North East Lincolnshire LSCB Local Safeguarding Children Board

SERIOUS CASE REVIEW RELATING TO THE R FAMILY

November 2014

Final

Updated July 2015

Independent Reviewer ALAN BEDFORD

1. **INTRODUCTION**

1.1 **Background to the Review:** The previous Chair of the North East Lincolnshire Local Safeguarding Children Board (LSCB) concluded that the circumstances of the case concerned met the statutory requirements for a Serious Case Review (SCR) as set out in statutory guidance Working Together to Safeguard Children (DfE March 2013). These are that there should be an SCR for every case where abuse or neglect is known or suspected and either a child dies or a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

1.2 The young baby in this case suffered bruising, a number of fractures, and head injuries which were committed deliberately. An initial look at the case by the LSCB identified some possible warning signs, so the criteria for holding an SCR were met. . The parents were both convicted in relation to the injuries: the father in relation to the assaults, and the mother for failing to protect the child.

1.3 **Terms of Reference:** The 2013 guidance no longer provides core terms of reference for SCRs, but says that final SCR reports should provide a sound analysis of what happened in the case and why, and what needs to happen in order to reduce the risk of recurrence.

1.4 This SCR will :

- Appraise the quality of work in this case
- Establish what lessons can be learned about the quality and effectiveness of agency and multiagency working
- Identify the key themes that characterised work with this family
- Make proposals for improvement where any shortfalls are identified
- Involve front line staff and family members in the Review

There is a key underlying question:

- Could the injuries have been prevented? If so, why, and what can be learned from this to help other vulnerable children, and staff, in the future.

1.5 **Review Process:** The Review used the flexibilities contained in the guidance to follow a methodology that fitted local needs. To think through a way forward, a scoping day was held, chaired by the independent reviewer, with some front line staff and some managers and safeguarding advisers. (The day was designed just for front line staff but there were Police concerns that this might create evidential issues for some key witnesses- who were then involved by the Review in a different way). The group, which had available summaries of each agency's involvement, identified the key points of agency interaction with the family for specific focus, and also identified key themes for the Reviewer to explore. This was a helpful way in both engaging staff in thinking about the possible learning, but also making best use of Review time by agreeing focus.

1.6 Thereafter, the independent reviewer met all the staff involved with the case, examined agency files, and the dialogue between reviewer and reviewed about what happened and why, and what might be done better, provided rich source material for this Review.

1.7 To support the process there was a small Reference Group of senior staff from involved agencies which the reviewer could use as a sounding board , and if necessary to facilitate any stumbling blocks in the process. The Board's SCR Working Group quality assured the final draft before presentation to the Board.

1.8 The staff group reconvened to consider the draft SCR, to advise on whether it was describing appropriately the facts and issues, and to consider what recommendations would be most helpful for their work. Nearly all staff and first line managers involved were present and it was a very rich and productive session. The Review would like to thank staff for their openness and commitment to the learning process. All key staff, even those who had left the area, were fully cooperative.

1.9 **Family Involvement:** The independent reviewer met the mother, maternal grandmother and paternal grandparents. The father did not respond to the invitation. After the sentencing, both parents were offered the chance to discuss the Review before publication. A meeting took place between mother and the LSCB Manager and Safeguarding Strategic Manager to share the findings from the review. Father did not respond to the invitation to meet.

1.10 **Independent Reviewer:** Alan Bedford was asked by the LSCB to undertake this Review. He has a background in child protection social work with the NSPCC, where he was also national training manager. Following this is spent 18 years in the NHS, the majority of the time as a CEO in Trusts and Health Authorities. He now works independently as Alan Bedford Consulting on a range of issues from infection control, to emergency health care, to safeguarding. From 2009-11 he was Director of Safeguarding Improvement for NHS London, leading a London wide peer review programme, and from 2009-13 was chair of the Brighton and Hove Safeguarding Children Board. He has conducted a number of SCRs, is accredited as a SCIE Systems Reviewer, and has completed the 2010 and 2013 national training for SCR authors.

1.11 **Anonymity:** As the focus of SCRs is about learning, it is inappropriate to identify the children and family concerned. This Review will not therefore describe the family in detail. Some facts may be altered slightly to enhance anonymity.

1.12 **Agencies Participating:** All involved agencies participated in the Review. These included:

North East Lincolnshire Council:

- Children's Social Care
- Children's Centre

- Health Visiting

Humberside Police

Northern Lincolnshire and Goole NHS Foundation Trust

- Midwifery
- A&E
- Paediatrics
- Diagnostics

North East Lincolnshire NHS Clinical Commissioning Group

General Practice

- Two surgeries

NAViGO Health and Social Care Community Interest Company

- Mental Health Services

Sheffield Children's Hospital NHS Foundation Trust

1.13 **Report Structure:** This report describes the history in Section 2, appraising professional practice in key events. In Section 3 there is 'Learning and Why' which identifies the key themes of professional practice and why those patterns of work occurred. It is in understanding the 'why' that needed improvements can be identified. The 'Conclusion' in Section 4 summarises the learning, and answers the key question about whether protection could have been quicker.

