



Gloucestershire Local Safeguarding Children Board

Serious Case Review

**“Philip, (and his siblings, John
and Darren)”**

Version 1.0 (30.11.16)

Lead Reviewer:

Jane Wiffin

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1 INTRODUCTION

1.1 Reason for the review (All names used are pseudonyms)

This is the serious case review report in respect of Philip, who was aged 3 at the time of the critical incident described and two other siblings Darren aged 10 and John, aged 5. The review was instigated as a result of Philip being taken to hospital by his Mother after four days of abdominal pain and vomiting. At hospital Philip was found to be very seriously unwell, with multiple, significant bruising, several fractured ribs and a perforated intestine. All these injuries were assessed as non-accidental. Mother and her partner (Ian) were arrested on suspicion of GBH S.18.

Ian was charged and pleaded guilty to S20 GBH and Mother was charged and pleaded guilty to S5 of the Domestic Abuse, Crime and Victims Act 2004. Ian has since been sentenced to 3 years imprisonment. Mother received a 12 month sentence, which was suspended for a 12 month period.

1.2 Methodology

This review was undertaken using a new methodology developed by GCSB. Full details of the process are contained in Appendix 1 alongside the general and specific terms of reference in Appendix 2. Each agency involved with Philip, John and Darren produced a chronology of involvement, an analysis of practice and recommendations. The analysis contained in these documents is used as the basis for the analysis of practice contained in section 4 of this report and the single agency recommendations are included in Appendix 3.

1.3 Family Involvement

Mother was invited to contribute to the review, but after talking it through with a Social Care Team Manager felt she was unable to do so and declined the offer of meeting with the Lead Reviewer.

1.4 The Author

This report has been written by Jane Wiffin. She is a qualified Social Worker with extensive experience of safeguarding practice. She is an experienced Serious Case Review author, having completed over 30 reviews. She is completely independent of services in Gloucestershire.

2 The Family

All names have been anonymised	Relationship to subject (if applicable)	Age at time of critical incident
Philip	Subject	3
John	Brother	5
Darren	Brother	10
Mother	Mother	28
Father	Father	30
Ian	Mother's Partner	22
Maternal Grandmother	Maternal Grandmother	
All family members are White British		

2.1 **Family background known to professionals**

Mother and Father started their relationship when Mother was around the age of 17 and Father was aged around 19. They continued in an off/on relationship for many years. Mother told professionals that Father had long-term mental health difficulties, but he was not known to any services. Mother also reported that he was a drug user, taking heroin and cannabis, and he has a number of convictions for drug related offences. Nothing is known about Father's extended family except that they had wanted to have contact with the children, but Mother had been reluctant because it might bring the children into contact with Father.

- 2.2 Mother and Father had their first child, Darren, when Mother was 19. Mother started using heroin when Darren was around 4 years of age, and she reported that she sought help from her GP after three months, was referred to a specialist substance misuse service and was prescribed buprenorphine, a replacement for heroin. She was still being prescribed a reduced dosage of this drug during the time under review, although there had been plans to help her detox and end her use. Darren went to stay with Maternal Grandmother (MGM) at some unspecified point because of Mother's heroin use and has been intermittently in her care ever since. The precise nature of these arrangements remain unclear, and there were times when Darren was present in the family home and said to be due to return to live full time with his Mother. It is unclear if this actually happened. After the birth of Philip, Mother was noted to have suffered from post-natal depression. Little is known about Mother's extended family, except that Mother said that MGM was very supportive, lived locally and Mother's sisters also helped her.

3 **NARRATIVE CHRONOLOGY OF PROFESSIONAL INVOLVEMENT WITH THE CHILDREN**

- 3.1 This section provides a summary narrative of the professional involvement with the three children, and is drawn from the single agency reports produced as part of this review and the practitioner events held. It attempts to give a sense of what happened, what is the appraisal of the professional response at different points across the timeframe and to comment on why practice was as it was, where this is known. This forms a foundation for the Findings which analyse the practice response as a whole.

Early Concerns: At the beginning of this period of time Philip was 18 months old, John was 3 yrs old and Darren 8 yrs old

3.2 **No dates are included for reasons of anonymity**

At the start of the review the Health Visitor asked the Children's Centre to provide Mother with support because she was struggling to manage the children's behaviour and a Community Family Support Worker (CFSW) provided Mother with informal support over a number of years. There were concerns about John's delayed speech, the poor home environment and Mother reporting that Father had mental health difficulties. The Children's Centre suggested Mother attend a parenting course, which she declined, and John started to attend Nursery. Mother was also supported by the

Community Nursery Nurse (CNN)¹ to manage the children's behaviour. The Health Visitor had regular contact with Mother, but gradually Mother stopped being available for appointments, and although the Health Visitor found Mother easy to talk to, she felt that Mother did not follow or implement much of the advice given.

- 3.3 At the end of this year Father started to misuse drugs again, specifically heroin having stopped for a number of years (as reported by Mother). There was conflict in the home, and there was a protracted period where Mother asked Father to leave, which he eventually did 6 months later. Mother called the police to complain of Father's disruptive behaviour; he was at the house trying to retrieve property and all three children were present. The Police notified Children's Social Care (CSC) who assessed that no action was necessary. Three months later Mother discussed further concerns about Father's drug taking and threatening behaviour with the CFSW and the Health Visitor. They were reassured when Mother told them that she had taken on the sole tenancy of the property and asked Father to leave. Nursery1 staff noted that John and Philip's behaviour became more settled at this time. A month later Mother called the police again regarding Father's disruptive behaviour and that the three children had been locked outside the house. The Police sent CSC a second child welfare notification and this was again assessed by CSC as requiring no action. Over this whole period Mother continued to seek advice about her concerns regarding managing John's behaviour, but she never took part in any of the parenting support services offered.

Commentary:

During a 12 month period Mother and two of the children were provided with a range of informal support from the Children's Centre, the Health Visitor and the CNN. It is hard to evaluate the effectiveness of this support, as Mother refused to take part in anything other than home visiting and nursery provision, despite asking for help to manage her reports of the poor behaviour of both children.

Although professionals were reassured when Mother took steps to ask Father to leave and there was a period when the children seemed more settled, given Mother's lack of engagement in services designed to meet the needs of her children, the Children's Centre should have offered a more formal early help response under the auspices of CAF². This would have enabled professionals to come together, share information and to set goals for the children's well-being. This could have made it easier for professionals to understand the long term nature of Mother's parenting difficulties during subsequent events. This is discussed in **Finding 1** regarding the provision of formal early help response.

12 months later: Philip nearly 3, John 5 and Darren nearly 10yrs old

3.4 Third referral to CSC

Over the New Year period Mother did not collect her prescribed medication and

¹ Community nursery nurses provide services aimed at improving the health and well-being of families with children up to the age of eight.

² The Common Assessment Framework (CAF) is a process for gathering and recording information about a child for whom a practitioner has concerns in a standard format, identifying the needs of the child and how the needs can be met.

through a routine test was found to have used cocaine, non-prescribed buprenorphine³ and diazepam⁴. A letter was sent by the drug agency to the GP in mid-January informing them of this.

- 3.5 Philip started to attend Nursery2 because Mother said she was unhappy with the number of hours provided by Nursery1. She was asked to provide information about Philip as part of the routine admissions processes and reported no health concerns, except delayed speech and dribbling. Nursery2 did not seek any transition information from Nursery1 at this time, but did make contact with Nursery1 six weeks later to express concerns regarding Philip's poor speech and Nursery1 confirmed that a referral had been made to the speech and language service. It was agreed that records would be shared between the two nurseries, but information was not shared until 6 months later.
- 3.6 At this time Mother contacted the police to report that Father had come to the family home, threatened her with a knife and taken John and Philip away. A family friend later returned the children. At this time Father was wanted by the police in regard to two outstanding court warrants. Mother made a statement to the police regarding a potential charge of theft; she subsequently withdrew this statement, saying she did not want to work with the police, and she was described as hostile. A referral was made to CSC, the third in a nine month period, and an Initial Assessment⁵ i was agreed.
- 3.7 A Social Worker visited the family at home and met with Mother, John, Philip and Maternal Grandmother (MGM). Mother explained that Darren "*mostly stayed with his maternal grandma*"⁶ because Mother had previously had a drug problem. Mother told the Social Worker that she had been drug free for six years and continued to be prescribed a heroin substitute. The quality of care provided by Mother on the day of the home visit was assessed as good and Mother was observed to have a warm and caring relationship with both children. The assessment reported that Mother was aware of the potential impact of Father's behaviour and drug use on the children; Mother said she would take action to prevent him having contact if he used drugs again. She said that she was taking forward her complaint against Father with the police. This led to the conclusion that Mother was a protective factor for the children; the Social Worker did not know that Mother had withdrawn her statement to the police, and had refused to help them. The Social Worker engaged with the children and observed them playing, but did not see them on their own and reported that she had hoped to talk to Father, but had no contact details for him.

³ Buprenorphine is a prescription medication for people addicted to heroin or other opiates that acts by relieving the symptoms of opiate withdrawal

⁴ Diazepam is used for the treatment of disorders with anxiety and treatment of alcohol withdrawal.

⁵ An initial assessment was a short assessment of a child referred to Children's Services focusing on establishing whether the child is in need or suffering/likely to suffer significant harm and to determine the services required and if a more detailed Core Assessment should be undertaken. This has been replaced by the Single Assessment process:

http://www.proceduresonline.com/swcpp/gloucestershire/p_assessment.html?zoom_highlight=single+assessment+process

⁶ This quote is taken from the Initial Assessment completed by Children's Social on 17 January 2014

- 3.8 Mother was asked for consent at the start of the assessment for information to be sought from other agencies. The assessment included contact with the drug agency, who were asked about Mother's parenting and attendance at appointments and the drug worker reported no concerns and regular attendance. The drug agency does not appear to have been asked about any recent drug use and they did not mention that Mother had been misusing drugs over New Year. The Social Worker spoke to the GP who said there were no concerns, and it appears they were not asked about Mother's drug use and did not share the recent information they had received from the drug agency regarding Mother using illegal substances over the New Year. Nursery1 was contacted and highlighted slight issues regarding John's behaviour, but they did not say that they had had long term contact with Mother, had concerns about her management of the younger children, and that she had been offered support through parenting classes which she did not accept. They were unaware at this point that Philip had just started at Nursery2 as no contact had been made with them. Information was not shared with any agency about the reason for the Initial Assessment, and the worker at Nursery1 did not share the request with anyone else at the nursery or record that the request had been made.
- 3.9 The assessment concluded that Mother was providing good care to her children, had an extended support network and there was no need for any further action by CSC; but did not reflect on whether any early help response was necessary. Mother gave consent for the completed assessment to be shared with agencies and Nursery1 and the GP were provided with a copy, as well as Mother. The drug agency was informed there would be no further action by CSC, but did not receive the assessment. Nursery2 did not receive the assessment. There was no direct contact with the Health Visiting service, but a copy of the Initial Assessment was sent to them, but this did not prompt a visit to the family.

Commentary

It was appropriate that the police made a referral to CSC regarding concerns about the welfare of the children and this was responded to appropriately and in a timely way by CSC.

Multi-agency information sharing: The drug agency was only asked about Mother's parenting, a question they were not qualified to answer, but not asked about Mother's recent drug use, and information held was not shared. The GP was asked a general question about concerns, but not told about the reason for the referral so could not fully evaluate what information was required. Nursery1 were also not aware of why the assessment was being completed so focussed on here and now information, rather than providing a clear outline of their historic involvement and concerns. The police were not asked for an update on the progress of the police investigation. It is clear that the Social Worker did not ask the right questions and other agencies were not sufficiently curious about the concerns, which meant they did not evaluate whether the information they were providing was appropriate. The issue of information sharing is a theme within the report and is discussed in **Finding 2**.

Focus on the lived experience of the child: There is evidence that the Social Worker did engage with the two younger children, but did not speak with the children on their own or seek their perspectives more clearly. It is of concern that there was not more curiosity about

the circumstances of Darren. It was reported by Mother that he was “staying” with MGM because of her early drug use, but this was six years earlier. The Social Worker should have asked what the exact arrangements were, how often he was at home, when he saw siblings and Father and what the future plans were for the stability of his home circumstances. This issue was never addressed during the time under review and is addressed in **Finding 3**.

Parental self-report: There was too much focus on Mother’s self-report of her circumstances, which would have been shown to be falsehoods if some aspects of the multi-agency knowledge had been sought and shared. The issue of parental self-report is discussed in **Finding 4**.

Involvement of Fathers and Father figures: It was effective practice that the Social Worker considered the need to seek information from Father, but was hampered in doing so because of a lack of information about his whereabouts. She also sought police information about Father, but the risk that Father could pose was not clearly articulated, and the focus was only Mother’s ability to address Father’s risky behaviour, as opposed to holding Father responsible for his behaviour and its impact on the children and Mother. The issue of the involvement of Fathers and Father figures is a theme running through this report and is addressed in **Finding 5**.

Overall, the conclusion that the threshold for CSC to provide services was not met was in line with existing thresholds given what was known at this time, this may have been different if CSC had sought or been provided with information about Mother’s illegal drug use, her history of difficulties with parenting and support services not being accessed or Mother withdrawing her complaint against the police - all of which would indicate that Mother was unlikely to accept advice about early help services and a different response was needed. The assessment does not provide a view regarding the need for an early help response and it may have been appropriate for the Children’s Centre to continue to offer early help support. This is addressed in **Finding 1**.

