Serious Case Review

EXECUTIVE SUMMARY

Re SCR 0310

September 2011

Independent Chair of Panel - Margaret Styles

Independent Overview Author - Ron Lock

1. Introduction

1.1 This serious case review (SCR) was commissioned due to the circumstances of the youngest child of a family who received life threatening injuries in early 2010. This child, who will be referred to as Rachel in this report, and who has since recovered, was under 2 years old at the time of her injuries. Following a criminal investigation into how the injuries were caused, Rachel's mother was prosecuted and found guilty of one count of cruelty, for which she received a two year custodial sentence.

1.2 Rachel and her older siblings were all from outside of the UK and moved to this country a few months before the serious injury to Rachel occurred. At that time, none of the family could speak English and the mother was a single parent. The older children were all of school age at the time of Rachel's injuries. Also at this time, the family were living with another family who were also recent new arrivals to the UK.

The Serious Case Review (SCR) Process

1.3 The criteria for undertaking this SCR related to relevant government guidance; "when a child sustains a potentially life-threatening injury through abuse or neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard and promote the welfare of children"[1]

1.4 The purposes of this Serious Case Review were to; -[2]

(a) Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;

(b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and

(c) Improve intra and inter-agency working to better safeguard and promote the welfare of children.

1.6 In order to undertake the SCR, each agency that had some direct involvement with the children and their family was required to undertake an Individual Management Review (IMR) to look openly and critically at its practice in relation to their involvement with the family. In undertaking this, each agency was also required to produce a chronology of its contact with the family. The managers conducting the IMRs did not immediately line-manage the practitioners involved and were not directly concerned with the services provided for the children or family.

[1] Para 8.11, Working Together to Safeguard Children, Dept. for Children, Schools and Families, March 2010

[2] Para 8.5, Working Together to Safeguard Children, Dept. for Children, Schools and Families, – March 2010,

1.7 Senior representatives from relevant organisations in Gloucestershire were brought together to form a SCR Panel in order to review and analyse the material from the IMRs. The composition of the SCR Panel changed prior to the completion of the work, and the SCR was given a renewed focus with a new SCR Panel Independent Chair and new Independent Overview Report author. This changeover occurred in June 2011 following difficulties experienced by the original panel in undertaking the work required. For the latter part of the SCR process, this was chaired by the Independent Chair of Gloucestershire Safeguarding Children Board. Another independent person, with extensive professional experience in safeguarding children and young people, was commissioned to write the Overview Report, and Executive Summary.

1.8 The Serious Case Review Panel

Panel Members (Before June 2011):

Designated Doctor	Gloucestershire Hospital Trust.
Head of Service – Social Care	Children and Young People's Directorate – Gloucestershire County Council
Designated Nurse for Safeguarding	NHS Gloucestershire
Local Authority Development Officer	GSCS
Named Nurse Safeguarding Children	Gloucestershire 2gether NHS Trust
Detective Inspector, Child Abuse Investigation Team	Gloucestershire Constabulary
MAPPA Manager	Gloucestershire Probation

Panel Members (After June 2011)

Head of Education Welfare Service/Locality Manager	Children and Young People's Directorate – Gloucestershire County Council
Interim Project Officer	Children and Young People's Directorate – Gloucestershire County Council
Detective Superintendent of Protective Services	Gloucestershire Constabulary
Director of Clinical Development and Engagement	NHS Gloucestershire
Head of Quality Assurance	Children and Young People's Directorate – Gloucestershire County Council
Director of Learning and Development	Children and Young People's Directorate – Gloucestershire County Council

Independent Chair (June '11 – Sept '11) - Margaret Styles

Independent Overview Report Author – (commissioned from June '11) – Ron Lock

Also in attendance at Panel Meetings: -

- Head of Race Equality and Diversity Service (in a consultative capacity at selected meetings)
- GSCB Business Manager and GSCB Administrator

1.9 Family Contribution

The children's mother contributed to the SCR by being interviewed with the aid of an interpreter, and resulting information was used within the Overview Report to add to the analysis of professional practice and in respect of the family's experience of professional interventions. The older children were also seen in order to gain an understanding of their perspective, although they were unable to contribute in any significant way to the analysis of professional practice.

