Serious Case Review

Redacted

OVERVIEW REPORT

Re SCR 0310

September 2011

Independent Chair of Panel - Margaret Styles

Independent Overview Author - Ron Lock

Contents

Introduction

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

1.2 Rachel and her siblings originated from outside the UK and moved to this country just a few months before the serious injury to Rachel occurred. At that time, none of the family could speak English and the mother was a single parent. The older children, who will be referred to as Wendy, James and Timothy, were all of school age at the time of Rachel's injuries. Also at this time, the family were living at the home of relatives that had also arrived in the UK a month earlier.

1.3 Although it was initially considered that this case did not meet the criteria for a SCR, following successful criminal proceedings against the mother and information being retrieved in respect of the involvement of different agencies with the family for the period up to Rachel's injuries, the original decision was revised, which led the Gloucestershire Safeguarding Children Board to require that a SCR be undertaken. This decision was made in December 2010.

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

1.5 The purposes of this Serious Case Review are to; - [2]

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

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

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

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

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

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

1.7 Senior representatives from relevant organisations in Gloucestershire were brought together to form a SCR Panel in order to review and analyse the material from the IMRs. The Independent Chair and Independent Overview Report Author who were initially commissioned to undertake the work in respect of this SCR, changed prior to its completion, and the SCR was given a renewed focus with a new SCR Chair being appointed and an author being commissioned to complete the work. There were also changes to the composition of the SCR Panel. This changeover occurred in June 2011. For the latter part of the SCR process, this was chaired by the Independent Chair of Gloucestershire Safeguarding Children Board. Another independent person, Ron Lock, who has extensive professional experience in safeguarding children and young people, was commissioned to write this Overview Report, and therefore complete the work of this SCR.

Terms of Reference

2.1 Time Period

The time span to be covered by this SCR is from Winter 2009 up to the day after Rachel was admitted to hospital, and the date of the Strategy Meeting.

2.2 Agencies required to provide Individual Management Reviews: -

- Gloucestershire County Council – Children and Young People's Directorate - Social Care
- Gloucestershire County Council – Children and Young People's Directorate - Education
- NHS Gloucestershire
- Gloucestershire Hospitals NHS Foundation Trust
- Gloucestershire Constabulary
- Great Western Ambulance Service, NHS Trust
- A Health Overview Report was also completed.

2.3 The Serious Case Review Panel

Independent Chair (for period Jan'11 – May '11) – Julia Oulton

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

Panel Members (Before June 2011):

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

Panel Members (After June 2011)

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

Also in attendance at Panel Meetings: -

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

Independent Overview Report Author – (for period Jan '11 – May '11) – Joanna Nicholas

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

2.4 Independence – (from June 2011)

The Independent Chair of the SCR Panel had no previous managerial or operational knowledge or involvement with this case. She is also the Independent Chair of the LSCB, and this reflects

relevant government guidance that "The Panel Chair can be the Independent LSCB Chair"[3]. All the IMRs have appropriately identified that their authors were independent of the case. The Overview Report Author, Ron Lock, has had no previous involvement with this case or with any of the agencies required to contribute to this SCR. The author's professional social work experience is in safeguarding children and young children, and since 2002 has provided the independent perspective as either author or chair, of a number of SCRs in the South of England – this has included being the author of one previous SCR commissioned by Gloucestershire LSCB which was completed in 2006.

2.5 Specific Issues for the SCR to consider: -

In conjunction with the terms of reference for SCRs as set out in Working Together, Para 8.20, the following specific issues were identified by the original SCR Panel as requiring particular attention. Two of the specific issues were removed by the reconstituted SCR Panel as they related to links with adult services, which proved not to be relevant in this case. The remaining specific issues are: -

A) Had agencies adequately supported the family since their arrival in the UK?
B) Was practice sensitive to the racial, cultural, linguistic and religious identity of the children and their family?
C) Was practice sensitive to the lifestyle and cultural issues affecting the family, especially their financial situation?
D) Did agencies use interpreters when speaking to family members; was the use of interpreters carried out in an appropriate way; did the use, or otherwise of interpreters impact on the provision of services for the family?
E) Did the immigration status of the family members impact on the parents ability to meet the children's needs?
F) Were the decisions and actions taken in this matter in line with the policies and procedures of individual agencies and the Gloucestershire Safeguarding Children Board?
G) Were appropriate services provided in relation to the needs of the children and in line with the decisions and actions taken in this matter and were those services child-centred?
H) Were practitioners aware of and sensitive to the needs of the children in their work and whether the voice of the child was listened to?
I) Were practitioners knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
J) How did interagency communication and working together impact on the provision of services and the welfare of the children in this matter?
K) IMR authors must identify ways of supporting and improving practice within their agencies, through IMR recommendations and action plans, where deficiencies have been identified.

[3] A Guide to Inter-Agency Working Together to Safeguard and Promote the Welfare of Children – March 2010, Chapter 8, Paragraph 8.16

L) Was communication within the organisation and between the organisations, timely and effective?
M) Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
N) Did the organisation refer concerns appropriately to other organisations (according to inter–agency and/or internal procedures)?
O) Was the depth of information provided in the referrals appropriate?
P) Did the organisation make appropriate and timely assessments of the parents/children, in line with internal organisational procedures?
Q) Did assessments of parents take into account possible risk to the children?
R) Was action taken in a timely manner and in accordance with agreed policy and procedures?
S) Is there any evidence to suggest that there were missed opportunities for sharing information?
T) What would have made a difference to the outcome?

2.5.1 As part of the advice to IMR authors via the template that was provided for them to assist with the completion of their reports, the issues identified above were included as additions, where relevant, to those listed in Working Together Para 8.20. Three specific issues which could not be easily incorporated into the standard terms of reference were separately listed at the end of the template, to ensure they were analysed.

2.5.2 Within the Overview Report, whilst all of the above issues have been addressed, they have been included within particular sections of the Analysis section, rather than separated out into the specific headings as identified above. This has enabled the analysis within the Overview Report to be written in chronological order.

2.6 Methodology – The SCR Process

2.6.1 This serious case review was not begun until December 2010. While the serious case review sub group had looked at the case at the time of occurrence, the events at the school were not available to members. The reason for this has not been found. The press reporting around the time of the mother's conviction later in 2010 made it plain that there were other older children in the family who seemed likely to have been involved with agencies. Knowledge of their existence and circumstances caused the GSCB chair to seek further information whereupon it became clearer that the criteria for conducting a SCR were met.

2.6.2 The panel, which was largely but not entirely made up of members of the then SCR sub group, began its work. An overview author and a panel chair were appointed by the GSCB business manager in consultation with the independent chair and the Director of children's Services (DCS). The panel began work and IMR authors were given their instructions. However it soon became clear that IMRs were not progressing in Children's Services at least and that relations between various role holders in the review were breaking down. The panel was not able to offer

adequate challenge or overcome emerging difficulties, largely because its members were at a level too junior to commit their organizations to action, or to overcome delay and difficulty.

2.6.3 In May 2011 the Independent Chair of the GSCB took the decision to dissolve the SCR panel and reconstitute with membership drawn from main board members and others generally working at a level senior to those previously. The Independent Chair then took the decision to chair this panel herself and a new Overview Author was appointed. Terms of reference were reviewed and a new timetable agreed. Simultaneously the GSCB agreed that its own structures should be redrawn, and it was agreed that the function of the SCR sub group should be assumed by the executive committee, which is made up of board members from Health, Social Care, Police and Education, and which acts as the driver of progression of the board's strategy. The executive is chaired by the Independent Chair. She will not therefore chair SCRs in future.

2.6.4 These recent changes have been put in place only in part because of the procedural and substantive shortcomings in this SCR, but also because the board has decided that this work must be given attention at senior level in agencies at all stages and recommendations to action will need commitment at the earliest stage of the process.

2.6.5 At the time when the original panel was dissolved in May 2011, drafts of an Overview Report had been completed as well as a number of drafts of some of the IMRs. Following the creation of a new SCR Panel, all IMRs were again reviewed and where necessary, additional requirements were made of some of the IMR authors in order to complete the reports to the style and standard considered necessary to satisfactorily complete the SCR.

2.6.6 Meetings of the new SCR Panel took place on the 7th July 2011 primarily to review the Terms of Reference and review all IMRs, on the 3rd August 2011 to consider the first draft of the new Overview Report and revisions of IMRs, and the 30th August 2011 to consider and agree all final drafts and to confirm the recommendations from the IMRs and the Overview Report and the IMR action plans.

2.7 Individual Management Reviews

Gloucestershire County Council – Children and Young People's Directorate (CYPD) - Social Care,

2.7.1 The final version of this IMR focused solely upon the social work input to this family whereas initially it was incorporated with the work within the Education settings. The IMR author was appropriately identified as being sufficiently independent of the case. This IMR provided detail of the interventions by the Children and Young People's Directorate (CYPD), and gave analysis of the two key pieces of interventions which took place, one at the time of a referral for an Initial Assessment and the later child protection investigation interview immediately following the injuries discovered on Rachel.

2.7.2 Whilst there were some shortfalls in practice which were fully considered within the IMR, these were generally attributed to lack of attention to detail of individual practitioners, and that management oversight was to some extent compromised by some inefficiencies in the electronic case management systems and other contextual matters. The IMR highlighted the range of changes that have already taken place to improve practice, including a new audit service framework, and referred to these within its recommendations. The IMR also appropriately recommended that greater access to interpreters should be afforded to the Emergency Duty Team.

Gloucestershire County Council – Children and Young People's Directorate (CYPD) – Education

2.7.3 The Education services, primarily via the school which the children attended, had the greatest contact with the family over the short period that this SCR covers. This IMR author, who was sufficiently independent of the school and related education services provided for the family, examined in detail, the events from the children's first introduction into school up to when a child protection referral was made. The IMR gave a clear picture of the challenging local community which the school serves and of its attempts to provide relevant services to a local child population with high numbers of minority ethnic children and immigrant families. The IMR usefully balanced these challenges with the services which these children in particular received.

