports and check actions taken in cases where a child is directly involved. This team has also provided mandatory seminars for all universal services staff about risk analysis and the importance of maintaining child focus.

8.12 The hospital has provided training and resource packs to deal with issues emerging at the outset of this review.

8.13 In Children's Social Care child in need cases are no longer closed without multi–agency consultation and, wherever possible, a review meeting.

8.14 Communication to schools regarding safeguarding has been improved to include a termly newsletter, head teachers briefings and a termly meeting with child protection leads.

9. Conclusions & Summary of What Has Been Learned

9.1 Information sharing and multi-agency decision making were key to C's case. Cases involving the toxic trio of domestic abuse, mental health issues and substance misuse cannot be worked effectively by any single agency.

9.2 The police held a great deal of information about what was going on in the family home, as did the family nurse partnership. The community midwifery team, primary care providers and the nursery also had information to contribute to the multi-agency arena. Not all of this information reached Children's Social Care and if it did this was not always in a timely way. This had a considerable impact on assessments, planning and the response.

9.3 However, when the case did reach points at which multi-agency discussions were required under statutory guidance, the appropriate agencies were not present to contribute to those discussions. On some occasions this is because the appropriate professionals were not invited, on others it was because they failed to attend. This review is able to see the full picture, including what was known by all agencies at the time. Practitioners did not, and made the decisions that made sense to them based on the facts that they knew. When the Emergency Duty Service was required to undertake a joint visit with police after C was admitted this did not take place. This was due to demands on the service during a busy weekend.

9.4 Nevertheless, some decisions were questionable even when based on the facts that were known. Examples are the decision to step the case down in October 2012; the decision not to conduct a child protection medical in September 2013 and the decision not to hold a strategy discussion in response to the incident on 2 October 2013.

9.5 Multi-agency notifications of C's mother's second pregnancy were not made, resulting in no targeted health visiting support being offered and children's social care not being aware of the pregnancy until a domestic dispute notification was received from the police. This meant that the child in need plan ended at the same time as the intensive support of the family nurse. What was needed during the antenatal period was targeted health visiting support, a fresh assessment of risk and a plan to take account of the extra stress of the new baby. Instead the new birth visit conducted by the health visitor on day 14 was very brief, with paperwork not completed and the issue of domestic abuse not being raised. There is insufficient evidence to suggest that the impact of the toxic trio was given sufficient weight in the risk assessment for the children. Even though the three factors did not have this label at the time, there was an awareness and this was a missed opportunity.

9.6 C's sibling's vulnerability was highlighted in early assessments which were rooted in the family history. These assessments showed that on the whole key agencies understood this history. However, an appreciation of the risk presenting as a result of the toxic trio was less evident at times. It may be that in Children's Social Care some of this was lost in the transition between teams.

9.7 Some of those involved in the care of the children appear as shadowy figures, with little recorded about them. There is fundamental learning from this case regarding involving family members in assessments.

9.8 Some assessments undertaken failed to see C's sibling holistically. They did not adopt a 'Think Family' approach, he was not seen with all care givers and they were not fully assessed. Whilst some positive opinions were clearly held of both C's sibling's father and latterly C's father and his extended family, their basis is unclear.

9.9 Whilst supervision was taking place, it did not always seem to fulfil its purpose in enabling practitioners to gain a perspective on the bigger picture and make a robust plan of action. Thus the response was sometimes lacking and opportunities to take action were missed. This lack of overview, combined with the incident focussed approach taken, leads to a question regarding who was taking a step back, looking at the chronology and taking overall responsibility for the case.

9.10 There were various factors which made it harder for professionals to work with this family. C's mother was difficult to engage and refused to participate in many of the programmes and services on offer. However, it is important to acknowledge that some professionals were able to engage her. The family nurse and some social workers made enormous efforts and did build a relationship with her. The family moved between homes on a regular basis and this acted as a barrier to them becoming known well, for instance by a single GP at the surgery.