1.14 There are in Section 5, recommendations for the LSCB to consider. They are addressed to the Board rather than each agency separately, given the Board's collective responsibility for assuring the quality of child protection systems. This report does not set out to describe and analyse each agency's contribution in detail. This is to adhere to the planned intention to focus on what is most important in the story and for priority learning.

1.15 The appendices cover updates from agencies on progress on issues related to this Review as at November 2014 and subsequently updated in June 2015, and also current progress by the LSCB on the recommendations.

1.16 **Family Structure:** The parents were unmarried, with two children. T was not yet 2 at the time of the admission to hospital with injuries of V who was then not quite 11 weeks old.

1.17 **Care Proceedings** There has been a Finding of Fact hearing in the Care Proceedings which looked at responsibility for injuries which were all determined to be of non-accidental origin. The father accepted causing the main injuries, and the mother accepted a 'failure to protect'.

2. History and Appraisal

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2.1 **Introduction**: This section only covers key events, rather than all professional contact with the family. It focusses on the areas from which there can be learning, but also limits information which might threaten anonymity. This section looks at 'what' happened and appraises the quality of the work. Section 3 analyses the events in more detail and looks at the 'why' questions.

2.2 At the time of mother's pregnancy with T the family had no involvement with social services, and was in receipt only of universal services - as with any other family. Agencies knew nothing unusual about the pregnancy or immediate post-natal period, and no concerns were recorded about T by maternity, GPs, community midwifery or health visiting, which might forecast later abuse. The mother was well linked into the local Children's Centre, where nothing was ever noted of concern. The father also engaged in some sessions at the Centre.

2.3 There is no policy in NEL, as in many other places, for either midwifery or health visiting to ask, as standard, questions about domestic abuse, but had the question been asked it is most unlikely that anything would have been said.

2.4 **Bruising to T.** When T was 3 months old a Practice Nurse at the GP surgery looking after mother and baby (when doing second immunisations) saw and recorded a bruise to the baby's lip and arm. A maternal explanation of sucking on a toy was noted, as was 'to keep an eye on and seek advice if more bruising'. This was not discussed with anyone else such as the lead GP for safeguarding in the Practice, or any other safeguarding adviser nor was the health visitor informed. The Practice Nurse thought that the lip mark was reasonably explained by the toy explanation, and cannot recall what explanation if any was given for the arm bruise. It would have been good practice to discuss the bruises with a colleague. The baby was not yet mobile so bruises are always of concern. (The mother and maternal grandmother had no recollection of the arm bruise when speaking with the Review). At the Finding of Fact hearing in the Care Proceedings on the two children, the medical view was that at least one of the bruises was likely to have been non-accidental.

2.5 In some parts of the country there is a policy requiring the reporting of bruising to non- mobile babies to children's social care and for a medical to follow. There is no such policy in NEL but, even so, no professional should make a decision without talking to someone else when there are bruises to so young a child. The fact that this event remained, unknown to others, in the GP clinical notes meant that it could not be taken into account when there were later events which might have been informed by the earlier bruising.

2.6 **Domestic Violence Reported to A&E.** When T was 8 months old, and 11 months before V's most serious injuries the father, with some male relatives, attended A&E on a Sunday to seek help, admitting that he had 'nearly killed' his partner having tried to 'strangle her and break her neck'. He had felt depressed for some time and

was under stress at work. He told a doctor he was unable to control thoughts of wanting to kill people, and also had thoughts of not wanting to be alive. He was appropriately referred to NAViGO's mental health crisis team. The mother told the Review how the attempted strangulation had given her bloodshot eyes and spotty haemorrhages in her eyes. This episode is examined in more depth in the 'Learning and Why' section below, but there were elements of the professional response which are both mystifying and worrying.

- A&E staff did not inquire about whether there was any child in the family.
- A&E staff did not refer the matter to the police, given that the partner might be at extreme risk and an assault had been described.
- A&E staff took no steps to make any inquiry as to the well-being of the victim
- The A&E discharge letter to the GP gave no indication of the magnitude of what the GP's patient had done or said, the diagnosis section just saying 'abnormal behaviour'.

It was not only A&E which did not consider or consider adequately the immediate safety of the family.