2.7.4 Whilst some good practice was identified, there were also a number of shortcomings in the response that these children received from the school, which in effect meant that only the eldest child had any meaningful school attendance for the three months covered by this review. The IMR endeavoured to explain and analyse the shortfalls in practice, and in the absence of clear records, supported this by interviews with key members of staff. Importantly, the school has now acknowledged where their practice had not reflected procedures or had not been in the best interests of the children. The respective recommendations and action plans have addressed these issues in order to support and monitor necessary improvements in practice or adherence to procedures. It was a view of the SCR Panel that any future SCR which required an IMR in relation to school involvement should be the responsibility of the individual school, via its governors, to undertake it, whilst still ensuring appropriate independence. (See Recommendation 12.5)

NHS Gloucestershire

2.7.5 This IMR related to the services provided by the health visitors, and its author had no line management responsibilities within the case. The IMR reflected only one contact by a health visitor with the other family resident in the household, and no direct contact with Rachel and her family. The IMR strongly raised the particular profile of the locality in which the families lived, with there being high numbers of mobile families, ethnic minorities and immigrant families and the impact that this had on the health visiting service. Although the limited contact with the family was not particularly compromised by these factors in this case, the

analysis was that more staffing resources are required to meet the needs of this diverse and challenging community.

2.7.6 The need for establishing priorities for intervention with newly arrived families, within clear timeframes, was a clear lesson that needed to be learned from the limited health visitor involvement with the family, and that early contact needed to take into account the family's ability to understand English. The lack of any involvement of a school nurse was given minimal comment as a service which could have provided some input to the family.

Gloucestershire Hospitals NHS Foundation Trust

2.7.7 This IMR reflected the only contact that the Hospital had with the family, which was when Rachel presented with life threatening injuries and her medical needs were assessed and dealt with by the Hospital's Emergency Dept. The IMR author had no line management responsibility for any hospital staff who provided services to Rachel.

2.7.8 The IMR gave full details of the practice of the Hospital staff in responding efficiently to Rachel's concerning injuries, and in ensuring that the statutory agencies were quickly made aware that the injuries were considered to be the result of abusive care. As with many of the other IMRs, it was noted that there should have been greater consideration regarding the use of professional interpreters at key interventions with the mother. This was not however reflected in a recommendation.

Gloucestershire Constabulary

2.7.9 This IMR did not follow the template which other IMR authors used, but was written more in the form of a single report without any of the specific terms of reference separated out. There was also no genogram. This was because the original SCR Panel did not consider that a full IMR was required from the Police. Although the Police only had one significant intervention with the family, which was their part in the joint child protection investigation with the CYPD Emergency Duty Team, the second SCR Panel considered that this report needed to be viewed as an IMR. The key aspects of the terms of reference are however addressed as part of the narrative insofar as how they related to this intervention in protecting Rachel and her siblings from the risk of further harm. An addendum was requested to provide additional detail and analysis to some of the aspects of Police practice in this case. The report did not confirm that the author did not have any line management responsibilities for the officers who worked on the case.

2.7.10 The IMR provided helpful analysis of Police interventions, of their prompt response to the concerns being raised about Rachel's injuries, and of the decision jointly made with the social worker to leave the siblings in the family home overnight following the investigative interview. The IMR recognised that some different actions could have been taken and that components of the investigative interview could have been undertaken differently and potentially more effectively, and therefore recommendations were identified to embed any learning from practice from this case.

Great Western Ambulance Service, NHS Trust

2.7.11 This IMR gave a detailed account of the Ambulance Service interventions with the two families that were involved in this SCR. The author confirmed that he was sufficiently independent to undertake the IMR. Two early interventions to attend to medical concerns about the youngest children of both families were analysed as being efficiently dealt with, with corresponding advice being given to the parents. The Ambulance Service's response and intervention when Rachel was found with significant injuries was clearly explained. Whilst the IMR found that practice complied with relevant procedures, some recommendations have been made in respect of some internal recording of data, and the need to audit incidents of children under 5 years of age. Clarity would be needed regarding which other agency should or could be recipients of data collected by the Ambulance Service, to help to inform their own interventions with the children.

Health Overview Report

2.7.12 This report summarised and linked together the interventions of the Ambulance Service, local health visitors and the Hospital. Although the mother and her children were registered with a local GP, there was no direct contact with any member of the family by the GP. The Health Overview usefully summarised and added to areas of analysis contained in the individual IMRs and for example drew greater attention to the need for the use of professional interpreters and to further develop the notion of how guidance could more effectively be developed to ensure new families from abroad receive a prioritised health visiting service.

2.7.13 In order to deal with the difficult and potentially controversial issue of staffing resources in the particular locality where this family lived, this report has identified the need for a review of the health visitor establishment county wide. Importantly a recommendation was drawn up to address the importance of relevant information sharing from GP practices to health visitors in order to assist with decisions about priority visiting to newly arrived families. Another recommendation has been made to the GSCB rather than solely to Health agencies – this recommendation will be subsumed within recommendations 12.1 and 12.2 of this Overview Report.

2.8 Involvement of Family Members

2.8.1 The original Overview Author interviewed the mother with the aid of an interpreter in March 2011 and there is also information contained within her Pre Sentence Report (PSR), and information from both of these sources will be used within the report to add to the analysis of professional practice and in respect of the mother's experience of professional interventions.

2.8.2 The children were also seen by the original Overview Author in order to gain an understanding of their perspective, although they were unable to contribute in any significant way to the analysis of professional practice. At the time they were seen they were established in foster care where they had been living for a year.

2.9 Parallel Processes

The criminal proceedings in respect of the mother had been finalised by the time of the completion of this SCR, and therefore did not compromise the collection of information and analysis of professional interventions. Following the investigation of the injuries in respect of Rachel, she became subject to Care Proceedings as did the remaining children within the family. These proceedings similarly had no impact on the work of the SCR.

The Facts

The Family makeup:

Mother and children: -

Rachel, (under 2 years) and older siblings of school age, including: Wendy, James and Timothy

Ethnicity

All the family originated from outside the UK, but during the period of time that the family resided in Gloucestershire, it was not apparent that any professional confirmed the family's ethnicity or religion with the mother.

Language

For the period of this SCR, none of the family could speak English, although it was considered by some professionals who had contact with her, that the mother could understand some very basic English.

The following section of the report reflects the key events and professional interventions during the time period in question.

3.1 The mother and her children arrived in the UK in 2009 and moved in with another family with similar origins. The reason for the family's move to the UK was unclear, although the mother later said she had been persuaded to come because it would give them a better life.

3.2 In late 2009, following a telephone call from a neighbour on behalf of the mother, the Education Welfare Officer (EWO) visited the home and saw the mother and all children. The EWO reported that the accommodation was bare, damp and overcrowded (other adults and another child were present), although in other respects it was said to be clean and well kept. The mother wanted her eldest children to attend the local school.

3.3 The EWO accompanied the mother and the children (including the baby Rachel) to a meeting at the school where they were given a tour of the premises. One of the school teaching assistants acted as interpreter. School admission forms were however completed without the children present and there were signed agreement forms in respect of two of the children but neither of the forms were signed by the children, which would have been normal practice. A worker from the local Race Equality and Diversity Service (READS) was also present in this interview with the mother. The EWO made a further visit two days later in order to give discretionary grants for school uniforms. Other adults who were present acted as interpreters. The EWO also arranged for Christmas presents to be donated. The family's status as immigrants meant that they were not eligible for any benefits. There was reported to be liaison between the EWO and READS although it was not recorded what services, if any, they directly provided to the family.

3.4 All of the older children attended the school for the first time on the same day but school staff had very limited knowledge of the family and their background as they were new arrivals to the area. Birth certificates and passports of the school age children were seen. The pupil composition of the school included a significant ethnic minority population, and accordingly there were teaching assistants who could speak different languages and were used as interpreters, one of whom was able to communicate with the mother.

3.5 On this first day at school, whilst it was reported that the eldest child Wendy settled well, this was not the case for the other children and it was observed that the mother's presence and attitude towards the children did not help them to settle. The staff's observations of the children were that they were undernourished with one teacher referring to them as "destitute". There was an incident when the mother physically pushed one of her children (James) to remain in the class with Timothy, who got upset and this ended in James biting one of the teachers, sufficiently serious enough to draw blood and to require hospital attendance. The view taken at the time by the school was that James had been very scared because he was in a new situation which he did not comprehend. The response from the head teacher was to ask the mother to keep James and Timothy at home whilst the school put an appropriate reintegration plan into place.

3.6 At a similar time, the EWO was made aware of another immigrant family staying at the family home with two school age children. It is understood that this family resided in the home for at least two weeks. This meant that for this period of time, there were five adults and seven children living in the two bedroomed home. Additionally, home visits to the home had identified a young teenage man also living there.

3.7 Approximately two weeks later, a 999 emergency call was made because of concerns for the health of Rachel who was said to have bad breathing. Upon attendance by the ambulance crew, Rachel was seen with her mother – a friend was present and gave information to the paramedic that Rachel had been unwell for a few days. Upon examination, there were no urgent medical concerns identified and the mother was asked to contact the GP after the weekend.

3.8 The mother registered her children with the local GP surgery on the next day, and basic details of the children were forwarded to the health visiting team.

3.9 Following the request from the head teacher for the mother to keep the two younger school-aged children at home, it was not until a month later, that James again attended school. On this occasion the mother was witnessed by school staff to slap James. The school designated child protection officer (DCPO) was informed of the incident and completed a child protection form, and although it was apparently the intention of the DCPO to contact Children's Services, this did not take place on this occasion. The school asked the mother to take James home directly after the incident (8.40 a.m.).

3.10 The family's health records were sent to the Health Visitors office three weeks after GP registration, and a week later a welcome letter was sent to the family address informing them of relevant contacts and services locally. The letter was written in English.

3.11 In early 2010 the health visitor made a visit to the home to meet with the other family residing there. The health visitor observed that Rachel was living at the same address and later left a telephone message for her mother to arrange a contact visit.

3.12 Also during early 2010 the DCPO from the children's school contacted the Children's Helpdesk with concerns in respect of Wendy who had been the only one of the mother's children to have attended school reasonably regularly since their first day. The concerns related to Wendy not being collected from school to go home to lunch at home on two occasions (she was not entitled to free school meals). Reference was also made within the telephone conversation, to the previous incident of James being slapped and pushed. The slapping incident was not however recorded on the form which was used to record the contact by the Children's Helpdesk although it was included in the follow up e-mail from the school. The action agreed was for the information to be passed to the Referral and Assessment (R&A) team of the Children and Young People's Directorate (CYPD).