9.11 Despite these barriers, enough was known by Children's Social Care to enable them to have responded in a more timely and decisive way. Opportunities to do so came in response to domestic incidents, but some of these were missed. There seemed to be an over reliance on the opinions of health professionals that all was well. Alternatives or additional strategies to the written agreement were not evident, with inter-agency debate being under-utilised as a tool to identify the best strategy. Parents were not challenged sufficiently and failure to engage was not always followed through with appropriate consequences.

9.12 C and his sibling were largely too young to communicate verbally, but C's sibling was able to give powerful indications as to how he was feeling, particularly in his responses to domestic incidents and his subsequent delayed speech development. The response to these indicators of risk was lacking.

9.13 There was a lack of professional curiosity about what day to day life was like in the family home and around some of the accounts they were being given by mother and her partner. The analysis of risk was not undertaken appropriately in a multi-agency setting, resulting in key areas of risk being missed.

9.14 There are some examples of highly effective inter-agency working, particularly around agencies making timely referrals to Children's Social Care, and these are highlighted in 5.5 above. Other notable examples of good practice have emerged, with some practitioners having gone the extra mile to engage C's mother and being successful in developing a good relationship with her. The learning from these patterns of good practice is equally beneficial as learning from shortcomings.

9.15 There is no evidence that agencies involved in this case were discussing challenging the plans that were being made to protect the children. A number of opportunities were missed to take the opportunity to approach a senior colleague or safeguarding lead to discuss challenging the plans being made by Children's Social Care.

9.16 C's case has generated a great deal of learning which has already translated in some significant and notable developments. These are summarised in section 8 above. There are further recommendations which result from this review and these appear in section 10 and in section 11 Appendix B.

9.17 Overwhelmingly, this case makes clear that over-reliance on the opinion of health organisations or on children's social care alone is to be avoided and all agencies must bring their own expertise to these difficult decisions.

9.18 One of the most striking features of this review is the commonality across the features of the serious case review of 2011 and, in some ways, the learning activity undertaken in 2013. This case represents a fresh opportunity for the Bracknell Safeguarding Children Board to tackle the Think Family issues, look at how some agencies can strengthen their links, improve assessments and reconsider how its messages are being disseminated by all partner agencies. A key opportunity will be for the Board to disseminate the learning from this review to as wide an audience as possible.

10. Recommendations for LSCB

Recommendation 1

The Bracknell Forest Safeguarding Children Board should lead a review of the process of sharing Domestic Abuse notifications from Thames Valley Police with partner agencies which specifically addresses:

(a) Whether incidents should be shared if children are not present;

(b) Whether fuller information should be shared;

(c) Which agencies should receive the notifications and what support is required to help their response.

Recommendation 2

Bracknell Forest Safeguarding Children Board should continue to reinforce and promote the need to ensure all partner agencies 'Think Family' i.e. consider all members of the family who may have an impact on children by listening to the Child's voice and understanding the impact on the child of the wider family circumstances on their day to day lived experiences. This would be achieved through:

(a) Its current initiatives e.g. Family CAF and Team Around the Child;

(b) Inclusion in the LSCB training programme;

(c) Increased promotion and use of Family Group Conferences

(d) Dissemination of the learning from this serious case review to adult service providers of substance misuse and mental health.

Recommendation 3

Bracknell Forest Safeguarding Children Board should assure itself that its current multi-agency training strategy incorporates improving understanding of binge drinking and the impact of the toxic trio of mental health, domestic abuse and substance misuse on the parenting of children.

Recommendation 4

The Bracknell Forest Safeguarding Children Board should undertake an audit of the approach being taken by all partner agencies to disseminate key safeguarding messages, policies and procedures and consider any barriers and action needed to address gaps.

Recommendation 5

The Bracknell Forest Safeguarding Children Board should undertake a review of how key partner agencies provide 'supervision' to ensure sufficient opportunity for reflective challenge and develop standards/expectations.

Recommendation 6

The Bracknell Forest Safeguarding Children Board should review current arrangements for strategy meetings and make proposals for change to ensure clarity on when they are undertaken and how agencies are involved.