- NAViGO mental health staff similarly took no immediate steps to assure the mother's safety, but did appropriately refer to Children's Social Care (CSC) on the day of the A&E attendance
- The Health Visitor was informed by CSC the following day, but made no visit to assess the well-being of the baby or establish if the mother was ok, assuming others had this in hand
- CSC began an assessment 4 days later, but initiated no immediate steps to check in person that T was safe and well, or that the mother was in a fit state to care for T (although the paternal grandmother was called on the day of referral and she said everything was calm and settled)
- Whilst NAViGO did inform the father's GP, neither the health visitor nor CSC made any contact with father's GP
- No one made any contact with the different GP Practice which the mother and baby attended
- No one informed the Police at any stage. This would have been the right course of action
- No one considered the relevance of the incident to the father's employment

2.7 A discharge letter was sent to the GP from A&E, but its contents range from inadequate to misleading. The 'diagnosis' was given as 'abnormal behaviour' with no reference to violence to others or the specific incident for which the father sought help. The 'treatment' was given as '1.Self Harm Team' and 'Crisis Intervention Team'. There is no evidence of a 'self-harm team' being involved. The GP who received this unsurprisingly wrote 'no action' on the letter, believing that as a referral had been made to mental health there was no immediate GP role. The GP had no idea (until the NAViGO forms arrived) that his patient had been involved in serious domestic violence. Other GPs in the Practice, who looked at the letter for the Review,

all thought that the letter was misleading. The mother and children's GP Practice had no idea the event had ever taken place.

2.8 **Mental Health Assessment** There is no record of A&E providing any detailed brief for NAViGO so there may have been none. NAViGO's crisis team responded immediately and assessed father's well-being. His apparent wish for help and willingness to take steps to receive help seem to have been accepted at face value, but there seems to have been no real attempt to assess the risks from him in the family context. The father was also assessed in the presence of his father and brother and as will be seen in section 3 the presence of relatives can skew professional judgement. The case was closed to acute mental health services that day, with a recommendation that he attend Open Door first for anger management and then, after that, Open Minds for stress management. (There is a view that 'Anger management' is not considered appropriate anyway as it is contra-indicated for domestic violence). The referral to CSC was appropriate but its speed did not reflect the possibility that mother or child might be at risk. It was not made until 16.05, ten hours after the Crisis assessment was completed. The assessing nurse has some memory of taking a call on the phone from the mother but nothing is recorded to this effect. If the call occurred, it is possible this was from the paternal grandmother as children's social care were given her details by NAViGO out of hours.

2.9 There were a number of limitations with the assessment. The father's word was taken that the mother was unhurt. That he had called the police was also accepted without any evidence. Despite him saying he 'nearly killed' his partner, the absence of psychotic symptoms seems to have led to what he did being played down. The fact that he 'had no plans to harm himself or others' may have been true but was probably also true the day before the domestic violence. The referral to children's social care presumably was deemed to cover any ongoing risks. It is not easy to conclude what else NAViGO could have done, but their rapid closure of the case despite the father's rather frightening statements to them and to A&E, influenced others to think the events had been of little consequence.

2.10 The father never attended Open Door and self-referred to Open Minds, which provides various psychological therapies. He had been advises to use Open Minds only *after* getting help from Open Door. (The Open Minds assessment is put in context in 3.26 onwards where it is concluded that it would be unreasonable to expect the Psychological Wellbeing Practitioner (PWP) at Open Minds to have made a wholly fresh assessment). His arrival seeking an appointment was therefore unexpected, and without a specific referral. (The Review was told that there is now a NAViGO procedure that requires a formal referral from Crisis to Open Minds if a patient is pointed in their direction). The PWP who saw him heard many things from him (which may or may not have been true) which were not in the Crisis team's notes of their assessment two days earlier.

- Father had had a charge of criminal damage
- He had punched a neighbour

- He had thoughts of wanting to hurt a work colleague
- Dishonourably discharged from the army 'for fighting'
- The mother had 'thumped' him before his attack
- Mother had burst blood vessels in her eyes as a result of the attempted strangulation. (He told Crisis she was unhurt)
- He did not call the police. (He told Crisis he had called the Police)

2.11 The PWP recorded 'No risk' in the case notes. It is not clear to this Review how that conclusion could have been reached given what the father reported, but to be fair the supervisor (who would not have been aware how much the PWP heard was new) did talk through the risks with her and agreed the outcome. The PWP says 'no risk' referred to no risk to the father himself.

2.12 Whether or not the PWP could have been expected to react independently to what she heard, it would have been helpful for the assessment to contain a clear narrative conclusion on the risk to others. This would have been useful in itself, but its absence allowed subsequent readers to see the whole thing as relatively low key.

2.13 The father was given a self-management technique for when he felt wound up, and two CDs on stress management. The fact that this was the only outcome of his assessments made it easier for the mother and professionals to believe what happened had been a one off. The father's GP Practice also received the notes from Crisis and Open Minds, and again wrote 'no action' as neither had concluded any significant concern and the plan indicated ongoing work with Open Door and Open Minds. The mother and child and a different GP to the father, unknown to NAViGO, and the GP received no information.