3.10 **Fourth Referral to CSC**

Seven weeks later Mother informed Nursery1 that Father had been released from prison and that the nursery should not allow him to collect the children. A meeting was organised about this, which Mother did not attend. Philip told one of the Nursery1 staff that “*My Daddy gone*”⁷ and John said in a different room that “*the police came for my Dad last night....Dad throwed make up at Mum, it’s OK now he’s in prison*”⁸. Mother was asked about this and said this happened a long time ago and that she now had a new partner.

3.11 The next day a staff member at Nursery1 noticed extensive bruising to Philip. She appropriately recorded these on a body map⁹ and showed this to Mother. Mother said

⁷ And ⁸—These quotes are taken from the Early Years Internal Management Review produced for the serious case review and taken from nursery records.

⁹ A body map is a recording format to note any marks or injuries on a child as part of concerns regarding physical abuse. They should record, date and sign and keep in the child's file.
http://www.proceduresonline.com/swcpp/gloucestershire/p_ch_protection_enq.html?zoom_highlight=body+map

that the injuries had been caused by the children fighting and the facial bruises caused by a metal object being knocked onto his face in the shed by John. The nursery did not think that this was an adequate explanation for the number of injuries seen and appropriately decided to make a referral to CSC late in the afternoon. Mother said she did not agree to the referral and they made clear to her that they would be making the referral anyway because of their level of concern¹⁰. The referral was made by phone initially and they made clear the nature of their concerns. They were asked to submit a written referral form, which they did the next day. The information was passed via the help desk to the Deputy Team Manager (DTM) of the Referral and Assessment Team. The DTM telephoned the police and it was agreed that CSC would undertake an Initial Assessment. The records states that it was agreed that a further decision would be made as to whether or not there was a need for Child Protection enquires (Section 47)¹¹ depending on the outcome of the visit. There was no acknowledgement that this was the fourth referral in the period of a year regarding these children. There is no evidence of a follow up discussion with the police following the home visit. The case was allocated to Social Worker2.

Commentary

This was an important opportunity to address concerns regarding an unexplained injury to a young child.

Referral to CSC: Nursery1 made an appropriate referral to CSC – making clear the extent of the injuries, undertaking a body map and asking Mother for an explanation. This was effective practice, which would have been enhanced by the written referral being completed at the same time as the verbal referral, and the historic concerns about parenting being included. The nursery could also have considered making the referral when they discovered the bruises, rather than waiting for Mother to come to the nursery at the end of the session; the delay meant that Philip went home before he was assessed by a Social Worker. This is addressed in **Finding 6** regarding early year's settings and safeguarding.

Strategy Meeting: The decision making process between the police and CSC remains unclear and unrecorded, but given the circumstances, it would have been expected that a strategy meeting/discussion would have been held given the extent of bruising and Mother's reluctance to allow a referral to be made. This is addressed in **Finding 7 regarding the lack of strategy meetings.**

3.12 Social Worker2 undertook a home visit the next morning and Mother, Philip and John

¹⁰ Concerns which have been raised, should, where practicable, be discussed with the parent and agreement sought for a referral to LA children's social care unless seeking agreement is likely to place the child at risk of significant harm.

http://www.proceduresonline.com/swcpp/gloucestershire/p_respond_abuse_neg.html#parental_consult

¹¹ Children's Services have a legal duty to look into a child's situation if they have information that a child may be at risk of harm. This is called a child protection enquiry or investigation as outlined in Children Act 1989. The purpose of the enquires is to gather information about the child and their family so that social workers can decide what action, if any, they need to take to keep a child safe and promote their welfare.

were seen. It is hard to know exactly what was discussed, because much of the information recorded in the Initial Assessment is copied¹² from the previous assessment. Mother said that the bruises to Philip were caused by the children's boisterousness/fighting and the facial injury by a fall on a metal object from the garden shed; it is recorded that Philip agreed with this. Mother told Social Worker2 that she had a new partner who did not live with her, but who was very good with the children. It was also reported that Darren remained living with his MGM. Social Worker2 recorded in the Initial Assessment that Mother was disappointed that the Nursery1 made a referral to CSC and as a consequence she would be removing Philip from Nursery1.

- 3.13 Nursery1 sent their written referral to CSC alongside a body map and the pupil information record which made clear that Philip now attended Nursery2 for some of the time; this information was seen after the home visit to the family. Nursery1 outlined that they had noted 27 small injuries, most of which were small bruises, some small scabs and scratches and four linear bruises that resembled a handprint¹³. They made clear that Mother had not given consent for the information to be shared with CSC because she said she believed she had already provided an adequate explanation to them. It is unclear whether this information was included in the verbal referral and the Initial Assessment does not acknowledge that consent was not provided or analyse the implications of this.
- 3.14 Social Worker2 recorded that contact was made with the GP surgery, but there is no evidence that this actually happened; the wording is taken from the previous assessment, and there is no evidence of this request in the GP records. Social Worker2 also reported telephoning the Community Paediatrician, and recorded that the advice given was that there was no need for Philip to be seen by a medical practitioner because the explanation provided by Mother was consistent with the injury. There is no record of this conversation taking place in the hospital records and this discussion/advice was not mentioned in the completed Initial Assessment. There was no contact with the Health Visiting service (they would hear about this referral and assessment 8 weeks later) and no contact with Nursery2 or the drug agency. The conclusion of the assessment was there were no child protection concerns and that the key issue was Mother's management of the two boys and that she required support to improve her parenting. There was no recommendation regarding an early help response.
- 3.15 Mother went to see the Nursery1 the next day and told them she would ask Nursery2 to provide full time provision for Philip because she believed that the referral made by

¹² Information from the previous assessment was automatically pulled through and required the Social Worker to change the text.

¹³ Injuries: Back of body: -Scuff/Graze marks to his lower back/- 4 x 1p size bruises to upper back/ - 4 x 1p size bruises on right hip/1 x 50p size bruise on left buttock/ 2 x 1p size bruise on left buttock/ 4 x Long bruises on right thigh. Described as being the width and length of a finger, and all fairly evenly/spaced./ 3 x 1p size bruise half way down left thigh. **Front of body**/ 1 x 50p size bruise on right hip/1 x 1p size bruise on right hip/ 2 x 1p size bruise on left hand side of chest, fairly low on the rib cage/ Scabs across his nose/- Smaller scabs around his eyes.

Nursery1 was unnecessary. Mother provided further information about her new partner, who she said she had known all her life. She said that he did not drink or take drugs and she trusted him around the children. The Nursery1 Senior Practitioner appropriately cautioned Mother to be careful regarding her new partner and his contact with the children.

- 3.16 Mother went to Nursery2 five days later and told them she was removing Philip from Nursery1 because they had reported bruising to CSC and she wanted him to attend Nursery2. Mother said that they should not have done this because she had explained to them that Philip bruised easily and that Philip and John were always fighting. This was not discussed or challenged and no contact made with either Nursery1 or CSC. She asked them to provide full-time provision for Philip.
- 3.17 Nursery1 phoned the Social Worker four days after making the original referral and they were told that the assessment had concluded that the bruises were consistent with the explanation provided by Mother and Philip. Nursery1 explained their concern that Mother had removed Philip and taken him to Nursery2 because they had made the referral; no action was taken regarding this. There is no evidence that any agency received a copy of the assessment, but Mother did.
- 3.18 At this time Mother also discussed her new partner with her recovery worker at the drug agency. Mother told the worker that he did not use drugs, “*hardly drank*” and was good with her three children (Darren was included in this). Mother said that the children were now more settled and that Darren’s behaviour had improved; she did not mention the assessment completed by CSC, who had made no contact with this agency. Mother was illegal drug free during this time, and appeared to be doing very well, with an improved mood and engagement in activities like attending the gym.

Commentary

This was a significant episode regarding an unexplained injury/possible physical abuse of a young child to which there was an ineffective response. The reasons for this appear to be issues regarding capacity for CSC and an inadequate assessment process.

Assessment of physical abuse: The assessment suggests that the Community Paediatrician was consulted and said no examination was necessary. There is no record of the conversation within health records, and this discussion is not included in the assessment. It is impossible to know the truth of this - but either contact was not made with the Paediatrician, which is extremely poor practice, or it did happen and there should have been robust challenge. This highlights ineffective practice with regard to the assessment of likely physical abuse that is discussed in **Finding 8**.

No medical examination: this is one of the most troubling aspects of this incident. Philip was never medically examined despite having over 25 small bruises. Given the number of bruises, regardless of the cause, this young child should have been medically examined. Mother was not asked by any agency involved to take him to the GP and she did not do so.

The assessment: Overall the assessment of physical abuse did not comply with the

requirement of either Working Together 2013ⁱⁱ or the NICE Guidanceⁱⁱⁱ. It lacked a child focus and relied too heavily on Mother's self-report. These are both issues that are addressed in the Findings. The assessment used the text from the previous assessment, only adding in a few comments regarding Mother's explanation of the bruising. This meant that this was not an assessment of the current circumstances or the children's needs.

This is discussed in **Finding 9**.

Challenge to parents: It is of concern that Mother's comments about being disappointed that Nursery1 had made a referral to CSC were simply recorded, without comment or challenge in the assessment. When Mother repeated this to Nursery2 they did not recognise that this was important, should have been challenged, and contact made with the Social Worker2. This is addressed in **Finding 4**.

The circumstances of Darren were not explored, and it appears to have been accepted that he did not live at home, and was therefore outside the remit of the assessment process. This is addressed in **Finding 3**.

Mother's new partner: At this point a number of agencies became aware that Mother had a new partner who had contact with the children. This was described in the assessment, without any analysis or any sense of a risk assessment. The nursery Senior Practitioner did caution Mother about contact with the children, but this was not discussed with any other agency. The drug agency also knew of this change, and the evidence presented to them was of a positive picture. There should have been more exploration of this new man in the family's life. This is picked up in **Finding 5**.

Multi-agency involvement: There was no contact with other agencies within the assessment process. Contact was not made with the Health Visiting service or the GP surgery and neither were informed that the assessment had taken place (the Health Visiting service was informed in August 2014 of this incident). Given that this was an issue regarding the physical well-being of a child under 5 contact would have been expected. It is of concern that the transfer of text from the previous assessment meant that it appeared that contact had been made with the GP. None of the agencies received a copy of the assessment as would be expected, and Nursery1 had to chase CSC for a response to the outcome of the referral. It is expected practice that any referrer is told the outcome of a referral to CSC. This meant that Mother was able to provide a skewed picture of the outcome.

The drug agency were not asked for information or informed that the assessment had taken place. This meant that they had no other picture of Mother or the children's circumstances other than Mother's own self report and presentation; this enabled Mother to present an image of her own and the children's lives as being more settled than was actually the case.

Lack of inclusion of nursery: Nursery2 were not formally informed that a child protection referral had been made or that an assessment had been completed by CSC. They were, however informed by Mother that a referral had been made, but were unaware of the full details and they did not make contact with CSC or Nursery1 to get more information. It appears that a pattern developed where the nursery were not included as part of the professional network, and they did not see themselves in that role. This is explored further in

Finding 6.

3.19 Further Bruising:

Eight weeks later Nursery2 noticed that Philip had a large bruise on his back; when asked about it he could not give any explanation. Mother was asked and said that Philip had fallen down the stairs. This explanation was accepted. Mother was advised to take Philip to the GP; this was not followed up, and this incident was not shared with the nursery designated safeguarding professional as would be expected.

3.20 Fifth referral to CSC

Three days later Mother phoned the GP, reporting that Philip had been vomiting, was tired and had some unexplained bruises. Mother was offered an immediate appointment, but she said this was not convenient and because this was just before the weekend Philip was not seen for a further four days. The GP noted extensive bruising, with "finger tip" type bruises and a possible bite mark on his buttock, bruising covering quite a large area of the back and a carpet burn in the middle of the back. It is unclear if Philip was asked about the injuries as this is not recorded, but Mother said that she thought they were caused by a reported family history of easy bruising, some medical issues related to early reflux problems and Philip's boisterous behaviour. The GP was concerned about the extent of the bruising and made an immediate referral to CSC and to a Paediatrician for a child protection medical examination.

3.21 The referral was viewed by the Deputy Team Manager and allocated for an Initial Assessment by Social Worker2. The GP surgery was informed of this. There was no strategy meeting held and no contact with the police. Social Worker2 telephoned the Paediatrician and explained that there had been a recent assessment because of bruising to Philip and that the conclusion of the assessment had been that Mother was struggling to manage her children's behaviour, and that it was this that had caused the bruising.

3.22 The Paediatrician saw Philip with Mother who reported that Philip had fallen down the stairs, was boisterous and there was a family history of easy bruising. When Philip was asked how his injuries occurred his answer was "from outside". The Paediatrician was concerned about the extent of Philip's bruising, and judged Mother's explanation to be inaccurate. The bruising was recorded on a body map and photographed and a Consultant Paediatrician reviewed these documents. Verbal feedback was provided immediately to the Social Worker and a written report was received a week later. The report outlines the injuries as:

"Large 8cm x 6cm fading bruise in the centre of the back, with a /carpet burn area, which is beginning to heal and scar. 3cm x 2cm area of bruising over left buttock. 3cm x 2cm area of reddish bruising/scratch marks on right buttock, this area was circular in appearance and had five discreet reddish bruises on the left side, with three longer scratch marks on the right side. There was a bright red spot in the centre. Bruises noted to top of right thigh 3cm x 2cm and 2cm x 1cm faded brownish colour. Two discreet bruises noted to right flank, both 1cm diameter. Three bruises

noted to left flank, all 1cm diameter. Red mark below left nipple 1cm diameter. Bruise to top of left thigh 1cm diameter.”