1.10 Parallel Processes

The criminal proceedings in respect of the mother had been finalised by the time of the completion of this SCR, and therefore did not compromise the collection of information and the analysis of professional interventions. Related care proceedings for the children similarly had no impact on the work of the SCR.

2. The Facts/Summary of Events

2.1 Within two weeks of the family's arrival in the UK, the eldest children were registered with their local school, although on the first day, whilst it was reported that the eldest child settled well, this was not the case for the younger siblings. The staff's observations of the children were that they were undernourished and poorly clothed. On this day there was an incident when the mother physically pushed one of her children, who then got upset, which ended in the child biting one of the teachers, causing an injury. The view taken at the time by the school was that the child had been very scared because he was in a new situation which he did not comprehend. The response from the head teacher was to ask the mother to keep the two youngest children at home whilst the school put an appropriate integration plan into place.

2.2 The pupil composition of the school included a significant proportion of non-English speaking and Black and Ethnic Minority (BME) children, and accordingly there were teaching assistants who could speak different languages who were used as interpreters, and one of these had been able to communicate with the mother.

2.3 Approximately a month later when the child who had bitten the teacher again attended school, the mother was witnessed by school staff to slap him. The school designated child protection officer (DCPO) was informed of the incident and completed a child protection form, and although there was the intention to contact Children and Young People's Directorate (CYPD) via the Children's Services Helpdesk, this did not take place on this occasion. The school asked the mother to take the child home directly after the incident.

2.4 The mother registered all her children with the local GP surgery and basic details of the children were forwarded to the health visiting team. Contact was attempted by the health visitor via a welcome letter to the mother (in English) and a later telephone message, although neither elicited a response, and so none of the children were seen by the health visitor or the GP prior to Rachel's injuries.

2.5 Three weeks after the incident when the child was slapped in school, the DCPO contacted the Children's Helpdesk with concerns in respect of the eldest child, who had been the only one of the children to have attended school reasonably regularly since their first day. The concerns related to the eldest child not being collected from school to go home to lunch at home on two occasions (she was not entitled to free school meals). Reference was also made within the telephone conversation, to the previous incident of the younger sibling being slapped and pushed. The slapping incident was not however recorded on the form which was used to record the contact by the Children's Helpdesk although it was included in the follow up e-mail from the school. The action agreed was for the information to be passed to the Referral and Assessment (R&A) team of the Children and Young People's Directorate (CYPD).

2.6 The team manager for the R&A team tried unsuccessfully to make contact with the referrer at the school, to gain more details in respect of the referral, particularly regarding the slapping incident. The case was allocated to a social worker a few days later as a Child in Need (Sec. 17) case, with a request to undertake an Initial Assessment. Ultimately however, no action was taken in respect of this assessment which was then overtaken by the events relating to the significant injury to Rachel.

2.7 An ambulance was called to the home address approximately 10 days following the referral from the school, after a 999 call was received stating that the youngest child, Rachel, was unconscious though breathing. The history given was that Rachel was found collapsed by an older sibling. Following ventilation, the ambulance transported Rachel to the local hospital. In addition to her poor medical state, Rachel was observed by the consultant paediatrician, to be unkempt and poorly cared for with multiple old unexplained scars and abrasions. The left arm was swollen, later identified as a healing fracture, and the mother explained that Rachel had fallen out of her cot four weeks previously.

2.8 The consultant paediatrician made contact with the duty social worker and said that there was clear evidence of non-accidental injury (NAI) to Rachel. The Police were also contacted. Later tests identified that Rachel had a brain haemorrhage. For medical reasons, Rachel was transferred to another hospital later that day to be retained in the paediatric intensive care unit.