3.13 On the following day the team manager for the R&A team tried unsuccessfully to make contact with the referrer at the school, to gain more details in respect of the referral, particularly regarding the slapping incident. The case was allocated to a social worker as a Child in Need (Sec. 17) case, with a request to undertake an Initial Assessment. Ultimately however, no action was taken in respect of this assessment.

3.14 One week following the school referral**,** an ambulance was called to the home address on a Sunday afternoon after a 999 call was received stating that Rachel, was unconscious though breathing. On attendance at the home by the paramedics, there were numerous adults and children present, and initially Rachel appeared lifeless. Ventilation was successful and Rachel was taken to hospital in the ambulance accompanied by the female family friend. The mother was expected to travel behind. On arrival at the hospital at 3.19 p.m., Rachel was admitted and was accompanied by the mother and a female friend. The history given was that Rachel was found collapsed by her older sibling (Wendy) whilst playing with toys. In order to revive her, Rachel was placed into a cold bath by the adults present (a different description was also separately given that he had a glass of cold water thrown over her). At the hospital, the child's temperature was noted as consistent with being in a cold bath, or that she could also have been suffering from hypothermia. In addition to her poor medical state, Rachel was observed by the on call consultant paediatrician, to be unkempt and poorly cared for with multiple old unexplained scars and abrasions. The left arm was swollen, later identified as a healing fracture, and the mother explained that Rachel had fallen out of her cot four weeks previously.

3.15 By 4.30p.m., the consultant paediatrician made contact with the duty social worker and said that there was clear evidence of non accidental injury (NAI) to Rachel. The Police were also

contacted. Later tests identified that Rachel had a brain haemorrhage. For medical reasons, Rachel was transferred to Bristol Children's Hospital later that day to be retained in the paediatric intensive care unit.

3.16 The social worker from the Emergency Duty Team liaised with the Police, and an arrangement was made for a joint visit to the family to ascertain who else lived there, particularly any children. A search of CYPD records had identified that the family were not known – it was believed that the details and spelling of names given by the family friend were incorrect and so the recent request for an Initial Assessment was not identified in the records at this stage. The Police had no records of previous contact with the family.

3.17 The joint visit was made later that evening (approximately 8.00p.m.,) when it was noted that the mother was seen, also with other relatives and neighbours who were acting as interpreters. The children in the home included Rachel's siblings and the child of another family. The children were examined and no marks or injuries were seen and it was reported that all the children were at ease with adults in the home. The social worker and police officer decided that there were insufficient concerns to seek Police Protection at this time.

3.18 A strategy meeting was held on the next day (Monday) following the R&A team being notified of the events from the previous day. Up to date medical information was provided to the meeting although tests were still ongoing. A decision was made that the Police would arrest all the adults in the household and that the R&A team manager would seek approval for an Emergency Protection Order to be applied for. In fact Police Protection was initially arranged for the children who were removed from the home later that day. Within the next four days, Interim Care Orders were granted in respect of all of the mother's children. No concerns emerged in respect of another child resident in the home at that time.

The Children's Experience

4.1 Although this SCR covers a short period of time of approximately three months, this was nevertheless a significant period in terms of the experiences of the mother's children. They had arrived in a strange country and the fact that they were described as quiet and subdued when initially seen in their home environment, seemed to reflect a level of inevitable insecurity. For the older children, the lack of understanding the language must have been particularly challenging, and despite the SCR process having no real knowledge of their lives in their own country, the changes to their lifestyle and culture must have been significant.

4.2 The fact that the mother also appeared to experience similar feelings of disempowerment and confusion in a new environment would no doubt have meant that her emotional and practical abilities to support and reassure the children would have been significantly decreased. This was potentially demonstrated in her frustrated responses to the younger children within their short experiences at school.

4.3 The children's presentation as having low weight and being very small, and that they all later needed dental treatment, implied that their day to day lives were characterised by poor care and inadequate diets. Wendy potentially fared better than her younger siblings in that she was able to regularly attend school – in fact at the time of the enquiries about the injuries to Rachel, she was the only one who had attained some ability to communicate in English. It was not clear whether Timothy and James were keen to attend school, but in reality the consistency, social interaction and care that the school could have provided for them, was regrettably missing from their lives at that time. The mother reported in her interview for this SCR that these two children did not want to attend school and she did not think that they had to attend. Although the only child to attend school was Wendy, she was nevertheless described as a loner who spoke little to others.

4.4 Because there was no assessment undertaken with this family and because they were not well known to professionals, it is difficult to fully appreciate what the day to day life would have been like for these children, other than it reflected a somewhat chaotic and insecure lifestyle, with inconsistent attachment to their mother and different adult carers. Professionals who did visit the home reflected how adults spoke on the children's behalf.

4.5 Also, none of the children had the presence of a father caring for them, and whether this was something that they experienced previously and therefore missed, either from a positive or negative perspective, was unclear. There were other male figures in the home who potentially may have provided a male influence, but as no assessment was ever undertaken in respect of their home circumstances, then the role of males in the household was not known.

4.6 What was apparent however was the level of physical abuse and neglect that Rachel suffered. This occurred over a fairly prolonged period of time and the fact that she had healing fractures would have meant that she would have experienced discomfort and pain for some weeks before she went into hospital. Rachel therefore experienced a very traumatic and abusive lifestyle for the short period that she lived in the family home. This will potentially mean that she will have some long term effects on her emotional development. Whether Rachel's older siblings witnessed any of the abuse was not known, but because of the extent of its occurrence, it seems possible that the other children had been aware of it. If this was the case, it must have been very frightening. It is encouraging that all the children now seem to be thriving in foster care.

Analysis

The relevance and quality of professional interventions and assessments with this family

(Relevance to Terms of Reference "Specific Issues": - A, F, G, I, J, L, N, O, P, Q, R, S, T)

The early school involvement

5.1 The first contact that any professional made with this family was by the Education Welfare Officer (EWO) who made a prompt response to the mother's request to have her older children placed in school. This was just a few days after their arrival in the UK, and very soon after this, the EWO had made arrangements for the children to be enrolled at the local school. The EWO was appropriately supportive by providing material support via school uniform grants and Christmas presents. In this way the EWO recognised the needs of the family and the inability of the mother to be able to provide for them. The EWO was reported to have a specialist role in working with certain immigrant families in the area and that he was therefore able to recognise the particular needs that the mother and her children would have. The EWO followed relevant procedures by entering the children on the appropriate data base. He also appropriately gave some information to the mother about local services and how to settle the children into school.

5.2 There is some conflicting information between the Education IMR and the respective Chronology regarding whether the mother attended the school with the children on the day that they were enrolled. Whilst it was reported that the EWO took the mother and all her children to the school for a tour of the premises where they also met the head teacher, it was also reported in the IMR that the mother was on her own and that the children were not included as part of the admission checklist. Ordinarily it would have been expected for the children to be seen and involved in this admission visit, so it would have represented a less than ideal start for these children if they were not engaged in the school process from the outset[4]. The children's absence seems to have been evidenced by the agreement forms not being signed by either Wendy or Timothy – which again would have been expected practice. There was no agreement form that was found in respect of James, and the reason for this was not known, but reflected inconsistent practice which again would not have assisted with the children's integration into their new school environment.

5.3 Whilst all the formal processes appeared to have been completed to get the children into school, not all the teachers were aware that the children were siblings, or of the family connections between them, and again this did not represent a robust admission and induction process that might otherwise have led to a more successful start to their school life. (It is important to note that this school now routinely make pre-admission home visits for children

[4] The EWO was re-interviewed by the respective Education panel member to ascertain the true picture of what took place, although he unfortunately could not now recall the detail of whether the children were there or not. Therefore the discrepancy of information could not be resolved.

who are new arrivals to the area). Although there was reported to be liaison between the EWO, the school and the local READS team, it was not apparent that this led to any additional services being offered to the family. The READS worker was involved in meeting the mother when she first attended the school. The school however sought more information from the EWO about the family. It is understood that the role of READS in circumstances such as these would be to help with the process of settling children into school who are of different nationalities and ethnicity, and for example to arrange a child to be targeted for English as an Additional Language (EAL) support. However, there was no evidence of direct involvement by READS or of notification being made to them about the children.

5.4 The relevant IMR identified that all the school-age children should have been notified to READS and that Wendy in particular should have received additional help as the only one of the siblings who remained at school. Neither the READS worker nor the respective teacher could recall if specific help was offered, and if so relevant records would apparently have been destroyed by the time that the IMR author enquired into the matter. In essence it therefore seemed unlikely that any additional support was offered to Wendy.

5.5 By the time of the children's first day at school, it was already being observed by school staff that the children appeared undernourished and "grubby", with one teacher referring to them as "destitute". Because of the additional factors in relation to their language and cultural differences, they were understandably unsettled in the school environment, and so it would seem that these children ideally met the criteria for the additional help that READS could have provided as support for their transition into school life. This was particularly the case for Wendy as the only child in the family eventually to continue within school. Because of the school's particular locality and diverse population, the school had chosen to retain funding instead of buying back support from READS. This funding had been used by the school to appoint teaching assistants/interpreters; therefore less specialist support from READS was available. Within the school, READS were still however available to provide their core service. To what extent the school teaching assistants were in fact able to communicate effectively with the children was not very clear, although of course it was only Wendy who spent any meaningful time in the school. Nevertheless it was apparent that the children needed more direct input than they in fact received. Formal READS involvement would have been important to help with integration into the school environment and to support their learning. The respective IMR by CYPD as part of a recent SCR in Gloucester[5] recommended that "Links between Schools, READS and the Education Welfare Service (EWS) needs clarification", and so the experience in this case would suggest that these "links" had still not been sufficiently clarified.

5.6 Because the school was used to working with children with similar cultures and from similar areas outside the UK, then they understood some of the stresses that such children could be under. About half the pupils were of Asian or Asian British and a further quarter were from

[5] SCR 0607 – Gloucestershire Local Safeguarding Board – 2007

other white European backgrounds. This context may well have initially helped to provide a welcoming environment for these children. The fact that one of the teaching assistants could act as an interpreter for the mother was no doubt helpful. However, because of the need to attend to the other two children, the teaching assistant/interpreter was unable to spend time with Wendy.