- 3.23 The Paediatrician’s conclusion was that there were no medical causes and that some bruises could be consistent with the explanation provided by Mother, but it was unclear what had caused the injuries on the buttock, and there was concern that one was a bite mark. Blood tests were taken, and found some iron deficiency (all other test came back normal) and oral iron was prescribed. In the written report from the Paediatrician there are concerns that Mother had delayed seeking medical advice and that the injuries would “*certainly reflect poor supervision of the child’s behaviour*”. Given that the Paediatrician had been asked to carry out a child protection medical, she believed that a child protection enquiry was underway. The medical report was sent to the GP, who received feedback regarding the outcome of the original referral a month later, confirming that the family were to be offered short term support; they did not receive a copy of the assessment at this time.
- 3.24 On the day of the child protection medical assessment, Mother told Nursery2 that she had been to see a Paediatrician because she was concerned that Philip bruised easily and blood test had been taken. She did not say that the medical was part of an assessment by CSC and they were not informed about this referral or assessment by any other agency.
- 3.25 An unsuccessful home visit was attempted by Social Worker2 a week after the referral was received, and a second unsuccessful home visit the week after. Social Worker2 had supervision and reported that the injuries to Philip were consistent with the explanation provided and there were no concerns; there was no current evidence that this was the case. It is unclear whether the fact that Philip had not been seen and his safety and wellbeing not assured were discussed.
- 3.26 Social Worker2 undertook a home visit almost a month after the original referral had been made; this was an unacceptable delay to address the cause of some unexplained injuries to a young child. Mother was seen with Philip and John. The subsequent Initial Assessment is very muddled. It once again uses information from the Initial Assessment undertaken in January, interspersed with more recent information. Darren is recorded to be still living with MGM at the beginning of the document, but in the analysis section he is described as having returned home and that his attendance at school was of concern. It is unclear where this information came from as there is no evidence that his school were ever contacted. There is no reflection on what this lack of stability might mean for a child of 10 and no attempt to ensure that clear future plans were made for him. He was not seen as part of the assessment, so we have no sense of Darren’s views about his circumstances.
- 3.27 Mother is reported to have provided two main explanations for the bruising – boisterousness and a family history of easy bruising and possible underlying medical issues. The assessment contains the paediatric report in full which contradicted Mother’s view making it clear that there was no current evidence that the bruising was medical in nature; further blood tests were planned. This contradiction was not

commented upon. The Social Worker did observe that both children were running around and that John “*jabbed Philip in the side with a toy very hard*”¹⁴ and this seemed to confirm Social Worker2’s existing hypothesis that the bruising was caused by rough play. There was no reflection on whether a child of five could inflict so many injuries. There is no sense that Mother was challenged about her strong assertion that there was a medical cause, there was no analysis of this and the final plan focussed almost entirely on medical issues.

- 3.28 The assessment does not make clear whether Mother’s partner Ian was seen but there is a comment that “*Mother’s partner seemed to have a good interaction with the children and was supportive*”¹⁵. This implies he was in the family home.
- 3.29 It is unclear whether the Social Worker spoke to the children alone because the information in the assessment was taken from January’s assessment.
- 3.30 No other agencies were contacted during the assessment; however because information from the earlier assessment was included, it appears that they were. For example, the positive information provided by Nursery1 in the first assessment was included, providing a completely false picture of the family circumstances, and wrongly reported that Philip attended four days a week. In fact he had been taken out of the nursery 8 weeks earlier and was now attending Nursery2 with whom no contact was made. The Health Visiting service were also not contacted/mentioned, there was no contact with the drug agency and the concerns expressed by the Paediatrician regarding Mother delaying seeking medical attention were not included, and therefore not analysed. This assessment was not sent to the Paediatrician for another month.
- 3.31 The assessment was completed a week after the home visit and concluded that “*further assessment of needs and support are required to reduce the risk of further excessive bruising or injury*”¹⁶. A transfer email was sent to the social work long term team which provided a different plan:
- the case was open for short term monitoring
 - there was no evidence to suggest Mother had caused the injuries
 - she was struggling to manage the behaviour of the boys with some recent improvement
 - Mother felt that there was some underlying medical cause for the bruising and so does not feel she needs parenting support.
- 3.32 During the time that the assessment was being undertaken, staff at Nursery2 noticed changes to Philip’s behaviour with reports of tantrums, throwing toys, pushing chairs, crying and banging his head on the floor. This was discussed with Mother who reported that she was going to take Philip for blood tests for possible anaemia.

¹⁴ This quote was taken from the Initial Assessment completed by the Social Worker

¹⁵ This quote was taken from the Initial Assessment completed by the Social Worker

¹⁶ This quote was taken from the Initial Assessment completed by the Social Worker

Nursery2 were unaware of the current referral or assessment and therefore this important information was not available.

Commentary

This was a second opportunity to make sense of extensive unexplained injuries/possible physical abuse of a young child to which there was again an ineffective response. The reasons for this appear again to be issues regarding capacity for CSC, very poor assessment practices by the individual Social Worker and some overall inexperience regarding the assessment of physical abuse.

Clear referral made: An appropriate referral was made by the GP. The GP received acknowledgment of the referral, actions to be taken and the name of the Social Worker was provided in line with expected practice.

No strategy meeting: As with the previous referral there was no strategy meeting or discussion with the police as would be expected. This is discussed in **Finding 7**.

The assessment was poor. The assessment once again used existing material from the assessment in January, with some additional specific information about current concerns. It made it a very muddled document, when a clear outline of the issues for these children was required. The assessment indicated that information from other agencies had been sought about the children's current circumstances, but information from the previous assessment was migrated into the document, and no contact was made with other agencies. This provided a false and misleading picture.

There was a very unclear plan of action that emerged from the assessment, with the conclusion being the need for further assessment, implying that there was a need for a Core Assessment¹⁷. This would have been an appropriate course of action. Instead the focus was on the boy's behaviour, potential medical issues and support to Mother. There should have been a clearer analysis of the issues and what would help to improve the lives of these children, as opposed to focusing on Mother and her concerns. This issue of poor assessment practices is discussed in **Finding 9**.

Poor Assessment of Physical abuse: this was a very unclear assessment of physical abuse and there was inconsistency in professionals asking Philip directly about his injuries. The Paediatrician made it clear, that there had been many injuries, not all were consistent with the explanation provided, and were therefore unexplained. She also made it clear that there was no known medical cause for the bruises at this point, but that blood tests were underway; Mother's view that there was a medical cause was recorded without comment or analysis. Mother's assertion that there was a family history of easy bruising was never explored further, or information sought about it and from this point onwards all involved agencies believed that there was a potential medical cause to future injuries. If this were the case Nursery2 who were responsible for Philip's care should have sought more information about the implications of this for their care of him. This is discussed in **Finding 8**.

Early signs of neglect: Information emerged during this episode of early signs of the

potential neglect of these three children. Mother delayed seeking medical opinion regarding extensive injuries and it was clear that if the injuries were not evidence of physical abuse, they were indicative of very poor supervision of a three-year-old child. Inconsistent information was recorded about Darren, and it remained unclear where he was living, and what the arrangements were for his care. This was also indicative of issues regarding neglectful care. **This is addressed in Finding 11.**

Overall there was a complete **lack of a child focus** and no reflection on what the impact of having so many injuries might be on a young child, regardless of the cause. In the section of the assessment on unmet needs it is recorded that “*Philip has been hit by his brother and also has climbed on things placing himself at risk*”. This implies that either he and/or his brother were responsible for the injuries. This was an inappropriate analysis. Darren was not provided with an opportunity to give a view about thoughts and feelings about living away from home. This is discussed in **Finding 3.**

Poor multi-agency involvement: There was no multi-agency involvement throughout this episode, which was masked by the inclusion information from the previous assessment. This is discussed in **Finding 2.** The Paediatrician believed that child protection enquiries were underway and it would have been appropriate for there to be some follow up with CSC to establish what the conclusion was given that some injuries remained unexplained. This did not happen, and the completed assessment was not received by the paediatric service until a month later. There is no evidence that the assessment was reviewed and discrepancies noticed. This could have been an appropriate opportunity for challenge to this very poor assessment. This would have been the only opportunity as no other agency received a copy of the assessment.

Reliance on parental self-report: There continued to be evidence across this episode that professionals relied too heavily on what Mother said, without there being a process for challenging or exploring whether it was true. The issue of easy bruising is a significant example of this. This is discussed in **Finding 4.**

Lack of inclusion of Nursery2: This is an emerging theme. They were not told that the assessment was underway, or that there might be concerns about physical abuse, poor supervision or medical issues regarding early bruising, despite Philip being regularly in their care. This lack of inclusion meant that the valuable information about Philip’s behaviour that they held was not included. Overall the lack of inclusion of nursery is discussed in **Finding 6.**

3.33 **CIN Process:**

Three weeks later Mother contacted the GP because Philip was unwell with a tummy ache, vomiting and was very tired. Philip was seen by the GP who found him to be well, but a little pale. Mother asked that Philip be tested for coeliac disease and it was agreed Mother would bring Philip in for some blood tests. Mother did not do this and had to be reminded in the next month and the month after that, and the test took place nearly six weeks after Mother made the request.

3.34 At this time the family were allocated a family support worker (FSW). The focus of this was said to be to help Mother to improve her parenting. However the goals outlined in

the Initial Assessment which formed the basis of the Child in Need plan were:

- Philip to have an appropriate diet;
- GP appointment to be made to test for Coeliac disease (acknowledged as a concern of Mother's);
- The risk of Philip being bruised accidentally or deliberately to be reduced;
- Philip to not place himself at risk and his brother to stop hitting him.

3.35 The FSW visited the family twice over the next four weeks. It was noted that Darren was living with MGM but would be returning to live with Mother and siblings in September. Mother told the FSW that she was certain that there was something medically wrong with Philip who continued to be unwell. Mother also talked about her partner Ian who she said was supportive, did not take drugs, but did not know that she attended the drug agency or had problems with drugs in the past; she asked the FSW not to mention these issues. Phillip and John talked about playing with Ian.

3.36 The FSW had supervision and reported that she thought Mother's parenting was good; this was the current focus of the work. It was agreed that there would be fortnightly visits and monthly Child in Need meetings (CIN¹⁸). The FSW was asked to obtain a full history of Mother's drug misuse, to follow up the health testing and that CIN Plan would be developed at the CIN meeting. None of these tasks were completed, and there appears to have been no challenge regarding this.

3.37 The CFSW from Nursery1 rang the Health Visiting service to ask if the family had an allocated Health Visitor. John was still attending the nursery and the CFSW had also had a discussion with Mother at the nursery sports day regarding Philip being unwell and possibly coeliac. Mother told the CFSW that CSC had carried out an assessment because of concerns about bruising.

3.38 The Health Visiting service made contact with CSC and were given information (which was wrong in the detail) about an assessment being undertaken. This led to a Health Visitor being allocated with the aim of helping Mother improve her parenting. The newly allocated Health Visitor telephoned and emailed the FSW and was left a message saying that there was to be a CIN Meeting in three weeks' time.

Commentary

Poor Planning regarding unexplained injuries: In July the family were allocated a FSW, rather than a Social Worker. This was because the focus was on parenting support and the FSW was very experienced at this. This focus was incorrect. The cause of some of the bruising on Philip, including a possible bite mark remained unexplained. Mother had made it clear that she did not accept that she needed parenting support because the cause of the injuries was medical. Although the paediatric assessment had made clear that there was no evidence that this was the case, the emergent plan from the Initial Assessment focussed almost entirely on medical issues. This is discussed in **Finding 9**.

¹⁸ A Child in Need Meeting is held so that children, young people, families and those professionals working with them are clear about their responsibilities within the Children in Need Plan, the role of the allocated social worker, timescales of the interventions and expected outcomes.

Holding children responsible for unexplained injuries: The plan also suggested that Philip had put himself at risk, which partially explained the injuries and that his brother John was also responsible because of rough play. There appears to have been no reflection on the appropriateness of holding children responsible for what were clearly adult parental issues. This is discussed in **Finding 3**.

Lack of follow through of agreed tasks in supervision: A clear agenda was set for the work of the FSW which was not followed through. This does not appear to have been noted or addressed in a subsequent supervision session. This was important because, if for example the FSW had checked whether the medical tests had been undertaken as she had been asked, she would have found that Mother had failed to take Philip for these, despite reminders from the GP. This could have changed perceptions about Mother.

Allocation of a Health Visitor: it is good practice that the CFSW contacted the Health Visiting service to see if there was an allocated Health Visitor. The family had some time before been assessed as requiring routine (universal) support and all the health milestones had been completed. Mother had stopped engaging, and did not seek advice. The Health Visiting service were not made aware that there were concerns, as would be expected, and therefore they could not reevaluate the level of support needed. It is effective practice that as soon as they were made aware of concerns they allocated a Health Visitor. However there is no evidence that a Family Health Needs assessment was undertaken at this point as would be expected.