2.9 Following information from the hospital**,** an arrangement was made for a joint visit to the family by the Police and the Emergency Duty Team (EDT) social worker to ascertain who else lived there, particularly any children and of any potential risks to them. Rachel's older siblings and another child of the other family also living at the address were examined and no marks or injuries were seen and it was reported that all the children were at ease with the adults in the home. The children were not seen alone. The social worker and police

officer decided that there were insufficient concerns to seek Police Protection at this time and the children were allowed to remain in the home overnight. No professional interpreters had been used in the interview, although some translating was done by a friend/neighbour.

2.10 At a strategy meeting the following day, up to date medical information in respect of Rachel was provided which strongly suggested that her injuries were the result of abuse. A criminal investigation by the Police began, and Rachel's siblings were removed from the home by CYPD. Interim Care Orders were later granted in respect of Rachel and her older siblings.

3. Key Issues Arising from the Case

Response to "Child in Need" concerns

3.1 Because of the additional factors in relation to their language and cultural differences, the children were understandably unsettled in the school environment, and so it would seem that these children ideally met the criteria for the additional help that Race Equality and Diversity Service (READS) could have provided as support for their transition into school life. This was particularly the case for the eldest child as the only child in the family eventually to continue within school. Because of the school's particular locality and diverse population, the school had chosen to retain additional government funding instead of buying back support from READS. This funding had been used by the school to appoint teaching assistants/interpreters, therefore less specialist support from READS was available. Within the school, READS were still however available to provide their core service.

3.2 Whilst there were early concerns via the school and the Education Welfare service that these children could be viewed as "children in need", there was no formal response to this undertaken, primarily in the form of a Common Assessment Framework (CAF). The rationale given for not completing a CAF was because it was considered that the mother would not engage in the process. In effect though, there had only been limited proactive contact with her. Because the school had only known the family for approximately three months, the school considered that this would have been an on-going consideration. However, greater impetus should have been put into undertaking a CAF, particularly as this family lived in overcrowded conditions, the children appeared undernourished and as an immigrant family, the family had no recourse to public funds.

3.3 When concerns arose, (such as the biting incident) it was inappropriate for the school to have sent the two younger children home with their mother, and although the intention was for an integration plan to take place, no initiative was set up for this and in effect the children did not return to school. Some assumptions were made that the integration process was in the hands of other practitioners when this was not the case.

3.4 It was also during this time that the head teacher authorised the absences of the younger children for what was considered "exceptional circumstances" although there was little

evidence of what these were in this case. The relevant grounds for authorising absences could not in fact be justified in these circumstances by relevant regulations.

Response to Child Protection concerns

3.5 The first incident to raise child protection concerns occurred when the middle child returned to school a month after the biting incident on his first day. This did not go well for the child who was upset and did not want his mother to leave him, but her response was to pull him by the hands and slap him on the cheek. This incident was witnessed by school staff, and when the DCPO was promptly informed, the incident was rightly viewed as evidence of child protection concerns, and was documented as such on the relevant child protection form.

3.6 There were then some unfortunate discrepancies regarding what actions were taken in response to this incident and what school records reflected. Although it was clear that the school's intention was to make a referral to CYPD via the Children's Services Helpdesk, this did not happen, potentially because relevant school staff were immersed in other work at the time, meaning that the referral was overlooked.

3.7 Formal child protection procedures were therefore not followed in that an instance of physical abuse should have been referred on the same day via the Children's Services Helpdesk. This was concerning and it meant that a clear cut opportunity was lost for CYPD to assess the family situation and of any risks to the children. This lack of action was to some extent compounded by the decision of the school to once again immediately send this child home with his mother. In effect this meant that the situation was left un-assessed and with no action undertaken to address the mother's behaviours and to meet the child's safeguarding needs.