2.14 **Initial Assessment (IA) by Children's Social Care** The worker receiving the call from NAViGO recorded a good account of what the mental health services had gleaned. It said that they had spoken with the grandmother who said father and T were at her house and that T would be staying overnight. The grandmother confirmed the police were not called. There are good notes about why an Initial Assessment (IA) should be done and its intended content .Perceptively it said that as mother had not called the police her ability to protect T needed to be assessed. It noted 'significant concerns' about the father's mental health.

2.15 It was agreed that an IA should be undertaken and it was allocated to a qualified social worker, who was given additional support from her principal social worker as she was in' her first year'. In fact, the social worker had only been in practice for a week, after a previous week of induction. It was unwise for this case, where the father had admitted trying to kill his partner, to have been given to a worker who had no experience of statutory work during training and had not yet completed an initial assessment. The negative appraisal of the IA in this section must be read in the context of the inexperience of the social worker and work pressures in the department- discussed in section 3.

2.16 Given that the presenting issue was potentially very serious violence to the mother, the first visit should have been quicker than 4 days in order to be sure of the child and mother's well-being. Given that the referral information included phrases like "nearly killed",' "smashed thrown things within the family home", "tried to strangle and break her neck", and it was known there was a child, not visiting promptly was an error. An immediate visit would have discovered the baby was only 8 months old and not 2 years as it said on the referral form. The mother should have been seen alone before the third home visit. According to the health visitor, the social worker told her she would be recommending closing the case 3 days before the mother had been seen alone.

2.17 The IA was concluded in the ten working days target, but there is no indication that either of the GP Practices, or the Children's Centre (which is part of Children's Social Care) or the Police, or NAViGO were consulted. CSC was not to know the Police had no prior record of domestic abuse - but the Police might have done and that would have affected the assessment. The Children's Centre which both parents and child had attended did not know the assessment was being done or why. It was informed amidst a list of such cases that T was now a 'Child in Need'. Had they then inquired of CSC 'what's this about' (as would have been good practice) they would have been told that the case was tagged for closure. Nevertheless, it would at least have given the Centre the opportunity to offer the mother support and keep an eye on things. The mother and child's GP practice did not know of the domestic violence or the CSC assessment until this SCR. The father's GP was aware of the event from NAVIGO and their assessment of father (although the A&E discharge note the GP received made no reference to domestic violence) but knowing CSC was looking at it too might have brought it higher up the radar.

2.18 Although the social worker and her manager agreed the case should be closed, it is procedure that there is a multiagency meeting at the end of a spell as a Child in Need (CIN) with the family to confirm this. This, the Review was told by the manager, should have taken place within 28 days of the closure conclusion. Not only was this not done within 28 days but by that time the maximum 5 week gap between visits to a CIN had been exceeded too, so the Principal Social Worker (PSW) told the social worker to make a home visit pending the CIN closure meeting being fixed- which the PSW would attend.

2.19 It is recorded that that home visit (6.5 weeks after the last one) was to inform the parents of the outcome of the assessment. The CIN meeting which was to make the closure was a week later and there is no indication that anyone from another agency was invited or consulted for the closure meeting, so it was just the parents the social worker and PSW.

2.20 The meeting confirmed the view in the written assessment that as the father was willing to seek help, and mother said she knew how to access help, that all would be well. The fact the mother said she was pregnant again at the meeting did not cause

sufficient concern to change the plan- although the PSW rightly said that midwifery should be informed.

2.21 The CSC submission to this SCR said that the assessment had taken too much at face value. The assessment 'should have given more credence to the potential for feigned compliance', especially "given our knowledge of the minimisation, denial, fear, and often low self-esteem of many victims of domestic violence". The CSC analysis continued to say that extended family collusion should have been more considered, and that the mother's pregnancy should have been explored more fully as part of the assessment process. The SCR agrees with this as the assessment is based on unsubstantiated or unmonitored statements by the parents. For example there was no evidence that the father was actively seeking or obtaining any help. Indeed, he told the closure meeting that Open Minds was not beneficial and he would go to the GP if he needed help.

2.22 The rather naïve assessment and the limitations of agency sharing around this serious domestic episode contributed to the domestic violence almost becoming a non-event as far as the whole professional community was concerned. Speaking to staff who worked with the family later, they either had no knowledge of the domestic violence or if they did assumed it was of little consequence given the way the main organisations ceased their involvement. The mother was also left with a sense of isolation (whilst revealing almost nothing to professionals). She told the Review "That was it, the social worker was gone".