3.39 **The First CIN Meeting**

The first CIN meeting took place at school. It was John's first day at school and appropriately the school nurse and the school support worker were present. The meeting was chaired by the FSW and was also attended by the Health Visitor, drug agency worker, Mother and MGM. Nursery2 were not invited, but found out about the meeting by accident and attended. The report of the CIN meeting notes suggests that the children were consulted before the meeting, but there is no evidence to suggest this was the case, and their views were not included in the discussion. The meeting was dominated by Mother and her concerns regarding Philip being unwell. Mother said that the GP had not yet conducted blood tests, but did not say that they had tried to contact her to remind her to bring Philip in which she had not done. The Health Visitor said she would support Mother to contact the GP, but Mother said this was not necessary. A very worrying picture emerged regarding Philip's wellbeing; Mother reported he was losing hair, was being sick 2/3 times a day and was sleeping in Mother's room because she was concerned he would be sick in the night and choke.

3.40 There were concerns expressed about Darren who was described as exhibiting aggressive outbursts and behaviour. His school were unable to attend the meeting so there was no further detail and he was reported to be back living with Mother, but spending time with MGM after school.

3.41 The meeting was convened to develop a plan, but this did not happen. Mother said she did not have time for parenting classes as she wanted to get a job. The only

update to the CIN plan completed as part of the Initial Assessment was that the Health Visitor would support Mother to seek medical help regarding bruising; there was no acknowledgement that Mother had already declined this. Mother's partner Ian was not discussed.

- 3.42 The Health Visitor had safeguarding supervision after the CIN meeting and the analysis of current concerns was that Mother was meeting the children's needs but there needed to be an assessment of Philip's development and to follow up on the health issues. The Health Visitor did ring the GP surgery to ask about progress of the blood tests, but was told these could not be discussed with her and she needed Mother to ring. It is unclear at this time whether the CIN meeting was discussed and that the information was required for that purpose. The GP practice were not asked to provide any information for the CIN process, despite the focus on health matters.
- 3.43 The GP surgery telephoned Mother the day after the CIN meeting and asked her to organise the blood test for Philip and the test was undertaken. Mother was told a week later that Philip was not coeliac.
- 3.44 Three days after the CIN meeting Nursery2 noted a large bruise on Philip's right ear (top and back) and when he was asked about it he said he had bumped his head. He was collected by another parent and she was asked to mention the bruise to Mother. This adult said that it had been there for a number of days, but the nursery should not worry because Philip bruised easily. Mother was spoken to the next day and said Philip had bumped his head. This information was not shared with the FSW as would be expected and Mother was not advised to take Philip to the GP.

Commentary:

CIN meeting lacked a focus on the ends and circumstances of all three children: The CIN meeting was convened in a timely way (given the summer holidays). It brought together a number of agencies. Nursery2 inappropriately heard about the meeting by accident, they had not been invited. The GP was not asked to provide any information, despite the focus on Philip's health needs. This process was ineffective in developing a child focussed plan. This is discussed in **Finding 10**.

At this point there remained concerns about unexplained injuries to Philip which were unacknowledged and no professional present had seen a copy of the assessment, or knew in detail its conclusions. This made it difficult for professionals to judge whether there was an undiagnosed medical issue. This was based entirely on self-report from Mother. Mother's views dominated without challenge. This was a further example of parental self-report which is addressed in **Finding 4**.

The discrepancy between Mother's stated concern regarding Philip's health and her failure to bring him for medical tests was not known because the GP was not asked to provide any information to the CIN meeting. This issue is discussed in **Finding 2**.

A worrying picture emerged during this meeting of a very unwell little boy. This should have prompted professionals to ask Mother to seek urgent medical attention for him and to ask

why this had not been done before. There was no reflection however, that the picture provided by Mother was not seen in nursery and if the bruising was caused by either an undiagnosed health issue or easy bruising it would be expected that Nursery2 would have seen more evidence of bruising in their setting. They only ever saw pre-existing bruising, and because they believed this was caused by a medical issue, did not report them. The reasons for this appear to have been poor knowledge and skills in the assessment of physical abuse, an over reliance on parental self-report without a full triangulation to other information and the lack of effective supervision for those centrally involved.

Lack of inclusion of Nursery2: It was only by chance that nursery 2 attended the CIN meeting, yet they had most knowledge about Philip, who was the primary focus of this CIN process. This was a consistent pattern which is addressed in **Finding 6**.

Children's voice and child focussed practice: There remained contradictory information about where Darren was living. It was noted that he was struggling with angry outbursts, but there was no discussion about why this was or whether this behaviour might be connected to the instability in his living arrangements and possible confusion about who was his primary caregiver. The children were reported to have been consulted before the CIN meeting, but there was no evidence that this happened and the records indicate that their views and/or life experiences were not discussed. This is discussed in **Finding 3**.

Mother's partner Ian was barely discussed, and there was no evidence at this stage that any professional considered what his role was in the family unit. This is discussed in **Finding 5**.

3.45 **Sixth Referral to CSC**

A week after the CIN meeting Mother and her partner Ian were arrested for handling stolen goods; two stolen laptops were found in the garden. During the search of the house, Police Officers found that the children's bedroom and other rooms had high external locks on the outside of the doors; they were in a position that the children could not reach. The Police Officer challenged Mother about these locks and their location, expressing concern that the children were locked in their bedroom and only the adults would be able to let them out. Mother said the locks were there to stop the children going into other rooms. The Police Officer spoke to John who said that he was locked in his bedroom and the adult with him (no record of who this was although was thought to be MGM) said that "*he shouldn't say things like that*". The sheets on John's bed were filthy and smelt unwashed; the room was described by the Police Officer as very sparse and they noted that there was no evidence in the kitchen that children lived there. The garden had personal belongings strewn across it. Mother said these belonged to Father and she had thrown them into the garden because they kept arguing. Photographs were taken, but not shared with any other agency. The police asked Mother to remove the locks and clean up the bedroom, which she did and the police made a referral to CSC.

3.46 The FSW went to the family home the next day. Mother denied locking the children in their rooms and said she would never do such a thing. She then said that sometimes the children took water from the bathroom and caused flooding, so there were locks on some rooms. The issue of Mother initially denying that the children were locked in,

and then admitting it happened on some occasions was not challenged or discussed further. It should have been made clear that the children should never be locked in their rooms. The FSW did not have a discussion with the police about the size and location of the locks and did not ask if photographs had been taken, this meant she did not have a clear picture of the seriousness of the concerns because the police had already asked Mother to remove the locks and clean the house. Philip had a bruise on his face and the FSW recorded that he had been heard to say he banged his cheek when he woke up. Mother said the disgusting sheets on John's bed were temporary because he had wet the bed and his normal sheets were being washed. Philip was asleep in Mother's room and Ian was also asleep in bed in the same room; this was not questioned. The FSW went to see John at nursery because she was aware that he had told the police about being locked in his room, but when asked again he said "no". There was no reflection on the meaning of this retraction by John or whether he had been told to say this. The FSW did not seek any immediate managerial advice about the appropriate response to this referral and no other agency was informed that it had happened.

- 3.47 There is some confusion about the sequence of events regarding this whole incident, but it appears there was a teleconference call between the FSW's manager and the Police four working days after the initial referral to CSC. Feedback was provided to the Police about the home visit and despite their original serious concerns, they were reassured that action was being taken and it was agreed that there was no role for the police, but that CSC would continue enquiries. The police understood interviews would be undertaken with the children at school, but this did not happen. No formal enquiries were undertaken. Overall it was inappropriate to ask the FSW to undertake this work, which should have been completed under the auspices of child protection enquiries.
- 3.48 Seven working days after the referral from the police the FSW had supervision with her manager. They discussed the referral and that Philip had a bruise on his cheek at the home visit, which was said to have been caused by a Lego brick. This was a different explanation to the one previously recorded, but there was no further discussion of this. The contradiction between John's disclosure and retraction was not discussed. The only agreed action was for the FSW to see Darren at school. The purpose of this is not made clear in the records and this never happened. The previously agreed tasks from the last supervision regarding these children were not reviewed and so the fact none of them had been completed was not acknowledged.
- 3.49 The next home visit did not take place for another three weeks and Mother discussed her concerns about Philip being unwell and tired. Mother said she had been to the GP who was to make referral to a Paediatrician. Philip had another bruise on his cheek and Mother said this had been caused by a child throwing an object at him. This should have been further explored. The house was seen to be clean and tidy.
- 3.50 The Health Visitor could not make contact with Mother for a few weeks and it was nearly two weeks before she could visit and undertake the developmental assessment where Philip was assessed as developing appropriately.

3.51 Mother saw her worker at the drug agency at this time. She had Philip with her who was described as happy and smiling, but who went to sleep during the appointment. Mother said that the police had raided her property because her partner Ian had hidden some laptops in the garden and they had been arrested. She also reported feeling stressed by CSC involvement. Mother's care plan was reviewed and the planned reduction in her medication was put on hold. The drug agency worker did not contact the FSW to ensure that she knew about the police involvement.

Commentary

Incident led practice: This was the sixth referral in a nine month period about the wellbeing of these children and was an opportunity to step back and consider what was happening. Instead the focus was on the presenting problem, rather than professionals seeking to understand the cumulative nature of the concerns and consider what was the overall picture for these children.

There was no formal assessment or enquiries: this was a serious incident which should have led to a strategy meeting, or at least a further assessment of this new information. The allocation of this case to an experienced FSW may have influenced this. This allocation was in line with existing custom and practice for cases where the main focus was parenting support. This was incorrectly the initial focus, but quickly it should have been clear there was something more serious happening here which required further investigation, and a qualified Social Worker was required. Capacity issues for CSC seemed to have played a part here.

Multi-agency working: despite this being a CIN case, with a multiagency group supposedly overseeing the plan, no other agency in the network was informed of this incident. When Mother told the drug agency that the raid had happened because of her partner Ian's actions, this should have been discussed with the FSW and the implications for the children considered.

The FSW did not make contact with the police to establish clear information about the state of the house, and ask for more information about the locks. The pictures taken by the police were also not included in the referral or discussed in the teleconference. This meant that the implications of the size and location of the locks in the context of the young age of these two children was not explored or analysed. In effect this worrying information got lost. This was further evidence of inconsistency/uncertainty in multi-agency working across the period under review and is explored in **Finding 2**.

Understanding of neglect: the information from the police suggested there were concerns about the physical care the children were being provided with and their emotional wellbeing in the context of being locked in their rooms, yet this was never described as evidence of neglectful care. The implications of the criminal activity taking place in the home, and the presence of unknown adults was not addressed as a risk factor for the safety and wellbeing for the children. This is discussed in **Finding 11**.

Parental Self-report: Mother dismissed the concerns of the police and the explanations she provided were given more credence than either the police or the disclosure from John.

This was completely inappropriate and further evidence of a reliance on self-report. This is discussed in **Finding 4**.

Continued concerns regarding bruising unexplored: Philip was seen on two occasions during this time (a three week period) with bruising, which were not appropriately assessed or the causality explored. This appears to have been caused by a lack of clarity of what was the main focus of the work, alongside the continued influence of Mother's insistence of a medical cause.

Lack of child focussed practice: Mother and her partner Ian should have been challenged about their decision making, which brought police raids to the house, where there were two young children living. This would have been a frightening experience, and was evidence that both adults were prepared to put their own needs above the needs of the children. This required further exploration. This is discussed in **Finding 3**.

Children's voice: The FSW did go and see John as part of her exploration of this critical incident. There is little available information about what was covered with this five year old, or what developmentally appropriate methods were used to give him an opportunity to share his view and any worries. The fact that John withdrew his assertion that he was locked in his bedroom should have been subject to further analysis. The issue was not that he withdrew it, but why he did so and what the implications of this were. The FSW was asked to go and see Darren, but this never happened, and Philip was not seen alone at all. This is the continuation of a significant theme of this review about the importance of understanding the lived experiences of children and enabling them to have a voice. This is discussed in **Finding 3**.

- 3.52 A month after the first CIN meeting there was a second CIN meeting which all professionals and Mother attended, but the FSW did not. The professionals found out that the FSW was unwell and it was agreed that the meeting would be rescheduled. Mother told those present that Philip did not have coeliac disease.
- 3.53 The next day Mother took Philip to the GP with abdominal pain, vomiting and bruising to the cheek. Philip was pale, but there were no concerns when he was examined.
- 3.54 The rescheduled second CIN meeting took place a week later. It was chaired by the FSW and attended by the same group of professionals as at the first, alongside Mother and MGM. Mother had asked the FSW not to share the details of the police raid, but agreed that the issue regarding the locks and dirty bedding could be discussed. Nursery2 shared that Philip had a bruise a few weeks earlier, but they had not been concerned because they understood that this was a medical issue which was being addressed by the GP. The FSW said that any bruises must be shared with CSC. She also asked Mother if any other adults or her partner Ian looked after Philip, Mother said no and she could not see why the FSW had asked.
- 3.55 Mother said that the GP had now made an appointment for Philip to be seen by the Paediatrician for further tests and this was confirmed by the Health Visitor. Professionals agreed that John was making good progress and that there remained

concerns about Darren's school attendance. MGM said that she found him difficult because of his angry outbursts, but at these times Mother would come and help. The children were reported to be too young to provide their views to the CIN review by the FSW. The existing minimal plan remained, and was updated with information about the potential appointment with the Paediatrician.