3.8 However, when concerns arose that the eldest child was not regularly being provided with lunch by her mother, this was referred to CYPD and at the same time reference was made to the slapping incident. Unfortunately the quality of the written and verbal communication at the time of the referral to the Children's Helpdesk was not sufficient to ensure that clear details of the concerns were noted and recognised. Although the member of staff at the Children's Helpdesk appropriately passed on the information to the R&A team, not all of the concerns were recorded and passed on, nor were the child protection concerns raised with the duty manager as required by procedures. In effect because of the lack of detail about the concerns, the follow up decision by the relevant manager was compromised. If the slapping incident had been given the prominence it deserved, even though it had occurred three weeks earlier, then it would have more likely have led to a child protection enquiry being undertaken, rather than the eventual decision to complete an Initial assessment in respect of this eldest child in the family as a Child in Need.

3.9 In this situation there was a responsibility not only of the person making the referral to be clear and concise about the concerns, but also of the recipient of the information to check back on any detail that required further exploration, for example in respect of any perceived level of risk to the children and any issues of immediacy. In fact basic details of the family were missing. Lack of adherence to these principles led to insufficient information and

analysis being attached to the referral. This appeared to have been recognised by the R&A team manager who tried to elicit more information from the school, but unsuccessfully on this occasion.

3.10 In effect what happened was that the situation was not given any level of priority, and there was no immediate response to the family and no Initial Assessment was commenced. The allocated social worker could not recall the case being allocated, and therefore took no action.

3.11 However, it was just a week later that the significant injuries to Rachel were reported. The ambulance service and the medical response at the hospital were very effective in ensuring that Rachel's medical needs were given attention, and the paediatric response to inform the Police and CYPD of their concerns that the injuries may have been the result of abuse, were timely and reflected efficient child protection practice.

3.12 Although the initial referral from the hospital took place in the late afternoon, it was not until approximately 8.00pm that the home visit by the Police and EDT social worker took place. Inevitably the lateness of the interview meant that it would likely have an impact on the children and their availability or for them to be sufficiently alert to contribute to a potentially traumatic interview. Its timing may have had an impact upon the eventual decision not to remove the children at that time.

3.13 This was clearly a challenging interview to undertake, in which the neighbour was used to act as an interpreter. All the adults and children were present, and it was appropriate practice that the social worker ensured that the children were physically seen for any signs of injury or abuse – clearly however this was not a medical examination. The language difficulties clearly generated some constraints and although the children were not seen alone, and this was a significant omission, they nevertheless were the focus of the concern and intervention. The home was said to be clean and the cupboards and freezer were checked for food. It was reported that no concerning disclosures were made by the adults or the children. It was not felt that the children needed to be medically examined and the decision made by the social worker and police officer was that the children would be allowed to remain overnight in the home.

3.14 Had this investigation occurred in office hours rather than on a Sunday evening, then it would likely have been conducted differently – certainly the specialist Child Abuse Investigation Team would have dealt with the matter rather than non-specialist CID officers. Also it would have been easier for medicals to be arranged and for professional interpreters to be used. But in the knowledge that the out of hours circumstances were not ideal, contingencies should have been considered and planned for as part of the earlier strategy discussion. Whilst it would no doubt have been difficult to manage in the circumstances of the visit, the children still should have been seen on their own. Even though confusion existed in the home, and it would have been challenging to have taken control of the situation and seen the children on their own in a meaningful and supportive way, this still should have been the main component of a robust investigative interview. In fact a means of exerting greater control of the situation potentially was to generate boundaries such as

arranging for the children to be seen alone. It was understood that the eldest child by now had learned some English.

3.15 In respect of the police/social worker decision to leave the children at the home, there appeared to be insufficient recognition that two key aspects of a more informed investigative interview were missing on this occasion. This was the lack of talking to the children on their own, and the lack of a professional interpreter. Once again if a professional interpreter had been used, it would have potentially helped to slow down discussions (the adults were said to be all talking at the same time), and helped the investigators to have exerted greater control over the situation. It therefore could be said that the decision to allow the children to remain at home was compromised by the omissions of important elements of the investigative process. On balance it was therefore the SCR Panel's view that the decision which was made for the children to remain in the home was an inappropriate one in the circumstances. There should have been greater preparation at the earlier strategy discussion. It is however acknowledged that the children did not come to any further harm by remaining in the home overnight.