Recommendation 7

The Bracknell Forest Safeguarding Children Board should request the Clinical Commissioning Group to request a review of health partners in order to understand how information sharing between GP, health visitor and family nurse partnership & all other relevant organisations could be improved. This review should consider how the role of the link health visitor may be strengthened.

Recommendation 8

The Independent Chair of the Bracknell Forest Safeguarding Children Board should write to the national ambulance safeguarding group and the national pathways group to highlight the potential for a non-accidental injury to be missed in the national 111 pathways triage system. The issue which arose in this case should be highlighted to reinforce the actions anticipated by the South Central Ambulance NHS Foundation Trust pursuant to its own recommendation.

Recommendation 9

The Bracknell Forest Safeguarding Children Board should conduct an audit of assessments to ascertain whether professionals are listening to the child's 'voice' and understanding the impact on the child of the wider family.

Recommendation 10

The Bracknell Forest Safeguarding Children Board should take account of the learning points within this review and ensure that they are incorporated into multi-agency training and/or dissemination events and single-agency training to engage as wide a range as possible of appropriate professionals across agencies. The learning points include:

- The capacity to undertake reflective learning exercises and to share that learning.
- The importance of including as much soft information as possible in their referrals to Children's Social Care when notifying them of incidents.
- Highlight for all agencies local and national guidance on information sharing and safeguarding children, including the need to share information as fully and comprehensively as possible.

- The importance of using named professionals and safeguarding leads for advice and guidance in cases involving complex issues such as mental health, domestic abuse and substance misuse.

- Reminder of the importance of referral to children's social care and the police and re-referral of any changes of circumstances.

- For all agencies to Think Family, seeing the child holistically within the family, including seeing the child with all care givers in order that a collective understanding is achieved of families' vulnerability

- Listening to the child's 'voice' and understanding the child's day to day lived experiences.

- Highlighting the need for the practitioner to check back regarding what they have been told or have discussed and the actions and timescales agreed.

- The importance of valuing the views of extended family members where they have extensive knowledge and experience that might assist with the assessment process.

11. Appendices

Appendix A – Terms of Reference

Generic Terms of Reference

1. Was any information known by any agency about parental mental health issues and/or substance abuse? If so was appropriate consideration given to how this impacted on parenting capacity?

2. Was any information known by any agency about domestic abuse or parental antisocial behaviours? I so was appropriate consideration given to how this impacted on parenting capacity and were appropriate referrals made?

3. Was the level and extent of agency engagement and intervention with the family appropriate?

4. Did agencies communicate effectively and work together to safeguard and promote the children's welfare?

5. Were appropriate assessments undertaken in a timely manner? Was the quality adequate and did they include all historical information?

6. Were fathers and extended family members included in assessments?

7. Were the decisions and actions that followed assessments appropriate and were detailed plans recorded and reviewed?

8. Were any safeguarding issues in respect of Child C and sibling SC identified and acted on appropriately and in a timely way by all agencies?

9. Were the children's views and wishes sought and taken account of in assessments and planning? Did this include the presentation of young non-verbal children being fully considered?

10. Was race, religion, language, culture, ethnicity or disability a factor in this case and was it considered fully and acted on if required? How was the uniqueness of this particular family recognised?

11. Were there any organisational or resource factors which may have impacted on practice in this case?

12. Were appropriate management/clinical oversight (supervision) arrangements in place for professionals making judgments in this case?

13. How did the multi-agency system enhance or impede effective practice and outcomes for this family?

Additional areas of focus

1. The implementation of the bruising protocol following a previous Bracknell Forest SCR in 2011: was this guidance considered by the professionals involved?

2. The Child protection conference process and core group arrangements: how effective were these arrangements in engaging the right professionals and protecting the children?

3. Following the children becoming the subject of child protection plans: did professionals follow local guidance and statutory procedures?

4. To what extent was the family history understood within agencies and incorporated into assessments?