- 3.56 The FSW felt very concerned about the situation and planned to talk with her manager about this the next day. Before she had a chance to do this Philip was taken to hospital by his mother and found to have a number of non-accidental injuries.

Commentary

The effectiveness of CIN processes: The CIN meeting was dominated by Mother's concerns regarding Philip's wellbeing, without there being any agreed actions other than the future appointment with the Paediatrician. This meeting was attended by all the appropriate professionals, but was once again ineffective in its task which should have been to review the circumstances of these three children, reflect on the CIN plan and discuss amendments or how to respond to a change of circumstances. This is discussed in **Finding 10**.

Stability for Darren: Darren was said at this meeting to be living with MGM, whereas at the last meeting five weeks earlier he was said to be living with Mother. This continued confusion and uncertainty about his circumstances was not discussed, and the evidence that this was having an impact on his wellbeing in the form of angry outburst and poor school attendance was not acknowledged. This is discussed in **Finding 3**.

Role of Mother's partner: A more direct question was asked of Mother about her partner Ian and his care of Philip at this point, indicating that there was beginning to be a growing understanding that professionals needed to understand this more. This is discussed in **Finding 5**.

Further bruising: It became clear during this meeting that Nursery2 had seen bruising some weeks before and had not reported it. This was because they believed that Philip suffered from some medical condition/easy bruising. This was clear in the meeting, but there was no discussion about this false perception despite the FSW's concern about this, as evidence by the use of exclamation marks in the CIN records and the Health Visitor's concerns. There should have been a more robust plan of action for the future. This is addressed in **Finding 8**.

Parental challenge: The CIN minutes report that the Mother asked the FSW not to discuss why the police had visited the family home, and although the FSW told Mother she would need to share the concerns about the state of the house, she appears to have agreed not to share the issues about criminal activity. This was important information for the multi-agency group to know about, and analyse in the context of the children's needs. The FSW should not have agreed to Mother's request, and she should have sought her manager's advice regarding this. This is addressed in **Finding 4**.

- 3.57 That evening Mother called an ambulance because Philip had been constantly vomiting for the last four days. The ambulance crew were immediately concerned

because Philip was extremely unwell, appeared to be small for his age and looked slightly malnourished and there had been a significant delay in Mother seeking medical help. This concern was replicated at hospital, and it was noted that Philip had lost 1.5kg in the last three months, a significant weight loss for a young child. There were additional concerns regarding Mother's attitude to Philip; she was distant, did not comfort him and left him on his own for long periods whilst he was receiving medical care. There was a strong belief amongst hospital staff that the cause of Philip's admission was child abuse, but the task of providing medical care dominated and safeguarding action was not taken that night. A strategy meeting was held the next day. Philip was treated medically overnight and transferred to Bristol Children's Hospital as a severe emergency with life threatening injuries six hours later. The details of the admission and the initial body maps of the injuries did not transfer with him. Family history was sought the next day. The siblings were placed with a relative.

Commentary

Philip was taken to hospital with significant injuries for which he received prompt medical attention. Professionals at the hospital noticed Mother's poor attitude and care of Philip but the task of providing medical care dominated, and these observations were not recorded, or any safeguarding action taken until the next day. This could have left other children vulnerable to harm. If the concerns were as serious as this the police and CSC should have been called. It is good practice that extensive records of the injuries were taken, but were not sent to Hospital 2 because they were left behind in the urgency of the transfer.

4 Findings

4.0 Introduction

At the heart of this review are significant concerns about unexplained physical injuries to a young child. It is essential that professionals are able to effectively identify, assess and take positive action when children have injuries of concern. This is one of the Findings of this review alongside 10 others outlined below.

4.1 Finding 1: The role of a formal early help response in keeping children safe

The case for preventative services is clear, both in the sense of offering help to children and families before any problems are apparent and in providing help when low level problems emerge. From the perspective of a child or young person, it is clearly best if they receive help before they have any, or have only minor, adverse experiences. Munro 2011^{iv}

- 4.1.1 Research, policy and guidance has highlighted the importance of intervening early in the lives of vulnerable children and their families; as the quote from the Munro review indicates intervening early is more effective in improving children's outcomes than later, reactive services, when problems have become entrenched and are more difficult to address. The focus here is on identifying the needs of children and young people before they have reached a point where their development and wellbeing is seriously compromised. This includes early assessment, in collaboration with family members, and the provision of services which meets children's needs. Although the early help approach relies on good partnership working with families, it also emphasises the need for professionals to be clear with parents about the likely negative long term consequences for children if they feel unable to engage with services intended to improve the life circumstances of their children. This requires professionals to develop good engagement strategies, and to be able to challenge parents appropriately.
- 4.1.2 Philip and John were identified as needing help because of their parent's difficulties. Mother had previously misused drugs, was struggling with Father's aggressive behaviour, and reported finding it difficult to manage the children behaviour. Some of these difficulties had led to her asking for Darren to be cared for by Maternal Grandmother. Mother reported that Father had poor mental health, misused drugs and was aggressive. These parental concerns are exactly the kind of issues which can impact on children and for which an early help response was designed. Over a 12 month period a range of professionals offered support which Mother said she would consider, but ultimately did not accept. During this time there was no assessment using the CAF process and therefore no formal setting of goals or plans to address the children's needs. The lack of a formal process meant that Mother's lack of engagement with services aimed at addressing the needs of her children was not formally acknowledged and the information was not part of the analysis of the first Initial Assessment.
- 4.1.3 The police referral (which was referral number three to CSC) which led to the first Initial Assessment made clear that there were concerns regarding Father's aggression and drug use and that Mother continued to struggle with the children's behaviour; there remained uncertainty about the wellbeing and living circumstances

of Darren. The conclusion of this assessment was that there was no need for further action. In reality this conclusion was really that the threshold for CSC had not been met, and given the available information this was correct. It did not mean that there was no need for services to be offered, and this could have happened using the early help process. In effect Nursery1 – part of the Children’s Centre – continued to offer support informally, but the lack of progress and a deteriorating situation would have been more clearly identified through a formal plans which was reviewed and would have provided context for the next assessment. The need for enhanced Health Visiting support might also have been recognised.

- 4.1.4 The fourth referral to CSC also led to an Initial Assessment and this concluded that support could be given through School or the Children’s Centre, without any sense of how this might happen. This recommendation was not made in the context of an early help response, despite there remaining concerns about Mother’s ability to cope with the children’s behaviour and ability to provide effective supervision. No other agency considered that an early help response was necessary.

There is no recommendation regarding this Finding as Gloucestershire County Council is currently working with partners to develop the Early Help offer across Gloucestershire. Early Help Partnerships and Allocations Groups have been developed across the County to support families and practitioners working with them to access the additional support they need.

The GSCB will need to be assured that this work is addressing the concerns raised in this SCR. This can be achieved by existing reporting processes.

4.2 Finding 2: Multi-agency Information sharing

- 4.3.2 Good quality multi-agency information sharing lies at the heart of effective safeguarding practice and there is clear guidance^v about its importance and the principles which underpin effective practice. Poor information sharing is a key theme across many of the Serious Case Reviews published in the last fifty years, and these reviews highlight the consequences for children, young people and their families if professionals are unclear about their responsibilities in this area. More recent reviews have highlighted that information sharing is about more than just passing information from one agency to another. It is about each agency sharing its own analysis of the child and families circumstances, and ensuring that those who know the child best communicate their understanding of the child’s world.
- 4.3.3 Information sharing is a two way process; each agency needs to be clear what it needs from others when undertaking assessments or inquiries about children’s wellbeing and all agencies need to think about the information and knowledge they hold, and actively consider its relevance. In this case information was sought from agencies during the first Initial Assessment, but the reasons for the assessment do not appear to have been made clear. Information about Mother’s drug use does not appear either to have been sought or shared. It is unclear why, but this was relevant information and could have led to a clearer analysis of substance misuse, and issue which was never fully explored.
- 4.3.4 This first assessment was shared with the GP and Nursery1 which was good practice, but both agencies filed the report, and the information was not used to make sense of

any of the children's circumstances. There appeared to be a fundamental misunderstanding about why this information was being shared. The assessment was not shared with the drug agency, who worked closely with Mother, and they therefore had no knowledge of any wider concerns. Information was also not shared with the Health Visiting service, and they were therefore not able to evaluate whether there was a need for an enhanced response.

- 4.3.5 Nursery1 did provide good information about their concerns and gave a clear picture of the extent of bruising to Philip. They also provided some analysis of Mother and concern that her explanation was not consistent with the injuries seen. This was good practice, which was undermined by the assessing Social Worker taking a different view, but not discussing it with the Nursery1. Nursery1 did not have a full opportunity to challenge this because they did not receive a copy of the assessment and were given brief information about the outcome of the referral they had made. However, the information they were given contradicted their concerns and this should have been challenged. They did not feel able to do this because they considered the assessing Social Worker to be the safeguarding expert. This is discussed in **Finding 6**.
- 4.3.6 During the second assessment contact was not made with any other agency except Nursery1 who had made the referral; information was migrated from the previous assessment, which meant it was out of date and not relevant to the current concerns. No agency was sent a copy of the assessment. This was extremely poor multi-agency practice and meant that agencies were not aware there were concerns about bruising and inadequate supervision. It is of concern that the assessing Social Worker indicated that advice had been sought from a Paediatrician, when there is no evidence that this was the case. Nursery2 were not made aware of the concerns regarding Philip, despite this information about their involvement being known to Nursery1 and the assessing Social Worker.
- 4.3.7 A clear referral was made by the GP regarding injuries to Philip, and a medical organised. The GP was informed of the outcome of the assessment, but did not receive a copy and therefore was not able to evaluate the response to their referral. The Paediatrician who undertook the medical was given verbal information about the recent assessment, but was not provided with a copy, which would have highlighted recent significant concerns regarding extensive bruising.
- 4.3.8 There was also little multi-agency contact during the third Initial Assessment, where once again information was migrated across. This meant that there was no multi-agency analysis, and Nursery2 were not asked to provide information about how Philip was in nursery; something they were concerned about. Once again the assessments were not shared with most agencies, with the exception of the Paediatricians who undertook the Child protection medical; they received a copy a month after it was completed; they did not review this document or comment on the fact that its conclusion was at odds with their analysis.
- 4.3.8 The CIN process did bring most agencies together; although nursery2 were not invited and the GP not asked for information. This was an important opportunity for information to be shared, and a clear plan developed. This did not happen; the involved agencies were not provided with a copy of the assessment, which formed

the basis of the original plan. The first meeting was dominated by Mother, and at the second meeting Mother was able to ensure that the family support worker only shared partial information about concerns.

- 4.3.9 Information was never sought about Darren and therefore his school was never aware that there were any concerns about the family, and were not asked for information about him.
- 4.3.10 There were significant gaps in the sharing of information across the multi-agency network regarding Philip, Darren and John. This appears to have been caused in part by the poor assessment processes, but also some lack of confidence and ownership by other agencies regarding their responsibilities to ensure that all information is shared, information is sought from others and discrepancies in the analysis of concern challenged.

Recommendation: the GSCB needs to understand what prevents professionals from working to the national information sharing guidance

Recommendation: the GSCB needs to understand in what circumstances it is appropriate for CSC to share the assessments with other agencies regarding children those other agencies are working with and clarify this to partner agencies

4.3 Finding 3: The importance of Child Focussed Practice

“everyone involved in safeguarding and support should pursue child-centred working and recognise children and young people as individuals with rights, including their right to participation in decisions about them” Munro 2011^{vi}

- 4.3.1 The South West Child Protection procedures^{vii}, underpinned by Working Together 2015^{viii} makes clear that one of the core principles of effective safeguarding practice is a child centred approach which is focused on the needs and views of children. This is reinforced by the United Nations Convention on the Rights of the Child (CRC)^{ix}, which recognises a child’s right to expression and to receiving information. This right is also reinforced by Article 10 of the Human Rights Act 1998^x and the Children Act 1989^{xi}, which requires a local authority to ascertain the ‘wishes and feelings’ of children and to give consideration to these when determining what services to provide, or what action to take (taking into account the child’s age and understanding). The Assessment Framework (2000)^{xii} also clearly states that direct work with children is an essential part of the assessment process because children are a key source of information about their lives and the impact any problems are having on them^{xiii}.
- 4.3.2 Despite this mandate, evidence^{xiv} shows that children are not being routinely fully included in safeguarding and support work. The consistent finding from serious case reviews is that professionals do not speak to the children enough; a report by Ofsted^{xv} on the themes and lessons to be learned from Serious Case Reviews highlighted that children were not seen frequently enough by the professionals involved in their lives, professionals focused too much on the needs of the parents,

and overlooked the implications for the child. This appears to be caused in part by workload pressures, parental resistance, undeveloped skills and differing views about at what age a child is able to participate.