3.16 The actions by the Police and CYPD the following day ensured that all the children were appropriately protected and placed in foster care.

<u>Response to the family's racial, cultural and linguistic needs as well as their immigration status</u>

3.17 This family's culture, ethnicity and language was a significant factor for the professional interventions with the mother and her children. However for the short period of time that this SCR covers, no professional knew with any certainty what the cultural background was for the family or the actual language and related dialect which they used.

3.18 It was certainly helpful that a number of involved professionals had some experience and knowledge of similar cultures. Also because of the experience of working with similar families in the locality, then these professionals from the school and Education Welfare service were able to provide some cultural sensitivity in their work with the family.

3.19 However, whilst local professional knowledge and experience of work with particular ethnic minorities within the community had its undoubted advantages, it was potentially a double edged sword. For example, in the absence of detailed or accurate knowledge of the family's background, there was the potential for local professionals to make assumptions about the characteristics and attitudes of the mother based on their previous experience of working with families of a similar culture and nationality. There was some evidence of this occurring in the dealings with this family.

3.20 Additionally the health visitor attempts to contact the mother for the introductory home visit via a letter written in English and also by leaving a telephone message in English did not reflect sensitivity to the family's culture and language. Unfortunately the GP registration system did not ensure basic information was passed to the health visitor to help make sure that the first contact was appropriate to the particular needs of this family who did not speak English. The significant minority of similar families in the area was well known and so

greater thought should have been put into whether a level of cultural sensitivity was needed to engage this family in health services.

3.21 The family were not entitled to any state benefits, including the children not being eligible for school meals. This family were therefore going to struggle to maintain a basic level of existence. In such circumstances it was surprising that a more proactive stance was not taken by professionals to identify the depth of the welfare concerns (potentially via a CAF) or for the School, with the help of the Education Welfare Service, to endeavour to get all the school age children more consistently into school and get them to take up what help was in fact on offer in the community.

3.22 In respect of migrant families, "The erosion of cultural and personal identity makes it hard for individuals to pursue their conception of a good life and construct a coherent sense of personal identity, which can lead to a wide range of psychological and social problems, for example depression, unhappiness, anger, a sense of meaninglessness and poor family cohesion"[3]. If a level of early proactive interventions, and greater encouragement to take up of the community resources that were available to the family (e.g. children's centre, relevant voluntary agencies) had been made, then potentially there may have been a different outcome for the family.

3.23 All of the IMRs make the point to varying degrees about the importance of professional interpreters in working with ethnic minority families who do not have English as a first language, and yet up to the incident of Rachel's injuries being discovered, no formal interpreter was used in any of the conversations between the mother and professionals from within the community.

3.24 Relevant government guidance states that "Family members or friends should not be used as interpreters, since the majority of domestic and child abuse is perpetrated by family members or adults known to the child"[4]. This primarily refers to the key points of intervention with families when child protection enquiries are being undertaken, and the only time when this was relevant in the work with this family was at the time when the Police and the Emergency Duty Team (EDT) social worker visited the family home on the evening following Rachel's hospitalisation for her injuries. This was a crucial interview, the purpose of which was to ascertain the safety needs of the remaining children in the household.

3.25 A major issue of using family and friends as interpreters, as often happened in this case, was that the subject family's rights to confidentiality were significantly compromised. In effect this meant that because of the language barriers, the mother and her children received a lower standard of professional care, and as has been referred to earlier, the children were not seen alone, primarily because of the way the interview developed and had to be managed at the time. It could therefore be argued that the Working Together statement

[3] Culture and Child Protection – Reflexive Responses – Connolly, M, et al – Jessica Kingsley 2006

[4] Para 10.8, Working Together to Safeguard Children – Dept for Children, Schools and Families, March 2010

that "All children, whatever their religious or cultural background, must receive the same care and safeguards with regard to abuse and neglect"[5] was compromised within this particular investigative interview.