2.23 The CSC did appropriately write to the mother and children's GP when they closed that case after the assessment, but CSC had not informed the GP that the case had been opened- or why it was opened or closed. This was not a helpful communication, as it conveyed nothing to that GP- who had no knowledge that the domestic violence incident had ever happened. Had CSC been explicit or, even better, consulted GPs during the assessment then it is possible that the bruising to T might have been discovered in the notes and influenced the CSC assessment. It may also have impacted how the GP reacted to the mother's later request for a termination. That termination was requested many weeks before the closure meeting with the family. There is no record that the father's GP was even told the case had been closed. Despite being required to do so in the IA instructions no checks were made with mental health services.

2.24 The parental announcement of the new pregnancy on the day of the closure meeting led to no revised plan, no discussion with mother alone, and the parents saying they were 'happy' with the news was naively accepted as making no difference to the assessment. (The mother had requested a termination six weeks earlier but then changed her mind a week later). Midwifery was appropriately notified of CSC's involvement.

2.25 **The pregnancy with V**. The mother sought a termination when pregnant for the second time because, she told the Review, the father thought it was too stressful with

another baby and work pressures. She changed her mind quite quickly as she couldn't go through with it. Had she been seen on her own after becoming pregnant she might have told the social worker that the pregnancy was not the shared happy event they portrayed weeks later at the CIN closure meeting. The GP seeing mother about this had no idea about the domestic violence known to father's GP, had no knowledge that the first child was 'Child in Need' and had no cause to look in T's notes and see the note on that baby's bruises. The GP said it would have been at the point of mother deciding to *keep* the baby that he would have been concerned had he known about the Domestic Violence the previous month.

2.26 As with T's pregnancy, all went smoothly. All the relevant appointments were kept and the birth of V was normal. The Children's Centre was again attended regularly.

2.27 **Seeking Help?** Credit was given to the father by A&E, NAViGO, and CSC for apparently seeking help after the violence to the mother. This has only come to light during the Review but, according to the paternal grandfather, he did not go to A&E for help with violence but because of concern with what seemed to be an extreme panic attack after the incident. The grandfather told the Review that his son appeared physically very distressed and that he feared his son turning blue for lack of breath. However, by the time they got seen in A&E he had calmed down and the panic attack was not visible.

2.28 There was a second time medical help was sought for a panic attack. Two days before V's birth, the mother called an ambulance as the father had had a 'panic attack', and was having chest pains and trouble breathing. The ambulance report recorded that there had been a 'heated argument' between the parents. He refused the ambulance suggestion he be taken to A&E. (Other agencies were unaware of this incident until after V's injuries). The father had apparently been very angry with the mother, and had caused damage including to T's toys.

2.29 **Further bruising to T.** This incident also did not come to light until legal proceedings after the injuries. The exact timing is unknown but was in the same month as V's red eyes and admission with pneumonia (below). The father has accepted he got angry with the 18 month old T after the child was (in father's view naughty). He smacked T, leaving marks to the bottom.

2.30 **First blood shot eye**. When V was 6 weeks old the health visitor made her second home visit, and V had a 'very blood shot eye' which mother said had been there a week. The health visitor assumed it was a scratch or infection and advised going to the GP .The mother recalls being told it was probably a scratch and said that going to the GP was a non-emphasised option, and not a strong recommendation.

2.31 It is probable that fractures had already been caused by then. The Finding of Fact concluded that rib fractures had been caused between V's 2nd and 6th week i.e. by the time the red eye was seen by the health visitor, and therefore at least 10 days before the chest x-ray described below. There are no clear guidelines on how to

respond to eye redness in young babies. The health visitor said that 'NAI did not come into my mind'. The fact that the eye was not drawn was unhelpful, as when meeting the Review the health visitor described a smaller mark. Although blood shot eyes can indicate trauma, the SCR the health visitor did not jump to an abuse conclusion, as having known the family for nearly two years nothing had caused her any concern and there are a range of possible causes. The health visitor did not link this with the domestic violence episode ten months earlier nor was she aware of the bruising seen on T at 3 months old. The mother did see the GP three days later but there is no evidence the eye was mentioned. The expert medical evidence at the Finding of Fact said that the redness was related to trauma.

2.32 **First Admission, and Fractures missed on X-ray.** Ten days after the health visitor saw the red eye, the parents took V to A&E with a history of a runny nose and cold, and reported that when father tried to clear some mucous from V's throat there was some blood on it. The A&E doctor thought it was a viral upper respiratory infection, prescribed paracetamol and advised returning, or going to the GP if not better in 24-36 hours. The doctor would not have been aware of father's attendance about the domestic violence, the bruise to T at 3 months, or V's earlier blood shot eye. Later that day, V was taken to the out of hours GP as still not well. There was concern about sepsis (infection) and V was admitted to the paediatric ward where sepsis and chest infection were diagnosed, and a chest X-ray taken with characteristics of bronchopneumonia.