- 4.3.3 Overall, the views and experiences of these three children were rarely sought. There were some exceptions. Nursery1 always asked Philip about the cause of his bruises, and shared this with others. Nursery2 often spoke to Mother about Philip and their concerns regarding him. This nursery were not consulted as part of the two main assessments so this information was not shared with any other agency. The Social Worker in the first assessment did spend time with Philip and John, and this is clearly reflected in the assessment. There does not, however, appear to have been any attempt to see them on their own to ask them their views about what had happened and consider any concerns or worries they had. The assessment does not also reflect on what was likely to have been a very scary incident where their Mother was threatened with a knife and they were taken away by their Father.
- 4.3.4 On the two occasions where extensive bruising was found to Philip, he was asked by the Paediatrician about the cause of his bruising, but more could have been done to explore the contradictions with what Mother had said. Neither he nor his brothers were seen alone during the last two Initial Assessments to ask what had happened, to provide them an opportunity to discuss any concerns or views about their circumstances and there was no sense of Social Worker2 reflecting on what the impact on Philip might be of so many bruises, regardless of the cause.
- 4.3.5 When the police made a referral about criminal activity and neglect the children were again not seen alone to discuss their views and to ask about day to day life. John made an allegation that he was locked in his room but changed the story the next day. There was no reflection about this retraction or the possibility that a parent/carer had influenced this. Research^{xvi} highlights how difficult children find it to make disclosures of abuse by family members, the pressures they feel and their need for professionals to ask questions, notice what life is like for them and investigate fully.
- 4.3.6 It is of concern that the most invisible of the children was Darren. There was considerable uncertainty about where he was permanently living, and a different story was provided by Mother and MGM during each assessment. Mother said that Darren had moved to stay with MGM because of her drug use, but this arrangement was said to be still in place some six years later. There was no discussion of what the implications of this uncertainty might be for Darren, how it might be exacerbating his behavioural difficulties and what the actual arrangements were. He was aged 9/10 years old and should have been offered an opportunity to talk about his circumstances and have the potential instability addressed.

Recommendation: The Gloucestershire Safeguarding Children Board should seek assurance from all partner agencies about the quality of child focussed practice and draw on any current work, such as audits, to consider whether there is any other evidence regarding poor child focussed processes which requires action.

4.4 Finding 4: An overreliance on parental self-report and a lack of challenge to parents

4.4.1 It is essential that all professionals working with children and their families do so in a respectful and open way. This is the cornerstone of partnership practice as embedded in the Children Act 1989^{xvii} and subsequent guidance and legislation. However, research and Serious Case Reviews emphasise the importance of not taking at face value what parents or carers say when asked about the possible abuse of children. The Munro review^{xviii} commented that adults in this situation have a number of motives for not always providing a full picture of their or their children's circumstances. The task of professionals is to remain in a position of "*respectful uncertainty*" and display "*healthy scepticism*" which in practice means:

- checking the validity of information provided by parents/adults by cross referencing/triangulating with other sources
- testing out the level of parental care and concern for children and the extent to which parents feel a sense of responsibility for their children and their well-being

4.4.2 Neither happened in this case, with significant consequences for Philip particularly, but also John and Darren. Information provided by Mother was often taken at face value, and overall there was an over-reliance on her own self-report of her circumstances, which was often unreliable, but which was included in reports, assessments and the minutes of meetings as statements of fact. The issue of easy bruising was an example of this. Mother reported a family history of easy bruising, without there being any evidence that this was the case, and she suggested that this might be the cause of the bruising to Philip. Despite there being no evidence that this was the case, this continued to be discussed as an issue at the CIN meetings, and was the reason why Nursery2 were not concerned about bruising to Philip because they believed this was a medical issue.

4.4.3 During the first Initial Assessment Mother reported that she would be pursuing police action regarding Father taking the children out of the house and threatening her with a knife. This was accepted as true, and seen as a protective factor because Mother appeared to demonstrate an understanding of the likely impact of the children witnessing domestic abuse and putting their needs first. In fact, Mother did not pursue charges and was described as hostile to the police as she did not want to cooperate with them. This provided a completely different picture of Mother's capacity to put her children's needs first.

4.4.4 There was no challenge to Mother regarding actions she took which were not in the best interest of her children, and which indicated a lack of respect for professional concerns. For example when Nursery1 made a referral to CSC regarding extensive bruising to Philip, Mother informed them that she would be taking him out of nursery because of this. Philip had been going to the nursery for some time and had become settled. This decision was not in his best interest, both in terms of his safety and wellbeing, but was not fully challenged by Nursery1 or Nursery2 when they were told about Mother's decision to move him. It was incorporated into the Initial Assessment

completed at this time without comment from either Social Worker² or the manager who authorised the assessment.

- 4.4.5 The FSW agreed with Mother's request before the Child in Need meeting not to share the police investigation of potential criminal activity from the home. This was inappropriate and meant that the opportunity to discuss the potential risks that this might bring to young children was not discussed or addressed.

Recommendation: The Gloucestershire Safeguarding Children Board should seek assurance from partner agencies about:

- The criteria they use to determine how reflection and critical thinking is embedded within their organisation in order to enable practitioners to consider the information they hold, what additional information they need, who would hold this information and how this process addresses the potential impact of parental self-report.
- Why they are content that this is working well
- Any steps that need to be taken to improve this aspect of safeguarding practice.

4.5 Finding 5: A lack of recognition of the role of fathers/father figures can leave children unprotected and at risk of harm

- 4.5.1 Fathers and father figures can play a very important role in family life and research suggests that they can have a great influence on the children's lives both positively and negatively^{xix}. Despite this there is considerable evidence that they can be marginalised by professionals who sometimes focus almost exclusively on the quality of care children receive from their mothers and female carers. The implications of this are that the benefits for children are often overlooked, and the risks posed by fathers and men more broadly are not well understood leaving children at risk^{xx}.
- 4.5.2 Father of the three children in this review was said to have significant mental health difficulties, he misused substances such as heroin, had a significant criminal history and was domestically abusive to Mother. The first Initial Assessment was completed as a result of concerns that he had threatened Mother with a knife and taken Philip, aged nearly 3 and John, aged 5 away in a car. The Social Worker completing the assessment recognised the need to make contact with him but had no address or contact details for him. The assessment described his difficulties, but there was no analysis of the significant risk he posed, and responsibility was placed solely on Mother to be a protective factor for the children.
- 4.5.3 The assessment should have made clear Father's responsibility for placing the children at risk, and of potentially causing them harm. Father went to prison and on release there is some evidence that he was in contact with the children, and continued to be abusive to Mother. This was reported by Philip and John to Nursery1 and although Mother was spoken to regarding this, she was dismissive of the concerns, and no further action was taken. No further contact was had by any professional with Father and he was unaware of the growing concerns regarding

Philip or the subsequent assessments. There is no evidence that attempts were made to contact him when two assessments were carried out: information was migrated from the previous assessment about his circumstances, despite this being historic information.

- 4.5.4 Mother told all the professionals she had contact with, about her new relationship with her partner Ian, which appears to have started around March 2014. There is no evidence that more information was sought about him, and Mother's assertion that he "got on well with the children" and "did not smoke or take drugs" was accepted at face value. He was mentioned briefly in the two assessments but no information was sought from him or Mother about his circumstances/background or family. The assessments were about physical abuse, and yet there were no questions asked about how much care he had of the children.
- 4.5.5 He was centrally involved in the concerns raised by the police about criminal activity and neglect, but the part he played was not analysed in the context of any further risks he might pose, and he was not interviewed alongside Mother about the incident. There was evidence that Philip was sleeping in the same room as Ian and Mother: indeed this is what the FSW found when she visited once the police had raised concerns. This should have been discussed further and its appropriateness and safety explored.
- 4.5.6 Professionals did not know that Mother's partner Ian posed a significant risk to Philip and they had no evidence that this was so. However, there is clear evidence from research and national/local serious case reviews there should have been more exploration of who this new man was and what part he played in the children's lives.
- 4.5.7 It is not clear exactly why professionals were not more curious or concerned. Research suggests that professionals are often reluctant to ask about new partners for fear of being considered intrusive, and a focus on Mother's is culturally embedded into some safeguarding practice. These are likely to have been influences on practice in this case.

<p>Recommendation: Review practice in relation to the role of fathers, building on actions identified through Finding 2 of the Ben SCR (June 2016) and widening to include children of all ages.</p>

4.6 Finding 6: The important role of the early years sector in safeguarding children

- 4.6.1 Working Together 2015^{xxi} and the EYFS (2014)^{xxii} make clear the central role that early year's setting/professionals play in promoting the welfare of, and safeguarding young children. They are in a position to identify abuse and neglect, as well as recognising when children's needs are not being met and parents/carers are struggling. It is important that these settings/professionals are aware of their dual responsibilities of sharing information with others and collecting information emerging from their contact with the child and family. Research and SCR's^{xxiii xxiv} highlight that early years setting often lack training and confidence in safeguarding practice and

are at times not incorporated into the safeguarding network. This latter point was central in this case.

- 4.6.2 The early years professionals in this case were critically important. They were the agency that knew the two younger children best; they saw Philip and John on a regular basis and recognised early on that Mother needed support to meet the children's needs. Nursery1 appropriately suggested that Mother attend parenting classes to address her difficulties, but she declined. They liaised with the Health Visiting service and sought their involvement, and made a referral to speech and language. They did not, however, formalise these offers of help and support into a plan which would have enabled them to set goals, and monitor progress or the lack of it. This would have been useful information for the first and subsequent Initial Assessments.
- 4.6.3 Nursery1 were contacted by CSC during the Initial Assessment and the information sought was focussed on attendance and potential concerns, not what support had been provided. The nursery were not told why the assessment was being undertaken, and they did not ask; the telephone conversation was not recorded or shared with the Designated Safeguarding Lead (DSL), and therefore this information was not available on either Philip or John's records – making it impossible to build up a picture of the children's circumstances. Nursery1 did receive a copy of the first completed Initial Assessment, and this was filed in the records, but does not seem to have been read or used in anyway. It was also not shared with Nursery2 who were not aware that an assessment had been completed or that there were any concerns regarding Philip.
- 4.6.4 When Nursery1 noticed bruising to Philip they recognised that these were of concern. They delayed making a decision about what action to take in order to ask Mother for an explanation. This delay meant that the referral was not addressed until the next day, and given the extent of the bruising it would have been good practice to have asked Mother to come in earlier or tried to get an explanation by telephone. The referral was followed up with a written referral the next day, which arrived after the Social Worker had gone out to see Mother and the children.
- 4.6.5 This was a comprehensive referral, giving a clear outline of the injuries and the concerns regarding Mother's explanation. They did not include the information provided by both children about their Father visiting, throwing things at Mother and being arrested by the police. It is not clear why, but this was important information. The nursery were not informed about the outcome of their referral, in line with expectations, but they did appropriately follow it up. They were told by Social Worker2 that the assessment was underway, that the issue was supervision of the boys, and that the explanation was consistent with the injury (they were not informed that Philip had not been seen by a Paediatrician). They did not challenge the outcome. This was because of issues of confidence and a belief that CSC are the safeguarding experts.
- 4.6.6 Nursery2 were not consulted in either the second or the third assessment. This meant that when they noticed bruising to Philip sometime later they were not able to consider the significance and when the third assessment was being undertaken the

only agency that was seeing Philip was not included. They were also not invited to the CIN meeting, and only got to attend by chance.

- 4.6.7 In both nursery settings there was an inconsistency in the provision of safeguarding supervision, variable recording practices and an overall lack of confidence in fulfilling their safeguarding roles and responsibilities. These are all essential ingredients of effective safeguarding practice.
- 4.6.8 The single agency report produced by the Early Years' service highlighted staffing pressures and lack of clarity on roles and responsibilities as influencing factors, alongside a lack of management oversight and supervision in place.

An extensive action plan has been developed by the Early Years' service and the GSCB will need to be made aware of progress regarding this.

Recommendation: The GSCB should reinforce the need for all professionals to recognise the important role played by Early Year's settings in the support and safeguarding of vulnerable children and promote a multi-agency approach to all aspects of assessment and planning for vulnerable children.

4.7 Finding 7: Practice didn't demonstrate the role of Strategy Meetings to ensure multi-agency information is shared.

- 4.7.1 When concerns are identified that suggests that a child/young person has suffered or is likely to suffer significant harm¹⁹ it is required that a strategy discussion/meeting is convened²⁰. The purpose is to share information about the child and family and to form a view about whether there is a need for further enquiries under the auspices of child protection enquiries or in the form of further support. Strategy discussions/meetings are an important opportunity for key agencies to step back to consider a child and families circumstances and consider what "strategy" or approach to adopt. The absence of strategy discussions/processes has been linked with fixed thinking and silo practice^{xxv}; the process whereby one agency follows its own agenda without collaboration with the professional network.

¹⁹ The Children Act 1989 introduced the phrase "significant harm" to describe the amount of harm that a child must be suffering before Children's Services become involved in family life against the family's wishes. For example, Children's Services must: carry out child protection enquiries if they *suspect* a child is suffering or is likely to suffer significant harm, and take steps to protect a child whom they have *reasonable cause to believe* is suffering, likely to suffer, or has suffered significant harm - either in agreement with the family or through the court. There is no definition of "significant" but the law requires local authorities and the courts to compare your child's health and development with a similar child to establish whether the harm is significant.