5.7 Nevertheless, the intention of the mother, the EWO and the school that the children should successfully commence their school education in mid-December did not in effect materialise. Although Wendy, the eldest, remained at the school and ultimately achieved fairly good attendance, in effect the two younger children did not attend school again up to the injury to their baby sister two months later. On his first day, James was seen to be pushed by his mother and he also bit a teacher, and this was rightly seen as a serious incident. In accordance with procedures, the teacher reported the incident to the DCPO and both this teacher and the relevant teaching assistant, made written statements. The relevant IMR reflects that the school understood that in the light of the unusual and confusing situation that the children found themselves in (it was not thought that they had previously attended school in their country of origin), that James's actions could be viewed as symptomatic. The DCPO considered that the incident did not warrant a referral to CYPD, and therefore no child protection form was completed.

5.8 Because of the context of the incident, and that to the school staff's credit, both James and Timothy were eventually calmed down, and even though there were some differences of opinion about whether the mother's behaviour towards James was excessive or not, the decision by the DCPO to not refer to CYPD was understandable in the circumstances. However it seemed incongruous for the head teacher to decide to then send these two children home with their mother. The situation necessitated better communication between the DCPO and the head teacher in respect of the most appropriate action in this situation. Certainly the decision that there was no need for a referral or discussion with the Children's Services Helpdesk was completely understandable if the school felt that they had the situation under control, that they had managed the incident satisfactorily and were also able to monitor any outcomes. However by immediately sending James and his younger brother home with their mother, the situation had moved out of the school's sphere of influence.

5.9 The school had a behaviour policy which was available to inform actions but was not apparently utilised. Another option of removing James from the class in order to help him calm down, potentially with the help of the teaching assistant who would have created a better chance to communicate with him, was also not used as an option. The head teacher however considered that he had concerns for the welfare of the other children in the class and on that basis sent the two children home with their mother.

5.10 Whilst the reasoning for this decision to send the two other children home was to set up a re-integration plan, no plan in fact followed. In essence it appeared as though the children had been given little chance to see if they could be integrated in the first instance, and so it could be

argued that there had been insufficient attention given to addressing the presenting problem before the head teacher's decision was made. Clearly the head teacher held the responsibility for making such decisions but in these circumstances it was difficult to understand its rationale. There was an additional concern that the mother's rough behaviour towards the children was exacerbating the situation, and the head teacher remained concerned at the disruptive aspect that the children created at school.

5.11 The reasons for the lack of implementation of any eventual re-integration plan seem to have been partly because there were assumptions made by the head teacher that either the EWO or the teaching assistant was preparing the plan. However there was no record of this task being delegated, and the EWO's and the teaching assistant's belief was that the plan was the responsibility of the head teacher. This is endorsed by procedures. Additionally, with Christmas fast approaching, it was recognised within the IMR that the school may have been otherwise preoccupied, and that once the holiday period had passed, the re-integration plan would commence, but in essence the impetus seemed to have got lost. Whether the intervening holiday period was a factor or not was unclear, but whatever the reasons for the failure to set up the re-integration plan, the impact was that neither James nor Timothy effectively returned to school, which would otherwise have helped them to integrate into their new community and also enabled their care to be observed and monitored if necessary. An effective re-integration plan potentially could have taken place in the New Year, supported by material that READS had available to provide practical suggestions for such circumstances, for example by using the recommended "buddy system". This was a missed opportunity to use the formal process of a re-integration plan in an innovative and useful way.

5.12 It was also during this time that the head teacher authorised the absences of both James and Timothy for what was considered "exceptional circumstances" although there was little evidence of what these were in this case. The relevant grounds for authorising absences could not in fact be justified by relevant regulations[6] in these circumstances. Whilst the relevant IMR also questioned why the children were not referred to the EWO for attendance problems, it could hardly be relevant to do so if the head teacher had authorised the absences in the first place, although certainly James's poor level of school attendance met the criteria for a referral to the Education Welfare Service (EWS). In effect the eldest child Wendy was the only child that attended school, although her attendance was at a rate of 82% (18 of 22 attendances).

5.13 The local procedure was that any child with an attendance under 85% meets the requirement for a referral to the EWS and yet no referrals were in fact made. It was understandable why this did not occur in respect of James whose absence had been authorised, although there were no reasons given why Wendy was not referred. This was probably because on the one hand, Wendy as a new school starter from an ethnic minority family with no previous experience of school attendance, only just fell below the criteria for referral, and on the other hand, this

[6] Paragraph 6 (2), Education (pupil registrations) (England) Regulations 2006.

school's pupil profile meant that they had a high % of absences, leading to the EWO's comment in the respective IMR that "they would be continually making referrals to EWS" if the criteria were adhered to. Additionally when Wendy did not attend school, contact with home was quickly made to get her back into school – this reflected good practice by the school.

5.14 Nevertheless, as there was a clear criteria for when to refer children to the EWS for attendance issues, it was not appropriate for different thresholds to be applied in these circumstances. Interestingly it was in a previous SCR in Gloucestershire[7] which was in relation to a traveller family, when the CYPD IMR recommended that "Absences from school should be referred to the EWS at the normal threshold for all children". It was apparent that this objective has continued to be difficult to maintain and that it therefore needs to be addressed at a strategic level.

5.15 In her interview with the first Overview Author, the mother did not appear to know that the children were of the statutory school age and were required to attend school. The role of the EWO could therefore have been particularly helpful and informative to the mother who wanted the children to attend school but felt unable to get them to school against their wishes. This could therefore have been a useful opportunity for a meaningful intervention with the family.

5.16 The management of the attendance of James and Timothy and of their needs within school was poor overall and did not seem to relate to circumstances presented at the time. They were clearly vulnerable children who needed the structure and routine that school would give them. The relevant IMR author has interviewed the head teacher about the decisions that were made at this time, particularly as in this case, the relevant procedures for sending children home and authorising absences was not followed. The head teacher has acknowledged where there were shortfalls in practice and the IMR has appropriately stressed the expectation for procedures to be followed in the future. Overall, what occurred at this time would not have been a rewarding experience for the mother or for the children, as one of their first contacts with authority.

5.17 The relevant IMR usefully quoted from the last Ofsted inspection at the school (November '10) which praised the induction process for addressing families with a wide range of needs, in particular "those who are new to speaking English". Unfortunately these standards were not evident for these children, particularly regarding the experience for James and Timothy. The reasons for this remain somewhat unclear other than there were some individual errors, and it was a busy time in the school year, with more than these children starting school at this time. There was also said to be workload pressures for staff, and poor recording practices would not have helped to inform decision making.

<u>Early child in need concerns</u>

5.18 Within the first ten days of the contact with the mother and her children, it was apparent that the family was struggling financially and would no doubt continue to do so without benefits.

[7] SCR 0607 – Gloucestershire Local Safeguarding Children Board - 2007

With the local knowledge about such families arriving in the UK, professionals were aware that the mother would have no recourse to any public funds. With the children also being observed by staff as poorly dressed and undernourished, it would have been reasonable to expect that there would have been some further assessment initiated to understand the family's circumstances and more particularly the children's needs. This would at least have provided some compensation for the lack of any action by the school following the difficult first day for the children.

5.19 The early presentation of the children also gave rise to concerns about their level of physical care and diet. On visits to the home by the EWO, The mother and the children were said to be subdued, with no knowledge of English, and in the school environment, the mother had shown herself to be uncaring and rough with the children. In recognition of these circumstances, the EWO had appropriately given details of local sources of help for the family, including the local Children's Centre, and offered to make referrals accordingly, although this was declined. Whilst this supportive approach to the family was a positive way to introduce them to what help could be accessed, in reality because of the subdued personality that the mother presented and her undoubtedly feeling disempowered in this new environment, then it was probably unlikely that she would initiate contact with such services. It was apparent from the mother's interview for this SCR that the EWO was the only professional whose name she could remember, and although she recalled him as being helpful, she could not recall that he had later helped to get the older children into school. Also the mother could not recall any posters at school in her native language explaining where to get help if needed, (although whether she was literate or not was not known). During this three month period, every thing had been initiated by other adults or a neighbour on her behalf.

5.20 When the EWO found there to be another family staying in the home, alongside the presence of a teenage man, then the level of overcrowding was an additional concern. Additionally, once Timothy and James had been authorised to remain at home, then there were sufficient reasons to be concerned that the needs of the children were not being met, but there was no process by which any professional could monitor their care or support the family.

5.21 In summary, there were sufficient concerns apparent during late '09 for a Common Assessment Framework (CAF) to have been initiated by the school or the EWO, in order to assess the children's needs and if necessary get additional help for them. Certainly there was no known involvement of health services with the children, and there was no reference to whether the involvement of the school nurse had been considered. The rationale given for not completing a CAF was because it was considered that the mother would not engage in the process. In effect though, there had only been limited proactive contact with her, and so it seemed presumptuous to have made that judgement. Although the relevant IMR states that "despite the school's best efforts, they still could not engage the mother" the evidence of what was done in this regard was not very strong. Certainly the teaching assistant/interpreter had made some connection with the mother who had communicated with the school in terms of Wendy's absences, but to what extent there had been any proactive intention to further engage her in any assessment

activity, was not apparent. Additionally the DCPO said that there was an "on-going consideration" of instigating a CAF and that because of the short time that Wendy had actually been in school that they were still striving to get an initial understanding of her situation. Nevertheless, an early opportunity for an assessment, potentially via a CAF, was missed. The respective IMR has identified that this school were used to undertaking CAFs and had utilised them fairly regularly, so lack of experience of using this assessment process would not appear to have been an additional reason for not considering it.

5.22 As has been explained in the relevant IMRs, there were numerous immigrant families from similar areas in this part of Gloucestershire, and whether the lack of completion or consideration of undertaking a CAF was because this family did not reflect any worse situation than others in the local community, can only be conjecture, but may nevertheless have been a factor. In this way there may have been a tendency to accommodate inadequate levels of childcare when the potential or expectation for change was low.

5.23 The school had developed a useful format of weekly meetings for the staff to discuss priority issues about children at the school and the view was that both Timothy and James would have been discussed in this forum. However the usual practice of the EWO recording such discussions did not seem to take place as there were no records of such discussions occurring in respect of this family. This appeared to have been something of a feature in this case regarding activities by the school and education services generally in that whilst it was believed that actions were taken, (e.g. READS notification, discussion at weekly meetings, decisions made about referrals to CYPD), they were not in fact recorded. Some aspects of case recording practice have been appropriately raised as part of the recommendations from the respective IMR.