3.26 Although the use of neighbours, friends and extended family at other times in the work with the family by the EWO and the school, was understandable in these less formal interview settings, the same issues applied in that this compromised the family's confidentiality, the ability for their voice to be heard, and helped maintain the mother in an isolated and potentially oppressed position.

Sensitivity to the needs of the children

3.27 In essence, because of the issues about the children's ethnicity and language difficulties, and the very few occasions that professionals had contact with them, then it was difficult to identify occasions when there was sensitivity to their particular needs. Overall therefore there was no sense that the children's wishes and feelings were known or sought by professionals.

3.28 However there were some occasions when there should have been greater direct involvement with the children such as the time of their admission arrangements into their school. Also not all the teachers and staff in the school were aware of the sibling relationships, which would not have helped in respect of demonstrating sensitivity to their needs.

3.29 At the time of the biting incident, whilst there was a clear opportunity to seek the views of the child in question, this was not taken as it was considered by school staff that they understood what had happened and that James was very anxious at that time. Whilst the school staff had sensitively calmed the situation for the children, and demonstrated clear professionalism in this respect, there appeared to be a lack of direct communication with the children. More generally, school staff did try to engage with the eldest child of the family who continued to remain in school, but overall there appeared to have been an insufficient amount of time spent with her to confirm the language she spoke.

Inter-agency communication and management oversight

3.30 There needed to have been greater management oversight within the school to ensure that actions followed decisions taken, such as the need to integrate all of the children into school, and that referral processes to CYPD were adhered to.

3.31 Insufficient management oversight could similarly relate to the relevant CYPD managers in respect of the poor referral that was taken from the school and then the failure of the social worker to commence the Initial Assessment that was allocated.

[5] Para 10.13, Working Together to Safeguard Children – Dept for Children, Schools and Families, March 2010

3.32 Improved procedures and guidance on record keeping have been instigated since this case took place, and regular meetings between the head teacher and the DCPO have been set up to enable more effective sharing of practice issues and to monitor actions. The school governing body clearly also had a role in terms of management oversight and that there was an expectation that they would for example, have greater knowledge of child protection referrals made and processes for integration plans for children.

3.33 Effective communication occurred between the Hospital, the Police and CYPD following the discovery of Rachel's injuries, and the Strategy Discussion/Meeting was appropriately convened in line with procedures.

3.34 It was acknowledged that it had not been routinely checked that children were being seen alone as an essential part of child protection investigations, but that this practice in terms of management oversight needed to be improved and monitored and that actions were now in place to take this forward. There could have been more proactive management oversight of the Police role in the investigative interview in ensuring that the need for interpreters was actively considered.

3.35 The respective IMR and Health Overview Report identified that an earlier risk assessment of the staffing levels for health visitors working in this particular locality, was not sufficiently addressed by management although it highlighted staffing difficulties for the health visiting team.

<u>The impact of local community and organisational contexts</u>

3.36 In the school that the children attended, nearly three quarters of the pupils had English as an additional language and about a third were at an early stage of learning English. Because of this makeup, as well as the fact that the literacy of parents was poor, then the provision of three teaching assistants, who were also interpreters, was an important recruitment decision to help address these issues. The school had recruited staff to support pupils who at that time were predominantly from BME backgrounds. As the proportion of children from other cultures and nationalities had since increased, the existing teaching assistants were not able to provide full language support and it was just one teaching assistant who had some ability to converse with the family. In this way the school's decision to utilise additional funding for recruitment had meant that it was ultimately not very able to react to the needs of a changing local population.