2.33 What was not seen on the X-ray were a number of rib fractures. Had they been seen then there would have been immediate child protection action, and it is almost impossible to imagine that V could have been at home to sustain the serious head injuries three weeks later. The Trust had a backlog of x-rays to be seen by a consultant radiologist (who would check routine x-rays after they had been examined at the time taken) and the x ray concerned was in a batch to go to an external diagnostics firm 4Ways Healthcare 17 days after the film was taken with a reporting deadline of 28 days after it was taken. It had been seen by their doctor the day before V's injuries were diagnosed but the report had not been sent through. The diagnosis also missed the rib fractures, so even had it been reported more quickly, and before V's admission with injuries, there would have been no protective action.

2.34 Although seeing the fractures would have made the single most important difference to the outcome of this case, a paediatric radiologist from the teaching hospital in Sheffield to which V was referred has said that the fractures 'may be less evident' to a non-specialist consultant radiologist'. (If this is correct then there was even less chance of a paediatrician who was looking for infection seeing them). Speaking to the Review he said he would not expect a paediatrician or non-specialist radiologist looking for infection to see them. In not knowing any signs of concern from the family, there was not a close look for fractures- as confirmation of pneumonia was the purpose of the first X-ray. The causes and implication of the delays and non-diagnosis are fully analysed in Section 3.

2.35 There was also a query about a possible heart murmur. The paediatric staff knew no more than A&E did about any past potentially significant issues. On day 2 of the admission it was decided to give 'home leave' on day 3 (it was a bank holiday) in between intravenous antibiotics. In the event, the parents sought to take V home for a while on day 2 and this was agreed.

2.36 On day 3, V was discharged on oral antibiotics rather than have another 'home leave', to return the next day for assessment – with open access if concerned. When V was brought back the next day for review a nurse saw another blood shot eye, recorded it (but no drawing) and asked a paediatric doctor to look at it. The doctor's view is not recorded, but the nurse said the doctor viewed it as of no consequence. Neither the nurse nor doctor knew about the previous red eye, the domestic violence, or the bruise to T when 3 months old. The discharge summary made no reference to the eye. Oral antibiotics were to continue for another four days. It is likely that most rib fractures had occurred by this point.

2.37 According to the father, who told the police after the injuries, V's sibling T had a bruised eye on the day after V's first admission. From family photographs of T taken at the time the expert medical view at the Finding of Fact was that this was also a non-accidental injury. There is no record of any professional being aware of this bruising at the time.

2.38 **V's continuing illness.** Despite being discharged as both an inpatient and outpatient, V remained unwell. Six and seven days after returning as an outpatient (when the reddened eye was seen) both parents took the baby to the out of hours clinic. On the first occasion (with both parents) V was wheezy and distressed. The conclusion was that V was simply still recovering from a chest infection. On the second occasion, V was brought by mother with vomiting. The notes say the mother was reassured and was happy to monitor at home. With nothing at this point known that would have alerted clinicians to the possibility of trauma, the response by the out of hours GPs seems unremarkable. In the 12 days, between seeing the out of hours GP and V's arrival at hospital with life threatening injuries, mother attended the Children's Centre with V, immunizations were given and V had the 8 week GP assessment (presumably delayed by the holiday period).

2.39 The baby's weight had fallen from the 50th centile at 4 weeks, to 9th centile at 9 weeks. There is no comment on this in the notes, but it may well have been seen to be related to being unwell for a recent two week spell. It would have been good practice for the hospital and clinic record the reason for the weight loss.

2.40 **The second admission and diagnosis of injuries**. At not quite 11 weeks, after a second episode of violence from father to mother earlier that day, V was taken to hospital in the small hours, an ambulance having been called by the father. The baby was very ill and according to the EMAS report to the SCR the work of the crew 'could not be faulted'. They were on scene within 7 minutes of the call. At the hospital V was cared for by A&E staff and a consultant paediatrician arrived within 15 minutes

of being called. Two chest X-rays were taken and showed a number of healing rib fractures on both sides. There were also several bruises on legs and torso. An urgent CT scan was taken and this showed bilateral brain haemorrhages, it was quickly concluded that the injuries were non- accidental. A transfer to the specialist paediatric facilities in Sheffield was necessary as injuries were so serious and this was done quickly. The Sheffield hospital was advised of the non-accidental diagnosis. At Sheffield, further tests showed old and new brain haemorrhages, a fractured vertebra, bi lateral and sub-retinal haemorrhages. A shin fracture was also later identified. There were serious concerns as to whether V would survive but the baby did- becoming well enough to return to hospital in Grimsby a month later. The care in both hospitals was prompt and thorough. It is likely that the injuries covered nearly all V's first 11 weeks, and the Finding of Fact considered the possibility of up to five separate incidents of trauma.