5.24 There was no Family Needs Assessment undertaken by the health visitor during January and February, following the mother registering the children with the GP in late December '09. The respective Health IMR and Health Overview Report identified that when the health visitor wrote to the mother on the 26th January and left a telephone message on 3rd February, then this meant that contact with the family had been made within the prescribed framework of four weeks from GP registration. In reality however these were attempts at contact, rather than anything meaningful in terms of establishing a link with the family.

5.25 It was not helpful that the information coming from the GP registration process was very limited, meaning that the health visitor did not know that her attempts to communicate in writing and verbally in English to the mother, would have had very limited chance of leading to a response because of the language barriers. It is understood that whilst the country of birth is recorded as part of the registration detail, language is not. This appeared to be very short-sighted, but even if the registration form does not make reference to language, it should have been considered as important to record this important detail in the circumstances. Because it was apparently usual practice to consider the need for an interpreter at the time of the first GP appointment, the fact that the family did not attend the surgery to see the GP, meant that this

did not take place. Even if the GP surgery was to have collected information about linguistic ability and ethnicity, it was apparent that there were no guarantees that this would necessarily have been passed on to the health visiting service. This matter will need resolution. If more information had been collected at that time in respect of the needs of the family and passed to the health visitor, then this would have helped to identify information not only in respect of their linguistic needs, but also that the family should have been afforded some level of priority in receiving an initial Family Needs Assessment.

5.26 It was a few days after contact with another mother and baby in the home that the health visitor realised that another baby (Rachel) resided at the flat, and the telephone message was then made to the mother. It was eleven days later that Rachel was admitted to hospital with serious injuries, although within that time frame, she would have had earlier injuries that were possibly evident on her body.

5.27 The respective Health IMRs cite limited staffing resources as having had an impact on the delivery of community health services locally, although it was not apparent that this was the major reason why Rachel's circumstances were not subject to a Family Health Needs Assessment. It was more an issue that the health visitors were working in a demanding environment with a high workload, without additional staffing resources, which made the prioritising of family needs, and meeting them appropriately, a challenging process. No doubt however, as the health visitor who made the last contact with the mother by leaving the telephone message, then did not return to work for a further month, this might have meant that the impetus was lost. Although details were left for the health visitor colleagues, there was still no information to suggest that there needed to be any priority for making this initial contact. In some respects, the progress from GP registration to health visitor initial contact with the family appeared to follow a pattern that was not unusual or viewed as particularly delayed. This therefore implied that if similar circumstances presented themselves again, that the response would not necessarily be very different. The key issue was therefore that if the process of GP registration could be more robust in identifying levels of need and priority for the initial health visitor contact, and as a minimum about the family's linguistic ability, then the health visitor would have relevant information upon which to base a more informed decision about when and how to contact the family. Although the relevant IMR, supported by the Health Overview Report, supports the need for a standardised welcome letter to new arrivals appropriately translated, this may not go far enough to ensure families are given priority attention.

<u>Initial child protection concerns</u>

5.28 The first incident to raise child protection concerns occurred when James returned to school a month after the biting incident on his first day. It was not apparent from the records if this was the first part of his re-integration plan or not, but once again this did not go well for James who was upset and did not want his mother to leave him. The mother's response was to drag him by the hands and slap him on the cheek. This incident was witnessed by school staff, and when

the DCPO was promptly informed, the incident was rightly viewed as evidence of child protection concerns, and was documented as such on the relevant child protection form.

5.29 There were then some unfortunate discrepancies regarding what actions were taken in response to this incident. Firstly, although the teacher who witnessed the incident stated that relevant child protection documentation was completed, this was not evident on the file. Furthermore although the DCPO stated that at the time it was her intention to make a referral to CYPD via the Children's Services Helpdesk, this did not happen. No clear explanation of why this referral was not made was given within the respective IMR, primarily because of the staff's limited recollection of what transpired, although the DCPO said that she may have been immersed in work, and that whilst recognising that a referral should have been made, she may have forgotten to contact CYPD in the circumstances. The IMR author correctly considers that it was a "serious mistake and a missed opportunity". The IMR does not give any indication of whether or not this school had a good history of making appropriate and timely referrals to CYPD, or that there was any difficulty in the working relationship between the school and CYPD. There was certainly no evidence to suggest that there was any tension or lack of confidence from the school towards CYPD. Some information in this respect may have given some clues to understanding the reasons for not processing this referral.

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

5.31 The next incident to generate child protection concerns was when Wendy was not collected from school on two consecutive days in early February 2010 to go home for her lunch. In response, the school provided lunch for her but was unable to locate her mother. The response by the DCPO to then telephone the Children's Helpdesk was appropriate in the circumstances. Concerns were identified as the failure for the mother to provide lunch, and reference was also made to the slapping incident which occurred approximately three weeks earlier. In fact the slapping incident was a more valid reason for a child protection referral than the lack of lunchtime arrangements being adhered to for Wendy.

5.32 Unfortunately the quality of the written and verbal communication at the time of the referral to the Children's Helpdesk was not sufficient to ensure that clear details of the concerns were noted and recognised. Although the member of staff at the Children's Helpdesk appropriately passed on the information to the R&A team, not all of the concerns were recorded and passed on, nor were the child protection concerns raised with the duty manager as required by procedures. In effect because of the lack of detail about the concerns, the follow up decision by

the relevant manager was compromised. If the slapping incident had been given the prominence it deserved, even though it was not a current concern, then it would have more likely led to the consideration that a Section 47 (of the Children Act) child protection enquiry was required, rather than the eventual decision that an Initial assessment was needed in respect of Wendy as a Child in Need.

5.33 In this situation there was a responsibility not only of the person making the referral to be clear and concise about the concerns, but also of the recipient of the information to check back on any detail that required further exploration, for example in respect of any perceived level of risk to the children and any issues of immediacy. In fact basic details of the family were missing. Lack of adherence to these principles led to insufficient information and analysis being attached to the referral. This appeared to have been recognised by the R&A team manager who tried to elicit more information from the school, but unsuccessfully on this occasion.

5.34 It could be argued that if the team manager felt there was insufficient information to make a decision about the sort of response that was needed, then it was not relevant to make any decision until that information had been collected. However in reality there were timeframes for a decision to be made which may sometimes put unhelpful pressure on a front line manager to make such a decision. Even so, within the team manager's deliberations there appeared to be an assumption that because the child was sent home after the slapping incident, that the level of concerns were not high. Nevertheless there were grounds for child protection enquiries to be made, and the eventual response was therefore a missed opportunity for a robust consideration of the safeguarding needs of the children. Difficulties with the case management IT systems did not aid effective decision making by the team manager.

5.35 The findings from the Ofsted unannounced inspection in late January 2010 does provide some context in that it found that "in some cases the information passed to the referral and assessment teams by customer services lacked sufficient detail and led to further work being undertaken by social workers before initial decisions could be made". This inspection was in fact just a few days prior to this particular referral being made so could explain why some of the inconsistencies occurred in the way that they did. The IMR from CYPD is reassuring in that new Contact Information and Decision forms have been created which now give greater clarity regarding referral information passed by Children's Helpdesk staff and of the actions needed.

5.36 If the referral had been given the status of a Sec 47 child protection enquiry, then the different level of priority would hopefully have led to the response being undertaken in accordance with procedures. If a robust child protection enquiry had then taken place, there was the potential that concerning childcare issues could have been effectively dealt with at that time. In effect what happened was that the situation was not given any level of priority, and in fact there was no immediate response to the family and no Initial Assessment was commenced. The respective IMR has identified that the allocated social worker had no memory of the family or of the case being allocated, and that it was an error on the social worker's part not to have known or understood that the case had been allocated to him/her. The respective IMR author rightly

points out that "Social workers have a professional responsibility for their own performance" but to what extent there was also a failing of the systems and structures to ensure that allocated work was undertaken, was less clear. Once again, an inadequate or poorly functioning electronic recording system was seen to have hampered the ability of managers to monitor the progress of work. In fact the IMR has identified a number of changes to internal procedures within the R&A team, including data management systems and management oversight arrangements which it is contested have generated greater efficiency in processing referrals.

5.37 It was within the seven day timescales for completion of this Initial Assessment (allocated on the 8th Feb) that the eventual serious injury to Rachel occurred (14th February), and so as the social worker had no supervision during that week, the lack of progress on the Initial Assessment would not have been picked up prior to the incident. This therefore suggested that there was more effective management oversight about the lack of completion of an Initial Assessment at the end of the timescale rather than oversight at the time when it should commence. Whether the reason for the failure to undertake this task in line with statutory procedures and professional standards was down to individual poor practice or poor management systems, the impetus for an effective piece of focussed intervention to take place via an Initial Assessment was nevertheless lost. In fact had the Initial Assessment commenced when it should have done, it would have covered a period of time when Rachel had likely suffered some of her injuries. The IMR has identified that efficient systems are now in place that enable tracking of the progress of work and additionally that a more rigorous audit framework is in place.

<u>The response to the life threatening injuries to Rachel</u>

5.38 The immediate response by the Ambulance service and then by the A&E Dept at the hospital was efficient and effective in responding to Rachel's serious life threatening injuries. The recognition that Rachel's injuries were likely to be the result of abuse was communicated in timely fashion to both the Police and Emergency Duty Team (EDT) of CYPD, and Rachel's medical needs were assessed as needing the specialist care of the Paediatric Intensive Care Unit at a neighbouring hospital, and Rachel was duly transferred there. The medical staff had taken a full history from the mother with the help of a neighbour as interpreter which was sufficient to identify that there was also a need to enquire with the EDT and Police about the safety of Rachel's siblings.