²⁰ Children's Services must hold a strategy discussion whenever there is reasonable cause to suspect that a child has suffered or is likely to suffer significant harm. The purpose of the strategy discussion is to enable the Children's Services' department and other relevant agencies (e.g. education department, health services) to share information, make decisions about initiating or continuing enquiries under Section 47 of the [Children Act 1989](#), what inquiries will be made and by whom, whether there is a need for action to immediately safeguard the child.

http://www.proceduresonline.com/swcpp/gloucestershire/p_ch_protection_enq.html?zoom_highlight=strategy+meeting#strategy_discuss

- 4.7.2 There were three significant referrals regarding Philip over a six month period, two of which related to extensive bruising, which at the point of referral were unexplained. Both these incidents clearly met the criteria of likely/actual significant harm, and should have led to a strategy discussion/meeting. This would have been an opportunity to think about and plan enquiries. Instead, on both occasions a Social Worker was asked to carry out an Initial Assessment to determine whether a strategy meeting was needed. In effect this meant a home visit to ask Mother her views about what had happened. Mother's view on the first occasion was that the injuries were caused by the boy's boisterous behaviour and fighting. This explanation was accepted without any further enquiries being undertaken. This was not an appropriate response.
- 4.7.3 The second referral was made by the GP and a medical organised. This medical did not form part of any safeguarding enquiries, and despite the conclusion being that some of the injuries were unexplained no strategy meeting was held, and again a home visit was undertaken, with some considerable delay. Once again Mother was the key source of information about what had happened to Philip. The absence of any multi-agency discussion meant that her view that this was a medical issue dominated, despite evidence to the contrary. The strategy meeting/discussion would have been an opportunity to step back and consider the evidence.
- 4.7.4 The third referral was from the police and related to concerns about possible child cruelty (high locks on the outside of the doors of the children's bedroom) and neglect. This incident was also not subject to a strategy meeting, and there were no formal planned enquiries, just another home another visit to talk to Mother and a discussion with John.

Recommendation: The GSCB seeks assurance from Social Care that actions in the single agency response plan are being addressed. This finding also links with Finding 5 (Ben, 2016) and Finding 4 (Lucy, 2016) and also in the establishment of a culture of high challenge and high support and restorative ways of working together.

4.8 Finding 8: The importance of effective decision making, assessment and management of physical abuse

- 4.8.1 At the heart of this review are significant concerns about unexplained physical injuries to a young child of 3 years old. There is evidence across the whole review that some professionals did not feel skilled at working effectively with physical abuse, and found it difficult to distinguish between whether injuries were accidental, caused by deliberate child abuse, indications of an underlying medical condition or are indicative of broader concerns of neglect or violence. This was manifest in this case in a number of ways:
- 4.8.2 The lack of any strategy discussion/multi-agency meetings meant that very narrow assessment processes were undertaken. These assessments were flawed in a number of ways. They lacked focus on physical abuse; information was migrated from the previous assessment and there was a lack of multi-agency involvement.
- 4.8.3 Lack of focus on physical abuse: The NICE Guidelines^{xxvi} make it clear that in order to establish whether a child has been physically abused there are a number of issues

to be considered alongside the usual domains of the assessment framework^{xxvii}. These are:

- the nature of the injury;
- the explanations provided for it by the child;
- the explanations provided by the parent and any other person involved;
- any contradictions or discrepancies in the story;
- Family history and known risk factors.

4.8.4 This information then forms the basis of an analysis and a clear conclusion drawn from the available evidence. This did not happen for Philip, despite much of this information being available.

4.8.5 The nature of the injury: An evaluation of the injuries to a child is a crucial part of decision making and planning. This requires good quality medical assessment that comes to a conclusion about whether the injuries are indicative of child abuse. The injuries in one of the referrals was extensive. The NICE Guidelines make it clear that professionals should be concerned where there are multiple bruises or bruises in clusters, bruises of a similar shape and size, bruises on any non-bony part of the body or face including the ears and buttocks and bite marks that are likely to have been caused by an adult^{xxviii}. These were all present. There was no medical examination of Philip after the first referral regarding extensive bruising. The exact reasons for this remain in dispute, but whatever the cause, it was a completely inappropriate response to the potential physical abuse of a young child.

4.8.6 There was a medical examination conducted as a result of the referral from the GP. Very little background was provided to the Paediatrician, beyond a brief and subjective summary of Social Worker2's conclusion of the previous assessment. A clearer outline of the history of concerns should have been provided, ideally in written form.

4.8.7 This paediatric assessment provided a full description of the injuries and an opinion regarding how consistent they were or were not with the explanation given. Some injuries were described as clearly unexplained. However, no clear view was given regarding whether overall this indicated that there should be concerns about child abuse or not. The Initial Assessment cut and pasted this report and made no comment on it. This assessment was sent to the paediatric department a month later. It was not reviewed, largely because it was not sent for action by Social Worker2 and it was not possible to hold it electronically. It was filed in the child's paper file.

4.8.8 Discrepancies in explanations: It remains hard to evaluate the extent of the discrepancies in the explanations provided by Mother regarding the bruising to Philip because these were always recorded in quite general ways, with two or three explanations. For example in the second referral the injuries were caused by "*Philip falling down the stairs, boisterousness and a family history of easy bruising*" There is no sense that Mother was asked by each professional that she had contact with to provide a clear explanation for all the bruising seen, and that this was shared across the multi-agency group. This is what is required for an assessment of physical abuse.

4.8.9 Philip was not always asked what had caused his bruising making it difficult to evaluate whether his explanations were consistent with his Mother's. When he was asked there were some discrepancies; for example when seen by the Paediatrician he said that the bruises were caused "by outside" and his Mother talked about falling down the stairs. This required further questioning and analysis.

4.8.10 Overall the response to unexplained injuries to a young child was inadequate.

Recommendation: Paediatricians should receive a full history when a CP medical is requested, which is backed up in writing.

Recommendation: The GSCB should review the guidance for all professionals regarding the assessment of potential non accidental injury and ensure it is compliant with the existing NICE Guidelines regarding child maltreatment, including information provided to paediatricians prior to CP medical.

4.9 Finding 9: Poor assessment practice leaves children's needs unknown and unaddressed

4.9.1 Good assessment matters^{xxix xxx}; they are key to effective intervention and to improving outcomes for children. Conversely, research has shown that poor or inadequate assessments are associated with unclear plans to meet children's needs, poor outcomes and drift.

4.9.2 The Assessment Framework (2000)^{xxxi} was developed to provide a conceptual framework for the systematic and purposeful gathering of information. It was intended that this information would be analysed in a child focussed way using knowledge of child development, attachment relationship, alongside recognising parenting issues which impact on parents capacity to meet their children's needs and with an acknowledgement of family history and the social context in which a family lives. Each child should be considered separately, and where appropriate given the opportunity to express their views about their circumstances and the end point should be a clear plan to address any identified needs.

4.9.3 During the time under review there were three Initial Assessments, but no early help assessment processes (this is addressed in **Finding 1**).

4.9.4 The first Initial Assessment was of a reasonable quality. The children were engaged with as part of the process, with the exception of Darren. Historic factors were considered, including the role of Father. Written consent was sought from Mother to seek information from other agencies.

4.9.5 Information was sought from other agencies, but it remains unclear whether the right questions were asked of them. For example the drug agency was asked to comment on Mother's parenting capacity, about which they had little knowledge, and no concerns. It is not clear whether they were explicitly asked about Mother's current prescribed or illegal drug use, and information about this was not shared. This was an important issue.

- 4.9.6 The assessment relied on Mother's self-reporting of her circumstances. She told the Social Worker that Father had mental health problems, having been diagnosed with schizophrenia, but there is no evidence that this was so. Mother also told the Social Worker that she would be pursuing charges against Father, something that was seen as an important protective factor. This was not true. The Initial Assessment is brief, and where it has not been possible to establish whether information provided by adults is verified this should be made clear.
- 4.9.7 The subsequent two Initial Assessments were extremely poor. Home visits were undertaken as part of the process and children were seen, but as both assessments left information directly migrated from the first assessment it is not clear exactly what was discussed, what engagement there actually was with any of the children or which agencies were contacted. The needs of Darren were marginalised and the very real concerns regarding both Philip and John not addressed. The assessment did not make use of the available information.
- 4.9.8 In the second assessment Mother had refused consent for a referral to be made by Nursery1 in the context of significant bruising to Philip, who was just three years old. This was not putting his interests first and she should have been asked about this and this information analysed more clearly. The same is true of Mother's assertion that she was not happy that the nursery made the referral. This should have been challenged and analysed. Both assessments were not clear that their primary focus was unexplained injuries to a young child, and this is addressed in **Finding 8**.
- 4.9.9 Gloucestershire has now introduced the Single Assessment process, in line with the Munro recommendations. This means that the impact of the timescale pressures evident here are lessened. What remains are concerns about parental self-report, child centred practice and assessment of physical abuse – all of these are addressed in the other Findings in this report.

Recommendation: GSCB to seek assurance from Social Care that this finding has been addressed through their Single Agency response.

4.10 Finding 10: The importance of clear and effective child in need processes

- 4.10.1 The Children Act 1989^{xxxii} defines Children in Need (CIN) as those children whose vulnerability is such *that they are unlikely to reach or maintain their health and development milestones without the provision of services to them and their families*. This is a serious issue for all children, and particularly for those under 5 for whom development is rapid and critical for their future. The emphasis placed on good quality assessment to determine the level of need is reflective of the potential risks for a child's future. Once an assessment is undertaken and needs identified it is expected that a child focused plan is formulated which addresses those needs, there is a clear outline of the outcomes expected, services to be provided and the reviewing mechanisms identified. This did not happen for Philip, John or Darren.
- 4.10.2 Philip and John were identified as Children in Need after the third Initial Assessment. The quality of the assessment was poor (addressed in **Finding 9**) and the resulting conclusion was muddled. There was no outline of the needs of Darren, and the goals in the assessment were focussed on the possible medical needs of Philip, the requirement for him to keep himself safe, aged 3 and that John needed to be aware

of the impact of his boisterousness; this was not child centred and bordered on holding the child responsible for the events that led to them being harmed. This is inappropriate.

- 4.10.3 No clear plan was put in place, and there was no management oversight of the lack of one. The brief CIN process in this case was not as effective as it could have been at beginning to make sense of and address these children's needs. This is despite good multi-agency inclusion and engagement. The issue appears to be that because there was a poor assessment, there was a poor foundation on which to build a plan. Despite this, a plan should have been developed through the expertise held in the meetings; Mother distracted the meeting by focussing on "here and now" problems and no professional noticed this was happening. The meeting was also hampered by Mother's request that some information was not shared – something that needed much greater analysis and reflection.

Recommendation: GSCB to produce a multi-agency Child in Need Strategy
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Finding 11: Poor recognition of the early signs of neglect

- 4.11.1 Chronic long term child neglect has a profoundly negative impact on children's lives, developmental outcomes and has far reaching effects^{xxxiii}. This is particularly true if neglect occurs in the first five years of life and is not addressed quickly^{xxxiv xxxv}. Research^{xxxvi} suggests that good quality assessment, which is clear about the particular parenting concerns, causal factors and precise impact on the children is critical, alongside a clear plan of action, with agreed goals, timeframes and a process for recognising where there is a lack of change, or parental false compliance is essential^{xxxvii}.
- 4.11.2 There were many concerns regarding the quality of care received by Philip. John and Darren, but no agency considered these as the early signs of neglect that needed to be proactively addressed. Concerns regarding bruising to Philip were attributed to a number of accidents or fighting amongst the boys which indicated at the very least an acute lack of supervision. Mother was never held responsible for this, and the third assessment suggested that it was the fault of Philip for not keeping himself safe, and John for fighting with him. Mother never took responsibility for these issues, and declined parenting classes which might have helped. Neglect of children is underpinned by the lack of recognition by their parents/carers of their responsibilities to them, particularly keeping them safe. Mother's attitude should have been challenged, and seen as neglectful care which needed addressing.
- 4.11.3 Significant concerns about the physical care/physical environment for Philip and John were raised by the police when they visited the family home. Photographs were taken, but not shared with CSC and Mother was able to dismiss the concerns without challenge. These issues should have been explored, and the issue of allowing criminal activity to take place in the family home addressed as significant indicators

of neglect. In fact, Mother was able to persuade the family support worker not to share this last piece of information with the rest of the involved professionals.