2.41 The Police and Children's Social Care were appropriately contacted .The parents were arrested and kept in custody for three days before being released on bail. A Strategy Meeting was held on the morning that V was admitted to share information and plan the investigation, This was well attended by police, social work, health visiting and safeguarding advisers and quite properly it was agreed to arrange a medical for V.(This showed no injuries) .

2.42 The professional dealings with the parents after the diagnosis are not addressed here, as they do not impact on the core questions for this review on predictability/prevention.

2.43 **Could the injuries have been prevented?** It is too easy to assume yes. However, other than missing the rib fractures on V's first admission which was critical (if they were spottable by an unsuspecting non-specialist radiologist or paediatrician) the question is much more complex. The possible warning signs are addressed below in sequence to see if concern might have been raised to such a degree that protective action would be taken.

2.44 The lip and arm bruising seen on T at 3 months by the surgery nurse should have been at the very least discussed with a GP and it would have been good practice to refer to CSC. It is not possible to tell now if the toy explanation was acceptable to a doctor with appropriate training, so one cannot conclude it would have led to intervention. However, sharing the information with the Health Visitor, and CSC (as would be required by some LSCBs), would at least have meant they had it in their records should there be future concerns. The medical expert advice at the Finding of Fact said, from the description of the marks and the age of the baby, that at least one bruise was non accidental.

2.45 Had there been such communication with CSC and health visitor, it is possible that the assessment of the implications of the later domestic violence might have been less trusting and more evidence based, but it is unlikely there would have been a different outcome to the assessment unless abuse to T had been proven. It might be

argued that CSC could have remained involved with the family beyond three or four assessment visits and the closure meeting, especially when it was learned mother was pregnant again, but with parental assurances, mental health services not diagnosing any ongoing role, and not knowing about the bruising to T, it would have meant staying involved on the off chance that something might just happen. CSC staff speaking to the Review said that they would not continue in a case like this without a specific role.

2.46 The one thing that might have justified greater involvement, and the possibility that mother may have shared the abuse she was experiencing, would have been the recognition that what the father did to his partner was very serious indeed, potentially fatal, and that simply to accept this as a one off was to underestimate the risk of repetition and possible incidental harm to a child. (Especially with another baby coming). For example, CSC did not know that father had told Open Minds about mother having burst blood vessels in her eyes as a result of the attempted strangulation. However, there can be no certainty that longer CSC involvement would have led to identifying the parental discord, or that injuries to the new baby would have been prevented. The full extent of the history of parental discord emerged sometime after legal inquiries were started.

2.47 Nor was the request for termination a major indicator as nearly all such requests are from those creating no risk to children. As the GP did not know that domestic violence had ever happened or that the existing child was a CIN, the GP could not have been expected to check T's records when the request came in, so this was not a missed opportunity in itself. However , had the GP known (CSC should have consulted him during the assessment) that CSC were assessing the risks at home following violence it might have led to more thought about the termination request and possible discussion with CSC. The termination request was made 6 weeks before CSC closed the case. It is hard to see that even more thought at this would have led to any intervention that could have guaranteed protection of the future baby.

2.48 The two bloodshot eyes on V were not seen with any thought of possible abuse, and neither led different clinicians to have any concern or decide on any treatment or further examination. It is unlikely that even if they had been examined, or more thoroughly examined that it would have led to X-rays looking for fractures as there was no suspicion, and the baby had an infection anyway. As one medical expert at the Finding of Fact put it regarding the red eye seen at the first hospital admission, 'at a time when an infant is being assessed for pneumonia, performing an examination of the eyes is not a high priority'.

2.49 It is just possible that had the health visitor or hospital nurse/doctor who saw the blood shot eyes known about the bruising to T and the domestic violence, and had NAViGO's and CSC's involvement been more sceptical- that it might have led to more thought about the eyes. But the chances of all his happening were very slim. The issue of the red eyes is explored further in Section 3.

2.50 What could be guaranteed to have made a difference is if the examination of the chest X-ray during, or even after, the first admission had led to fractures being identified. Several doctors did not see the fractures. Also, it is well known that people tend to see what they are looking for, or not see what they are not looking for. Identification would undoubtedly have led to a police and CSC investigation and the protection of V (and T). However, even by this point, quite a few injuries had already been caused so not all would have been prevented. Additionally, the hospital knew none of the background events which may have caused a more searching look at the X-ray, but as the family gave no cause for concern at the time, hospital staff would have had no reason to call round other agencies for background information.

2.51 One specialist paediatric radiologist (see 2.33) said in case notes that the fractures would be 'less evident to a non-specialist consultant radiologist. The Chair of the British Society of Radiology says a non-specialist radiologist should see them, but was not altogether surprised that one did not. The assessment here about whether the most serious injuries could have been prevented must be that had a consultant radiologist seen the X ray in a week or even two weeks of it being taken, and seen the fractures, the baby would have been protected. In this case, the Trust was missing its target of a radiologist seeing 90% of routine x rays in seven days. On the other hand it could not be guaranteed that a radiologist even if seeing the x-ray quickly would have seen the fractures, even though they should do.