5.39 A telephone strategy discussion appropriately took place between the Police CID supervisor and duty team manager of the EDT which agreed that there needed to be a joint visit to the home address to check on the welfare of Rachel's siblings as well as any other children who may have been living there. It was apparent from the Police IMR that they considered that it would have generated a more informative strategy discussion if the EDT had agreed to attend the hospital and discuss with relevant medical staff also. The paediatric opinion had in fact been given quite unequivocally to both the Police and the EDT, so there may not have been a lot to gain by a three way strategy discussion. Nevertheless, face to face discussions with the relevant paediatrician would no doubt have given greater detail regarding the extent of the non-

accidental injury concerns and how potentially they were caused. There was considered to be no risk that the mother would try to remove Rachel from hospital though the EDT requested that Police Protection powers be evoked if there was such a possibility. This was an appropriate plan in the circumstances, even though it was unlikely to occur. Procedural requirements in respect of the strategy discussion taking place were nevertheless adhered to.

5.40 Police detectives did however attend the hospital to establish any more information that might assist in consideration if any criminal offences had been committed. This additional detail was no doubt of help to the Police in informing the content of the later interventions with the rest of the family

5.41 Although the initial referral from the hospital took place at 4.30/4.40pm, it was not until approximately 8.00pm that the home visit by the Police and EDT took place. Inevitably the lateness of the interview meant that it would likely have an impact on the children and their availability or for them to be sufficiently alert to contribute to a potentially traumatic interview. Neither of the respective IMRs gave any indication about why there was a delay between the referral and home visit, although it is acknowledged that there may have been very valid workload or capacity issues which meant that this was the earliest that the visit could be undertaken. However, its timing may have had an impact upon the eventual decision not to remove the children at that time.

5.42 It was nevertheless appropriate that the focus of the joint visit was upon the safety and welfare of the children and to address any immediate protection concerns for them, rather than to explore any issues of criminal responsibility of the adults. This was clearly a challenging interview to undertake, in which the neighbour was again used to act as an interpreter. All the adults (including some adult members of the extended family), and children were present, and it was appropriate practice that the social worker ensured that the children were physically seen for any signs of injury or abuse – clearly this was not a medical examination. The language difficulties clearly generated some constraints and although the children were not seen alone, and this was a significant omission, they nevertheless were the focus of the concern and intervention. The home was said to be clean and the cupboards and freezer were checked for food. It was reported that no concerning disclosures were made by the adults or the children. It was not felt that the children needed to be medically examined and the decision made by the social worker and police officer was that the children would be allowed to remain overnight in the home.

5.43 Had this investigation occurred in office hours rather than on a Sunday evening, then it would likely have been conducted differently – certainly the specialist Child Abuse Investigation Team would have dealt with the matter rather than non specialist CID officers. Also it would have been easier for medicals to be arranged and for professional interpreters to be used. But in the knowledge that the out of hours circumstances were not ideal, contingencies should nevertheless have been considered and planned for as part of the earlier strategy discussion. Whilst it would no doubt have been difficult to manage in the circumstances of the visit, the

children still should have been seen on their own. Whilst it was understood that the confusion which existed in the home meant that it would have been challenging to have taken the necessary control of the situation and seen the children on their own in a meaningful and supportive way, this still should have been the main component of a robust investigative interview. In fact a means of exerting greater control of the situation potentially was to generate boundaries such as arranging for the children to be seen alone. It was understood that Wendy by now had learned some English.

5.44 Both the Police and CYPD IMRs considered that on balance, although there was a level of risk attached to the decision to leave the children in the home, this was an understandable professional decision to have made in the circumstances. Certainly this was a difficult judgement call to make, and whilst some things should have been undertaken differently (in terms of seeing the children alone and in using a professional interpreter), the decision reflected the view of the social worker and police officer that the children's interests were better served by remaining in the home for the rest of the night and for the professionals to await a more informed strategy discussion on the next day before making significant decisions. It could be argued that the children's immediate emotional needs were more likely to be met by remaining in the home at that particular time, particularly because it was late evening, that there was familiarity with their own surroundings and they were remaining with adults who they knew and with whom they could communicate at a time of family crisis. Nevertheless this of course needed to be balanced with the children's needs in terms of their physical safety. The police officer and social worker decided that there was insufficient evidence of immediate risk to the children and considered it was therefore an appropriate decision to allow the children to remain in the home overnight.

5.45 In respect of the police/social worker decision to leave the children at the home, there appeared to be insufficient recognition that two key aspects of a more informed investigative interview were missing on this occasion. This was the lack of talking to the children on their own, and the lack of a professional interpreter. Once again if a professional interpreter had been used, it would have potentially helped to slow down discussions (the adults were said to be all talking at the same time), and helped the investigators to have exerted greater control over the situation. It therefore could be said that the decision to allow the children to remain at home was compromised by the omissions of important elements of the investigative process. On balance it was therefore the SCR Panel's view that the decision which was made for the children to remain in the home was an inappropriate one in the circumstances. In fact if there had been greater preparation at the strategy discussion in terms of consideration of the impact on the children of the timing of the interview, how they were practically going to be seen alone, and also that formal arrangements needed to put in place for a professional interpreter to be used, then this would have no doubt led to more informed decisions and outcomes from the interview when it ultimately took place. It is however acknowledged that Rachel's siblings did not come to any harm by remaining in the home overnight.

5.46 On the following day, both the Police and the EDT referred the case to their respective specialist and R&A teams. It was very useful that the strategy meeting held was then well attended by appropriate professionals, and that although the medical staff from the local hospital were unable to attend, relevant documentation was sent to the specialist hospital which hosted the meeting. The clear decisions made at the meeting for all the adults to be arrested and questioned in respect of the injuries to Rachel, was clearly appropriate as was the decision for the children to be removed and placed with foster parents and for care proceedings initiated. Overall, once the injuries to Rachel became clearly known to be the likely result of abuse, there was evidence of effective multi agency practice to ensure the safety of Rachel and her siblings.

5.47 The use of the powers of Police Protection for the children was utilised rather than Emergency Protection Orders (EPO) being sought by CYPD. Although the Strategy Meeting noted that the grounds for an EPO had been established, it appeared to be a pragmatic decision to use Police Powers in that the Police were taking the initiative in arresting the adults, with a belief that the arrangements for establishing EPOs would take time because of the need to attend court to apply for them, and therefore unnecessarily delay the criminal investigation process. However, it could be argued that this could potentially often be the case when balancing the care and criminal perspectives of a child protection investigation.

5.48 In fact a review of the possible excessive usage of Police Protection powers was the subject of a recent multi agency audit in Gloucestershire, following a recent Ofsted inspection. The initial outcome was that there was a mix of factors for the amount of use of Police Powers, involving the Police being overly eager to act, CYPD being over reliant on the Police and slow to gather information, as well as responses by the court seen as being occasionally slow and unhelpful. However in respect of the particular cases viewed as part of the audit, it was considered that Police Powers of protection had been correctly used.[8]

Response to the family's racial, cultural and linguistic needs

(Reference to Terms of Reference "specific issues": - B, C.)

6.1 This family's culture, ethnicity and language were a significant factor for the professional interventions with the mother and her children. However for the short period of time that this SCR covers, no professional knew with any certainty what the cultural background was for the family or the actual language and related dialect which they used. It was nevertheless apparent that most of the professionals who worked closely with the family made reasonable assumptions that their nationality and ethnicity, although no professional had a sufficiently significant relationship with the mother to gain a confident understanding of her and her children's race, culture and language. It was only in the interview for this SCR that the mother confirmed her ethnicity.

[8] Report from "Ofsted Action Plan Requirement 10" (Nov '10) meeting of the Operational Leadership Team, held in June 2011.

6.2 It was certainly helpful that a number of involved professionals had some experience and knowledge of similar cultures – this was particularly so in respect of the EWO and the teaching assistants in the school, with the latter showing that they could communicate with the mother in related languages with some success. Also because of the experience of working with the significant minority of such families in the locality, then these professionals were able to provide some cultural sensitivity in their work with the family.

6.3 Whilst the simple fact of the mother and the children being in a new and strange environment had the potential to dis-empower them, this would have been further compounded by her inability to communicate effectively. There was also consideration by some professionals that the mother had learning difficulties, but this was never assessed. Clearly if this was the case, then this was a further challenge to the mother's ability to integrate into the community and express her and her children's needs. There was no intervention by adult services with the mother and therefore no issue emerged re communication issues between adult and children's services.

6.4 Whilst local professional knowledge and experience of work with particular ethnic minorities within the community had its undoubted advantages, it was potentially a double edged sword. For example, in the absence of detailed or accurate knowledge of the family's exact background, there was the potential for local professionals to make assumptions about the characteristics and attitudes of the mother based on their previous experience of working with families with similar backgrounds. For example, the EWO considered that "in his opinion" that the family were of a particular nationality and culture and that in his experience such families were not wiling to acknowledge their heritage, and therefore would presumably not divulge this. The Health IMR also referred to such families not wishing to discuss personal health issues and that they viewed health visitors as social workers, making them reluctant to engage. The fact that the mother sought help from the Ambulance service on two occasions, and on the first of which followed their advice and registered with a GP, would tend to suggest that she may not have been overly anxious about presenting or discussing health issues. Also the health visitor had found members of the extended family to be open about their health issues. Similarly, the school also considered that the mother was difficult to engage, based partly no doubt on the experience of other families with a similar background. Whilst overall these characteristics may well have been useful knowledge to inform interventions with the family, they were not in fact confirmed to be accurate with the mother about her particular family. It was therefore the potential that by valid attempts to address the cultural needs of the family, inadvertently they were being stereotyped. "There is a danger in applying a stereotype unthinkingly instead of using it to test a hypothesis about the particular family being helped"[9]

6.5 It was certainly understandable that for the relatively brief occasions that professionals had meaningful contact with the mother, that the focus was on tackling the prevailing issue at the

[9] Culturally competent protection of children's mental health" – Child Abuse Review Vol11 – Walker, Steven - 2002

time, and meant that it was perhaps unreasonable to expect priority to be given to having detailed discussions about the family's race, culture and language. This was further exacerbated by the use of neighbours and extended family members to act as interpreters and to what extent it would have been appropriate to ask questions about personal issues. However, without the clarity about the mother's and her children's cultural background and previous experiences, it was always going to be challenging for professionals to provide effective and meaningful interventions. The school had the greatest contact with the family and perhaps via initial registration processes and the developing relationship with the mother and Wendy in particular, then greater understanding of their cultural needs could have been more proactively sought. Greater use of expertise from the READS service would have helped to address the family's cultural needs more effectively. Later on, when the referral to CYPD led to a decision to undertake an Initial Assessment, if this had been commenced, then it would surely have been a central component of that work to have clarified the cultural and linguistic status of the family. Unfortunately it was another missed opportunity.