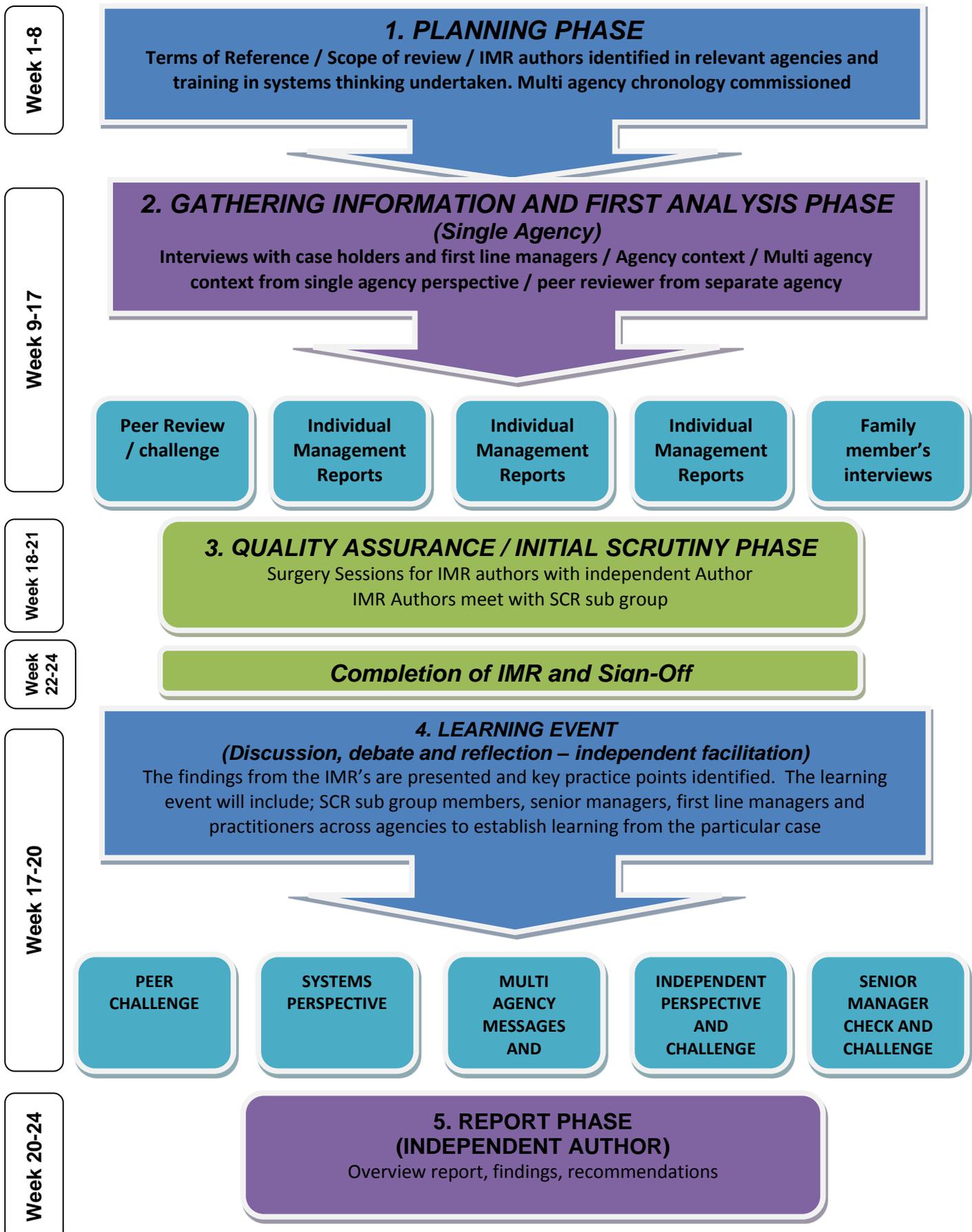
4.11.4 It is not clear why professionals were reluctant to name concerns as the neglect of these children. In part this appears to have been influenced by the poor assessments that took place, the lack of a clear early help plan which named concerns and attempted to address them, which would have revealed some lack of compliance on Mother's part. More latterly professionals sought to engage Mother in the CIN process; there was continuing evidence that Mother was unable to respond to professional concerns, but the need to keep her engaged appears to have had an influence on naming neglect at this early stage.

No recommendation is made here as Gloucestershire Local Safeguarding Board are currently in the process of ratifying a neglect strategy which will aim to equip professionals with the skills and knowledge to address the early signs of neglect effectively.

The GSCB will need to be reassured that this planned work addresses the issues raised in this SCR.

Appendix 1

Review Methodology - Gloucestershire's Multi Agency Appraisal of Practice (MAAP©) Model



1. Planning Phase

Terms of reference will be established and for a SCR will be agreed by the GSCB Independent Chair and the SCR sub group. Relevant agencies and practitioners will need to be identified and IMR authors agreed. Chronologies completed by single agencies (time period and depth to be stipulated).

IMR authors will receive a training session looking at systems methodology, report standards and this should ensure a shared understanding of the agreed approach. Timescales will be agreed and dates set for completed reports and learning event established. If SCR, dates set with GSCB SCR sub group and GSCB Exec.

An Independent reviewer with relevant experience will be identified. Their oversight and approval of the Terms of Reference is required.

Parent(s) need to be notified of the review by the GSCB and invited to speak with the independent reviewer. Key family members (including children and young people) where considered appropriate need to be invited to share their experiences.

2. Gathering information and first analysis phase

A multi-agency chronology is developed and shared with IMR authors. Each IMR author is required to review the case records of the subject child and the family members and provide an appraisal of practice against current agreed standards. Key practitioners need to be identified and an (sensitive/facilitative/collaborative) agreed interview approach taken. For example individual conversations followed by a group discussion. Peer reviewers will be identified from another agency to provide challenge and opportunity for reflection.

Individual management reports

An Individual management report will need to be produced.

The practitioners need to have the opportunity to comment on the final IMR which will provide a check in the system to ensure the IMR author has understood the context of the work as well as the practitioner's experience and barriers faced. There is a standard format for the report which focuses on the narrative behind the chronology, analysis and appraisal of events and practice, good practice highlighted and single agency learning and systemic findings to be discussed at the learning event. Once signed off, IMR's to be shared with agency staff involved.

3. Quality Assurance and initial scrutiny phase

Surgery sessions for the IMR authors will be provided and the independent author will offer advice and guidance to IMR authors to ensure quality and depth of report including analysis and appraisal of the issues. IMR's will be reviewed based on the feedback received. Once completed the IMR's will be shared with IMR authors and the SCR sub group and a meeting will be held to begin the cross referencing of conclusions and findings.

4. Learning event

Findings from IMR's are shared with all those attending the learning event. The purpose of which is to create ownership within single agencies in the learning process and receive peer challenge and feedback.

A multi agency systems approach is required. This discussion and learning event will be facilitated by the independent reviewer. The specific methodology will be planned depending on the needs of the review.

Multi agency perspective on the wider findings will be agreed and learning across agencies will be identified.

5. Report phase

The final report will pull together the key issues from the reports and learning event across the agencies. The report will highlight findings and challenges in the system and make recommendations to the GSCB via the SCR sub group.

Appendix 2

Terms of reference

General

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard children and young people and promote their welfare
- To review the effectiveness of procedures (both multi-agency and those of individual organisations) and understand what is present in our safeguarding system to enhance or hinder good practice.
- To inform and improve local inter-agency practice
- To improve practice by acting on learning (developing best practice)
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action

Specific:

- To examine the quality of risk assessment and understanding of the Levels of Intervention guidance
- To consider how and when the child's views and experiences were considered and taken into account in the decision making process
- To examine the level and quality of partnership working
- To consider whether professional differences occurred, and if so, how they were responded to
- To consider all agencies understanding of when information can and should be shared
- To consider all forms of abuse, not just physical abuse

Appendix 3 - Single Agency Recommendations

Gloucestershire Hospitals NHS Foundation Trust
Child Protection (GHNHSFT) Medical Reports, to include a section on information shared from primary health care professionals involved with the child
GHNHSFT Child Protection Clinical Paperwork to be revised and updated to:- <ul style="list-style-type: none"> • Separate information to be taken in the acute situation from information to be taken in next 24 hours • Separate body map diagrams
GHNHSFT Clinical (Interhospital) Transfer Paperwork to be revised and updated to ensure information related to safeguarding the child, travels with the child
Hospital staff to actively engage in Supervision for Child Protection Work

Early Years
Both Early Years settings and providers concerned in the case should improve record keeping providing greater clarity and clearer detailed information on their record forms in relation to all types of possible signs and symptoms of abuse. This recommendation could have wider implications for the Early Years Sector to generally improve practice.
Both Early Years settings/providers concerned should log all concerns both verbal and written in a chronology Both Early Years settings must ensure chronologies are completed at the time of each event occurring, and review these records to identify any patterns/concerns
Children's Centre family support provision should have clearer planning of expected and measureable outcomes from Early Help offers The Children Centre needs to have a clear action plan that provides details of support to be offered to children and families and clear information on what further action will be taken if support is not accessed and or outcomes are not successful.
At Nursery2, training on recognising possible signs and symptoms of abuse and neglect should be attended and disseminated to all staff, and be on-going and regular
At Nursery2 staff should receive regular supervision by the school Head Teacher who is the DSL which will give opportunities to share safeguarding concerns and this should be documented. This recommendation could have wider implications for the Early Years Sector to generally improve practice.
Both Early Years settings should establish and maintain an environment where children feel

secure, are encouraged to talk, and are listened to and their non verbal communication is carefully considered and recorded.

This must be documented and recorded, particularly when injuries or changes in behaviour are noted.

Both settings must have clear guidance available on information sharing. Both setting should be clear on when and with whom to share child protections concerns in a timely manner and how to follow those up with other professionals. Clearer guidance on sharing child protection concerns where settings are providing dual care must be in place.

This recommendation could have wider implications for the Early Years Sector to generally improve practice

Both settings should develop systems/processes for checking when children are absent from provision to ascertain the reason for this.

This recommendation could have wider implications for the Early Years Sector to generally improve practice.

Both settings should be familiar with and confident to use the Escalation Procedures should they disagree with a decision made by another agency.

This recommendation could have wider implications for the Early Years Sector to generally improve practice.

Both setting and Early Years Practitioners need to develop awareness and confidence in the need to involve parents and carers when concerns arise but be mindful to question and challenge information given by parents and carers with appropriate line managers, particularly where inconsistencies occur.

This recommendation could have wider implications for the Early Years Sector to generally improve practice.

At Nursery 2 family support should be deployed to work across the whole provision on site to support vulnerable families.

Gloucestershire Care Services

Although the situation may not have met the threshold that would result in services being offered from Children's Social Care it does not necessarily follow that support or work could not be carried out by other services as part of an early help intervention

Primary Health Care Team meetings are set up in a way to better improve communications between GP's, Health Visitors and Midwives with consideration to this being expanded to inviting children's social care to Primary Health Care team meetings

Preceptorship programme can be extended dependent on circumstances, particularly for staff returning to work following extended periods of leave.

GP

The practice should produce a protocol defining a specific process for managing the recording of all social service assessment reports. As well as being scanned onto the medical record in full a clinical entry should be made, highlighting the salient features and conclusions for all reports.

The practice should use a protected learning session to remind clinical staff of best practice in Child safeguarding. In particular this should remind professionals that they should always ask a child directly about what has happened to them, even if the child is very young. Also when social workers request information about concerns prior to undertaking an assessment doctors should always ask for, and document, the reason for the assessment, and what information is shared. The PLT session should also include informing staff of amendments to the practice safeguarding protocol (as mentioned above).

The practice should undertake a search of all medical records to identify patients with a documented history of substance misuse. The notes of all children living with the index patient should be flagged to indicate this risk.

Medical professionals need to understand the meaning behind a conclusion of “no further action necessary” following a social service assessment. I think this is generally misunderstood to mean that there are no grounds for concern, rather than that the concerns have failed to reach a predefined threshold.
I would suggest that this is discussed at a Countywide GP Liaison Child Safeguarding meeting to ensure this misunderstanding is corrected and explained.

Police

Deliver a new IT system which is fit for purpose to enable photographs to be stored as well as viewing all relevant information through one IT system.

Increase the staffing levels within the CRU and encourage greater levels of consultation with the CRU DS.

Ensure Public Protection maintains a level of detective capacity at both DC and DS rank to meet demand and deliver thorough investigations within the Criminal Justice timescales.

Children’s Social Care

Pupil Referral Records should be scrutinized by all staff receiving child welfare concerns to ensure that all education/nursery providers are identified, and that in cases of unexplained/suspected non accidental injuries all relevant professionals are contacted. The outcomes of each of these discussions should be clearly recorded as individual case notes.

Decisions in relation to investigation of unexplained injuries should where possible be taken following receipt of the written MASRF. If this is not possible, the MASRF information should be used to re-evaluate any conclusions already reached, once received.

The local authority should agree further arrangements and key standards for the holding of strategy discussions in partnership with the police.

<p>Undertake further workforce development activity to address the key areas of concern:</p> <ul style="list-style-type: none"> • Response to unexplained injuries and physical abuse • Critical thinking and analysis including use of supervision to facilitate this approach • Ensuring that front line workers are equipped with the right skills to ask the right questions when investigating suspicious or unexplained injuries • Managers challenge about the inclusion (or lack of) male partners in assessments • A mechanism to ensure challenge of an initial perspective in light of new information is embedded in practice
<p>Establish clarity regarding the expectations and managerial / social work oversight of cases held by family support workers whilst the work to cease this practice continues. The decision that this is not good practice has been made.</p>
<p>Ensure that arrangements are in place to provide robust management oversight of work being undertaken by FSW's</p>
<p>Continue the current work aimed at reducing social work case loads across all teams</p>
<p>Review guidance and policy in relation to Children in Need cases so that there are robust arrangements in place to:</p> <ul style="list-style-type: none"> • Ensure a full assessment is undertaken in all cases where there are unexplained injuries • Ensure that assessments fully take into account all household members and evaluate the impact of any new household members • Ensure that CiN plans are reviewed and developed following the first CiN meeting, and in light of any new events or information
<p>Ensure the practice of developing chronologies and utilising them in practice is embedded in the workforce.</p>

<p>Turning Point</p>
<p>We will ensure that our staff teams continue to access the GSCB Parental Substance Misuse training in order to support them in building their understanding of and skills in identifying hidden harm</p>
<p>We will consider our approach to lines of enquiry when service users report new partners</p>
<p>We will continue to emphasise the importance of accuracy and quality in record keeping</p>
<p>We receive ongoing support from the specialist substance misuse health visitor and midwife. A workshop to staff is due to be delivered at the end of June 2015. This will also support staff in reflecting on potential safeguarding issues.</p>

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