3.37 The school was judged "satisfactory" in their most recent Ofsted inspection since this case took place, which recognised the challenges that this school faced in working with a large proportion of children from ethnic minorities and also that the school was a Persistent Absence school with the percentage of sessions missed being well above average. The inspection noted "significant improvements" in addressing this issue. The day to day challenge of working in this school with the range of difficult issues it faced should not be underestimated and it was apparent from the recent inspection that the school was working hard to effectively address these.

3.38 There was an inherent danger however, that in working with a local community with such high numbers of ethnic minority families, including some as immigrants without recourse to public funds or benefits, that a form of "cultural deficit – accepting or applying lower standards" can develop. "Cultural deficit can lead to a lack of appropriate interventions, or even collusions. Professionals may have a different threshold of response to different communities, or respond differently but not necessarily appropriately. The result is that children are not protected"[6]

3.39 In terms of the health visiting services in the area, the respective IMR considered that their staffing was not at full complement or sufficiently resourced, and that this was a concerning factor in the sort of community that the health visitors served. The issue of "cultural deficit" was evidenced in the respective IMR stated that "the transient nature of the population and multi ethnic community made it difficult for health visitors to provide an appropriate service relevant to their needs". The difficulties experienced by health visitors working in this locality were identified, with reference being made to the language difficulties, the inherent suspicion of the service by some of the ethnic minority families, and the inability of health practitioners to be fully alert to cultural and religious customs. The number of transient families in the area further added to a very challenging community to work in. Therefore there was a greater need to be able to prioritise health visitor contacts, particularly with new arrivals in the area, and to have direct contact within a clear timeframe. This has been addressed as a recommendation within the respective IMR.

3.40 In respect of CYPD, several organisational changes between 2008 and 2010 were noted to have led to internal restructuring in terms of moving staff to teams in locality offices and the development of electronic recording systems. There were some inefficiencies of the management case recording systems at that time and there were low levels of social work staffing during the time period under review. The safeguarding Ofsted inspection of December 2010 however identified that "social work resources were adequate across the R&A teams".

4. Summary

4.1 Whether the serious injuries to Rachel were predictable or preventable is difficult to answer. In terms of predictability, there was no evidence that Rachel would become the subject of such serious abuse. In fact she was hardly ever seen by any professional and there was no assessment of her relationship or attachment to her mother. However, when they were seen, nothing untoward was noticed.

4.2 If professional interventions had been more timely and appropriate to the presenting circumstances of the family, then clear opportunities for understanding the children's needs and of any risks could have been utilised. This was primarily evidenced in the lack of a CAF and an Initial Assessment, and the potential that an earlier child protection enquiry (re the

[6] "Effectively protecting black and ethnic minority children from harm: Overcoming barriers to the child protection process" – Webb, E et al – Child Abuse Review Vol 11 – July 2002.

slapping incident) should have been undertaken. Whether the completion of these would have made any difference to the eventual outcome clearly cannot be known, although there was the potential that injuries to Rachel could have been spotted earlier. This case also emphasises the high importance of early prevention initiatives and their potential to identify problems at an early stage and to prevent their possible escalation.

4.3 Overall, agencies reported that relevant policies and procedures were in place, but that it was the application of these procedures by individual practitioners that was sometimes at fault. However, there were instances of limited knowledge by staff of the procedures relating to the provision of interpreters. This was a significant issue when considering the make-up of the community in which the practitioners worked.

4.4 It was very apparent that the context within which the professionals were working created additional challenges for them. "Child protection practice is fraught with difficulties. When culture is added to the mix, the difficulty of the work intensifies and becomes infinitely more complex"[7]. In this way therefore there needs to be greater reliance on procedures and objective evaluation of day to day practice, via management oversight to ensure that the same quality and level of service provision is afforded to children of ethnic minorities as is given to other British children.