6.6 Instances when there was insensitivity to the family's cultural and language included the health visitor attempts to contact the mother for the introductory home visit via a letter written in English and also by leaving a telephone message in English. Unfortunately the GP registration system did not ensure that basic information was passed to the health visitor to help ensure that the first contact was appropriate to the particular needs of this family who did not speak English. The significant minority of families with similar backgrounds, in the area was well known and so greater thought should have been put into whether a level of cultural sensitivity was needed to engage this family. Enquiries of what was contained in the GP registration process may well have given this information. The difficult behaviour by James on his first day at school, and the frustrations displayed by his mother in her handling of him, no doubt reflected the inherent emotional difficulties of a child attending school for the first time, but this was compounded in this situation by the added stresses of mother and child not understanding the language and being in a completely alien environment. These additional cultural and linguistic factors should have meant that greater attempts were needed to retain them in the school environment and help manage the trauma, rather than send them home.

<u>The impact of the family's immigration status</u>

(Reference to Terms of Reference "specific issues": - E)

6.7 The family were not entitled to any state benefits, including the children not being eligible for school meals. It was known that the family were in over-crowded accommodation and that the mother was a single mother who, unless she found work, had no way to provide for her children. It was recognised early on that the children were thin and hungry and that the family were very poor. It was therefore very apparent that this family were going to struggle to maintain a basic level of existence. It was therefore surprising that a more proactive stance was not taken by professionals to identify the depth of the welfare concerns (potentially via a CAF) or for the School, via the EWS, to work hard to get all the school age children into school and get

them to take up what help was in fact on offer in the community. Again the involvement of READS, whose role was to promote inclusion, minimise discrimination and to develop community cohesion, could have made a difference in mitigating some of the effects of the family's immigration status.

6.8 Schools with more than 100 pupils from Black and Minority Ethnic (BME) communities were eligible for financial support from the Ethnic Minority Achievement Grant[10] and this school chose to use the money to appoint the three bilingual teaching assistants. This was in contrast to other schools in similar situations in the county who used the additional finance to purchase extra support from READS. It was not clear whether the arrangements that this school had in place meant that the children received any less or better service, than if their arrangements had been the same as other similar schools. READS still potentially had a role with these children, as the core services were still available in the school, but in general their involvement with the children was very limited. In fact the READS worker was the professional responsible for admissions regarding children who did not have English as a first language, but this worker apparently had not recognised this responsibility at the time Wendy, Timothy and James attended school. Therefore the children did not receive as full a service as was available.

6.9 The mother attempted to seek work and was often absent from home, apparently leaving the children in the care of others for significant periods of time. To what extent this impacted upon her ability to parent the children was not known, or to what extent the pressures of The mother's immigrant status had any bearing on her attachment to her children, and particularly Rachel, who suffered serious physical abuse and neglect at her hands. Nevertheless it may well have been a factor. In respect of migrant families, "The erosion of cultural and personal identity makes it hard for individuals to pursue their conception of a good life and construct a coherent sense of personal identity, which can lead to a wide range of psychological and social problems, for example depression, unhappiness, anger, a sense of meaninglessness and poor family cohesion"[11] If a level of early proactive interventions, and greater encouragement to take up of the community resources that were available to the family (e.g. children's centre, relevant voluntary agencies) had been made, then potentially there may have been a different outcome for the family.

<u>The use of professional Interpreters</u>

(Reference to Terms of Reference "specific issues": - D)

6.10 All of the IMRs make the point to varying degrees about the importance of professional interpreters in working with ethnic minority families who do not have English as a first language,

[10] EMAG is a DfE fund devolved to Local Authorities and Schools to support minority ethnic pupils to support integration and achievement of new arrivals.

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

and yet up to the incident of Rachel's injuries being discovered, no formal interpreter was used in any of the conversations between the mother and professionals from within the community. This problem was exacerbated because professionals did not clarify with the mother what her language was, and there were some assumptions that dialects for her particular community would have made it difficult to find such a specialist interpreter. However this assumption was never really challenged and an appropriate translator was found who was able to communicate effectively with the mother when interviewed by the former Overview Author as a contribution to this SCR.

6.11 Working Together states that "Family members or friends should not be used as interpreters, since the majority of domestic and child abuse is perpetrated by family members or adults known to the child"[12]. This primarily refers to the key points of intervention with families when child protection enquiries are being undertaken, and the only time when this was relevant in the work with this family was at the time when the Police and the Emergency Duty Team (EDT) social worker visited the family home on the evening following Rachel's hospitalisation for her injuries. This was a crucial interview, the purpose of which was to ascertain the safety needs of the remaining children in the household. The reasons given for not using professional interpreters on this occasion was simply that the EDT did not have recourse to using interpreters and that it was unusual in their experience to need an interpreter for home visits. In more formal venues such as interviews at hospitals or in police stations, then there was apparently a reliance on the host agencies to provide interpreters via Language Line.

6.12 In effect, the investigation interview of the 14th February '10 was compromised by the lack of a professional interpreter. The EDT social worker later said that she would much rather have had the resource of an interpreter, as the interview was difficult to manage with adults talking to each other which she could not understand and that it was difficult to ascertain the mother's views and opinions. The relatives and neighbours were said to be answering all the questions on the mother's behalf. Additionally the social worker talked of relying on observations of the children's body language and behaviours as part of her assessment of any risk to them.

6.13 The Police IMR identified that there was no consideration of the use of Language Line, and this appeared to be partly because it was considered that a language which combined a particular nationality and a different dialect would be too difficult to resource via that service. Although the IMR considered that a translator from the mother's country of origin would not have been adequate in the circumstances, it proved to be so in other communications with the mother. The lack of an accurate earlier assessment of the family's linguistic needs meant that assumptions were inevitably, and to some extent inappropriately made. Whilst the Police IMR also rightly drew attention to the limitations of the use of Language Line, the issue was whether these limitations outweighed their use, as opposed to using the neighbours and relatives. This investigative interview was an emotionally charged situation and the adults in the family home

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

had an emotional connection to what was happening. Also no doubt their style of speaking for the mother would likely have had the impact of making her feel isolated and as a confused observer of what was happening, rather than engaged fully within it. A major issue of using family and friends as interpreters was that the subject family's rights to confidentiality were significantly compromised. In effect this meant that because of the language barriers, the mother and her children received a lower standard of professional care, and as has been referred to earlier, the children were not seen alone, primarily because of the way the interview developed and had to be managed at the time. It could therefore be argued that the Working Together statement that "All children, whatever their religious or cultural background, must receive the same care and safeguards with regard to abuse and neglect"[13] was compromised within this particular interview.

6.14 It needs to be acknowledged however that for an out of hours interview, that a pragmatic decision was taken to utilise the resources of the neighbours and relatives, although both the Police and the EDT (via the CYPD IMR) acknowledge with hindsight that this was not best practice. It was unclear whether any serious consideration had in fact been given to the use of professional interpreters when this should have been a priority consideration at the time of the planning of the interview within the strategy discussion. The way in which the use of neighbours and extended family as interpreters could seriously compromise an important child protection enquiry, were not apparently given due weight prior to the interview taking place.

6.15 The use of neighbours, friends and extended family at other times in the work with the family by the EWO and the school, was perhaps understandable in these less formal interview settings, but the same issues applied in that this compromised the family's confidentiality, the ability for their voice to be heard, and helped maintain the mother in an isolated and potentially oppressed position. The respective IMR identified that the EWS were unclear about the arrangements for access to interpreters and that it was easier to use people whom the EWO knew in the community or family and friends in the home. There should have been a much clearer formal process in place which did not mean that the more pragmatic and convenient, (but less professional) approach was otherwise always taken. The use of the teaching assistants as interpreters was clearly a useful resource that was available to the school, and they appeared to be successful in being able to communicate with the mother for the brief contacts that existed. It was unfortunate that there were not more opportunities created for the mother and the children to utilise help of the teaching assistants, to assist with a greater identification of their needs and to integrate them into the community, although the lack of attendance of Timothy and James at school and limited involvement of the mother in school activities, meant that such opportunities were not realised.

6.16 It needs to be recognised that the use of professional interpreters is a challenging process in itself, evidenced by "Many research studies have identified serious deficiencies in interpretation

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

services that have resulted in unfair treatment for some families involved in child protection…"[14] However it would appear to be that the most appropriate use of interpreters is at crucial stages of intervention, be that at times of formal assessments taking place or more importantly as part of child protection investigations. Additionally the Health Overview Report has strengthened the importance of the use of interpreters at times of health assessment and other important interviews with non-English speaking parents and carers.

Sensitivity to the needs of the children

(Reference to Terms of Reference "specific issues" : - H)

7.1 In essence, because of the issues about the children's ethnicity and language difficulties, and the very few occasions that professionals had contact with them, then it was difficult to identify occasions when there was sensitivity to their particular needs. The failure to maintain James and Timothy within school and lack of READS involvement meant that there was overall insufficient sensitivity to their needs. Whilst Wendy was reported to be quiet and a "loner" within school, at least she had had the opportunities for social integration and to develop her self-esteem. Rachel was not seen by any professional other than by the ambulance and hospital services when her medical needs were paramount and there was good practice in identifying and being sensitive to her needs at that time. In respect of any of the children, and partly because of the limited contact with them, there was no sense that the children's wishes and feelings were known or sought by professionals.

7.2 One occasion when there should have been greater direct involvement with the children was at the time of their admission arrangements into their school. Although it was asserted that the formal agreements with the mother and children would have been interpreted from English at the time, none of the children signed their agreements, which would otherwise have been normal practice. Although there was some discrepancy within the IMR regarding the children's attendance when the school admissions process was undertaken, it was not apparent that the children were directly engaged in any meaningful way. During the short time span being considered as part of this SCR, there were very few opportunities for the children's needs and wishes to be considered, so it was concerning that when such few opportunities arose, they were not taken. Also not all the teachers and staff in the school were aware of the sibling relationships, which would not have helped in respect of demonstrating sensitivity to their needs.

7.3 At the time of the biting incident (Para 3.5), whilst there was a clear opportunity to seek the views of James, the child in question, this was not taken as it was considered by school staff that they understood what had happened and that James was very anxious at that time. Whilst the school staff had sensitively calmed the situation for the children, and demonstrated clear

[14] "Every Child Matters – A critical review of child welfare reforms in the context of minority ethnic children and families" – Chand, A, - Child Abuse Review Vol. 17 – Jan-Feb 2008.

professionalism in this respect, there appeared to be a lack of direct communication with the children. Whether it was because of the language difficulties and James's anxiety, these should not have prevented the initiative being taken to engage James more directly and potentially show greater sensitivities to his needs at that time. More generally, the teaching assistant did try to engage with Wendy, as the only child of the family who continued to remain in school, but overall there was felt to be an inadequate amount of time spent with her to confirm the language she spoke. She was reported to be quiet and something of a loner, which was to some extent understandable if the school did not have clear understanding of her spoken language and engage with her effectively. To what extent this inability to get to understand Wendy's needs and her language, was related to the lack of time available to the teaching assistant or the lack of more direct involvement from the READS worker, is not known, but once again raised the issue for the school about whether the role of the teaching assistants and READS team were utilised to the greatest effect.

7.4 Once again, the lack of a CAF and the later Initial Assessment not being undertaken meant that opportunities to show sensitivity to the particular needs of these children were lost. Whilst at the time of the child protection interview of family members following Rachel's injuries, the focus by the social worker and police officer was upon the risks to the children, the lack of seeing them on their own and that there was no impartial interpreter, meant that this intervention was not fully sensitive to their needs. The effective formal response regarding the risks to the children following the Strategy Meetings did however more fully address their particular circumstances and meet their needs.

Inter-agency communication and management oversight

(Reference to Terms of Reference "specific issues" : - J, O, S)

8.1 Management oversight appeared to be lacking within the school in that the head teacher had overall responsibility for the processing of referrals to CYPD as well as the referral processes to the EWS and to identification of the need for input by READS, and there were problems in respect of all of these. Whilst it was clear that the head teacher needed to have trust and reliance upon members of his staff to undertake their roles effectively, this does not abdicate the head teacher of accountability when practice does not follow procedures. Most significantly was the failure to ensure that a detailed and timely referral was made in respect of the incident when James was slapped by his mother.

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

8.3 The head teacher and the DCPO within the school have acknowledged their accountability for actions and have since taken steps to address these. Improved procedures and guidance on record keeping had been instigated and regular meetings between the head teacher and the DCPO have been set up to enable more effective sharing of practice issues and to monitor

actions. The school governing body clearly also had a role in terms of management oversight and that there was an expectation that they would for example, have greater knowledge of child protection referrals made and processes for integration plans for children. The fact that the respective IMR, and this Overview Report , will be shared with them, will enable any necessary changes to be made to ensure that they have meaningful governance arrangements in place in the future.

8.4 Whilst relevant senior managers in CYPD were involved at appropriate stages of the management of the case, there were significant instances when practitioners did not share information with their respective managers. The practitioner from the Children's Helpdesk did not share the child protection issue with the line manager as expected, and the social worker did not tell the manager that he had not commenced the Initial Assessment that had been allocated. The IMR for CYPD has identified that improvements in systems for management oversight have now addressed these issues.

8.5 These instances represented difficulties regarding intra agency communication, whereas problems relating to communication between agencies can be more difficult to eradicate. For example the communication between the school and the EWS should have been better, and this was certainly the case in terms of communication with the READS. A crucial piece of inter agency communication occurred at the time of the referral being made by the school to CYPD, and this was not undertaken satisfactorily in that a key piece of information (about the slapping incident) was communicated in a muddled way. Effective communication occurred between the Hospital, the Police and CYPD following the discovery of Rachel's injuries, and the Strategy Discussion/Meeting was appropriately convened in line with procedures.

8.6 As part of the interviews undertaken for the IMR for CYPD, the EDT manager was interviewed and he acknowledged that he did not routinely check that children were being seen alone as an essential part of child protection enquiries, but that this practice in terms of management oversight needed to be improved and monitored and that actions were in place to take this forward.

8.7 The respective IMR and Health Overview Report identified that an earlier risk assessment of the staffing levels for health visitors working in this particular locality, was not sufficiently addressed by management, although it highlighted staffing difficulties for the health visiting team. This has been further addressed by recommendations in the respective IMR, endorsed by the Health Overview Report, for a review of the adequacy of staffing levels.

8.8 Management oversight within the hospital at the time of attending to Rachel's injuries was appropriate and effective in ensuring that her medical needs were met and that information sharing with other agencies was undertaken in order to address the safety needs of Rachel's siblings. Because the health visitor had no direct contact with the mother, then the issue of management oversight was not relevant, although when Rachel's injury became known, the health visitor appropriately informed her manager. Although management oversight did not

lead the police involvement in the investigative interview with the family following Rachel's injuries to be more proactive in using an interpreter or in ensuring that the children were seen alone, the actions were overseen by a CID supervisor. It therefore posed the question about whether management oversight could have been more proactive in ensuring that such factors were given greater consideration as part of the planning of the interview. The outcome of the interview was appropriately referred to the Child Protection Unit first thing on the Monday morning.

The impact of local community and organisational contexts

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

9.2 The school was judged "satisfactory" in their most recent Ofsted inspection (November 2010) which recognised the challenges that this school faced in working with a large proportion of children from ethnic minorities and also that the school was a Persistent Absence school with the percentage of sessions missed being well above average. The inspection noted "significant improvements" in addressing this issue. The day to day challenge of working in this school with the range of difficult issues it faced should not be underestimated and it was apparent from the recent inspection that the school was working hard to effectively address these.

9.3 There is an inherent danger however, that in working with a school population and local community with such high numbers of ethnic minority families, including some as immigrants without recourse to public funds or benefits, that a form of "cultural deficit – accepting or applying lower standards" can develop. "Cultural deficit can lead to a lack of appropriate interventions, or even collusions. Professionals may have a different threshold of response to different communities, or respond differently but not necessarily appropriately. The result is that children are not protected"[15]

9.4 In terms of the health visiting services in the area, the respective IMR considered that their staffing was not at full complement or sufficiently resourced, and that this was a concerning factor in the sort of community that the health visitors served. The issue of "cultural deficit"

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

was evidenced in the NHS IMR which stated that "the transient nature of the population and multi ethnic community made it difficult for health visitors to provide an appropriate service relevant to their needs". The difficulties experienced by health visitors working in this locality were clearly identified within the respective IMR, with reference being made to the language difficulties, the inherent suspicion of the service by some of the ethnic minority families, and the inability of health practitioners to be fully alert to cultural and religious customs. The fact that there are also a number of transient families in the area, further added to a very challenging community to work in. There was no direct health visitor contact in respect of Rachel. Despite the difficulties identified in respect of the organisational and community context, it was not apparent that these should have meant that Rachel in particular, was not seen at least once. The absence of the school nurse in terms of any contact with the family was also concerning, although the respective IMR identified that if there had been more permanent staff available in this locality, that it would have created more effective communication between the school nurse and health visitor. Within this challenging community there was a greater need to be able to prioritise health visitor contacts, particularly with new arrivals in the area, and to have direct contact within a clear timeframe.

9.5 In respect of CYPD, several organisational changes between 2008 and 2010 were noted to have led to internal restructuring in terms of moving staff to teams in locality offices and the development of electronic recording systems. To what extent these internal changes impacted on the ability of CYPD to deliver an effective service during late Dec -09 and early 2010, was not fully clear, although reference was made to some inefficiencies of the management case recording systems at that time. There were also some social worker recruitment difficulties which seemed to have impacted on the R&A team in that since February 2010, the staffing levels increased from five to seven social workers. Therefore in February 2010, sometimes only one social worker was on duty and this explained why it was the manager who was trying to contact the referrer on the occasion of the referral from the school in early February. The safeguarding Ofsted inspection of December 2010 however identified that "social work resources were adequate across the R&A teams".

Summary

(Reference to Terms of Reference "specific issues": - P, T)

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

10.2 If professional interventions had been more timely and appropriate to the presenting circumstances of the family, then clear opportunities for understanding the children's needs and of any risks could have been utilised. This was primarily evidenced in the lack of a CAF and an

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

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

10.4 It was very apparent that the context within which the professionals were working created additional challenges for them. "Child protection practice is fraught with difficulties. When culture is added to the mix, the difficulty of the work intensifies and becomes infinitely more complex"[16]. In this way therefore there needs to be greater reliance on procedures and objective evaluation of day to day practice, via management oversight to ensure that the same quality and level of service provision is afforded to children of ethnic minorities as is given to other white British children.

10.5 The impact upon an immigrant family living in an isolated environment cannot be underestimated, supported by the view that such parents "lack the interpersonal supports and skills to resolve conflicts between them and their children, and their situation is compounded by their relative social isolation and poor English. The children could experience conflict between the cultural expectations in the various domains of their lives, e.g. school and home environment. These variables combine to create a situation where the threshold for the parents behaving aggressively toward their children is lowered"[17]

11. Lessons Learned

- The use of friends and relatives to act as interpreters for professionals working with families whose first language is not English, could compromise their confidentiality, prevent important personal issues being raised, and possibly compound feelings of oppression for the family.
- Early prevention initiatives taken proactively with families where there are clear welfare concerns for the children can reap important benefits to the children and avoid family problems and risks to children escalating unnecessarily.

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

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

- It is essential for communication between professionals when child protection concerns are being expressed, to be clear and unambiguous. In this respect there is a responsibility on both the communicator and the recipient of the concerns to be confident that all relevant information has been shared regarding the detail of concern and of the actions that are to take place as a result. To not meet this professional responsibility will seriously compromise the quality of any follow up inter agency response to the protection needs of the children.

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

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

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

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

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

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

NB: The above "lessons learned" are broadly reflected in the Recommendations in the following section in this report, although not all are linked in this way as some "lessons" relate to reminders of safeguarding practice which are already supported by procedures or are included in the recommendations from particular IMRs.

12. Recommendations

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

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

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

12.3 The GSCB must be assured that its constituent agencies have a coherent policy in respect of the use of professional interpreters, and that its operational staff fully understands how they can access such resources. It will be especially important that particular key interventions such as Sec 47 Enquiries, Initial and Core Assessments, and family health needs assessments have a professional interpreter available whenever possible as a resource.

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

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

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

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

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