4.5 The impact upon an immigrant family living in an isolated environment cannot be underestimated, supported by the view that such parents "lack the interpersonal supports and skills to resolve conflicts between them and their children, and their situation is compounded by their relative social isolation and poor English. The children could experience conflict between the cultural expectations in the various domains of their lives, e.g. school and home environment. These variables combine to create a situation where the threshold for the parents behaving aggressively toward their children is lowered"[8]

5. Lessons Learned

- The use of friends and relatives to act as interpreters for professionals working with families whose first language is not English, could compromise their confidentiality, prevent important personal issues being raised, and possibly compound feelings of oppression for the family.

- Early prevention initiatives taken proactively with families where there are clear welfare concerns for the children can reap important benefits to the children and avoid family problems and risks to children escalating unnecessarily.

- It is essential for communication between professionals when child protection concerns are being expressed, to be clear and unambiguous. In this respect there is a responsibility on

[7] Culture and Child Protection – Reflexive Responses – Connolly, M, et al – Jessica Kingsley 2006

[8] Culture and Child Protection – Reflexive Responses – Connolly, M, et al – Jessica Kingsley 2006

both the communicator and the recipient of the concerns to be confident that all relevant information has been shared regarding the detail of concern and of the actions that are to take place as a result. To not meet this professional responsibility will seriously compromise the quality of any follow up inter agency response to the protection needs of the children.

- A failure to understand a family's race, culture, ethnicity and language will seriously impinge on a professional's ability to provide effective help to the parents and children.

- Care must be taken by professionals working in areas where there are significant numbers of ethnic minority families experiencing high levels of deprivation, not to allow their interventions to reflect an unintentional different threshold of concern and intervention being applied, potentially leaving children at greater risk than would exist in other parts of the county.

- If circumstances present themselves for formal assessments to be undertaken, then to not do so will constitute a significant "missed opportunity", meaning that any continuance of professional intervention or support services, will be ill informed, and potentially leave children in at-risk situations.

- A failure to see children on their own as part of child protection enquiries, will undermine the quality of the enquiries being made and will be unable to reflect the views, experiences and wishes of the children concerned and in turn the professional's ability to make informed decisions about their safeguarding needs.

- It is dangerous for professionals to make assumptions about the interventions of other professionals and of their analysis and contact with the family, without confirming or otherwise that assumption by checking with the professionals concerned.

- For first line operational managers to solely rely on trust and expectation that important tasks are undertaken by their staff, will be insufficient unless there are objective processes in place to support management accountability.

6. Recommendations

NB: These recommendations relate primarily to multi agency actions and do not replicate those separately and appropriately identified within the IMRs.

6.1 The GSCB should develop "best practice guidance" in respect of safeguarding newly arrived immigrant children, with a particular focus on the needs of those families who do not have recourse to public funds.

6.2 The development of such guidance should be proactively disseminated and publicised by relevant training/professional development events, particularly targeting those professionals who work in communities with high numbers of Black and Minority Ethnic (BME) families.

6.3 The GSCB must be assured that its constituent agencies have a coherent policy in respect of the use of professional interpreters, and that its operational staff fully understands how they can access such resources. It will be especially important that particular key interventions

such as Sec 47 Enquiries, Initial and Core Assessments, and family health needs assessments have a professional interpreter available whenever possible as a resource.

6.4 As part of the GCSB's requirement to critically evaluate the inter agency safeguarding practice, there should also be an evaluation of prevention services that exist in local communities with identified high numbers of BME and immigrant families. This will need to include an evaluation: -

- That such services are able to respond to the cultural make-up of the locality,
- That they are adaptable to changing needs,
- That they do not work on different thresholds for intervention than other localities, and
- That services reflect appropriate strategic commissioning arrangements.

6.5 The GSCB needs to be assured that Action Plans in respect of recent Serious Case Reviews and particularly those referred to in this report, have been completed or if not, that work is still being undertaken to ensure that they are completed within a clear timeframe.

6.6 In respect of future Serious Case Reviews which GSCB commissions and in which there is Education participation, responsibility for the arrangements of the completion of IMRs for schools should be with the school and their governors to undertake, ensuring the necessary level of independence of the author exists.

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