2.52 It is hard to see that the out of hours GPs seeing V a few days after discharge from hospital would suddenly suspect V's elongated illness was exacerbated by trauma, and the weight loss, given recent illness, history would similarly not ring trauma alarm bells.

2.53 In the opinion of this SCR, this is not a case like so many others where one can say the injuries were clearly both predictable and preventable. However, the SCR does identify areas of practice which if improved would have increased the chance at least of there being a more inquiring approach or greater scepticism about parental assurances. It would be dangerous to imply that there was much chance in the real word of everyone knowing all of the key events described above, or that even had they done that prevention could have been guaranteed . It is more a matter of 'increasing the chance' of some different thinking. For example:

- Had the bruising to T been reported to CSC (and there was in NEL no formal requirement for this then) it might have affected the CSC assessment of risk
- Had anyone made immediate face to face checks on mother's safety the extent of the assault might have been clear and might have led to a more concerned diagnosis of father
- Had the incident been reported to the Police, this might have led to action against father, or at the least some additional assessment of risk – which may have led to the incident being seen more seriously.

- Had CSC checked with both GPs when it assessed risks it might have led to more doubt about assurances that CSC was receiving- had the bruising to T been identified from the records
- Had the second mental health assessment realised it was hearing new information from the father it might have led to a rethink about the risks
- Had the CSC assessment been more sceptical it might have identified more risk.
- Had the health visitor not been given the impression that the domestic violence was of no great concern, it might have led to more thought about the eye
- Had the hospital known about any of the above (and there was little reason for them to do so) the red eye might have caused more concern, and the x-ray looked at more closely. (Even if it had, fractures may not have been seen).
- Had the X- ray have been reported in the normal timescale by a consultant radiologist*, the* fractures might have *been seen and protection instigated.*
- *Had the X* ray have been seen before the major injuries by a paediatric radiologist they would have been identified and it would have led to formal inquiries and protective action.

2.54 Only the identification of the fractures on the first hospital admission would have led to prevention- but not of all injuries, but only of those incurred after the X-ray was taken. The independent expert advice given to the Review suggests that a paediatrician could not have been expected to have seen the fractures, and while a non-specialist radiologist should be expected to see them, it was not surprising they were missed.

3 'Why' and Learning

3.1 **Introduction**: This section explores the reasons behind the agency performance which at times was less than ideal. It puts what happened in the systemic context as it was at the time, as it is only in understanding why things happened as they did that one can identify what needs to change. Staff interviewed are to be praised for their willingness to be open about how they approached the case, and for the way they worked with the Review to identify necessary improvements.

3.2 The key events described in the previous section will be put in context and analysed, and learning points identified. There will also be some overarching learning.

3.3 **Bruising to T:** This occurred when T was 11 weeks old so non-mobile, and any bruising or marks should be taken very seriously. The nurse who saw them was not a children's specialist although had undertaken safeguarding training. There was no LSCB policy about mandatory reporting of non- mobile bruising as there is in some parts of the country (the SCR recommends such a policy later) , so a worker can make a judgement on when to refer on or not. In fact the LSCB Procedures, whilst describing how to make referrals do not seem to specify *when* they should be made. They do say "Anyone who has concerns about a child or young person but is unclear whether they should make a referral, should consult with a senior or specialist colleague, or the Referral and Assessment Service within the Local Authority's Directorate of Children and Family Services," but this still leaves the matter to individual decision.

3.4 The nurse here decided that the explanation of one bruise was satisfactory so did not consider telling anyone else or referring on. Only one bruise was explained, and neither were drawn. It is always good practice to share with someone else injuries to a child, especially a young baby as this shares the responsibility of say deciding not to refer on. It also is a safeguard against being manipulated by a plausible explanation. The Practice Nurse did not know if any other agency e.g. health visitor knew anything that might have cast light on the marks.

3.5 The Practice concerned now requires such marks, if seen by a practice nurse, to be discussed with a GP. Recording is done electronically, so a drawing could not be made on the record. The nurse also told the review that health visitors use a different electronic system so cannot see each other's notes.

3.6 This SCR does not know if the bruising was inflicted or had a satisfactory explanation, but the learning points are similar either way.

- All staff who examine non mobile babies must be aware of the significance of marks and seek an explanation.
- That explanation should not be accepted by one worker alone, and should be discussed with a colleague, manager or safeguarding advisor.
- Bruises on non-mobile babies should be medically examined.

- Such marks should always be drawn, and described in detail in notes (Practices need to make arrangements for drawings to be made alongside the electronic record).
- Consideration should be given to how GP practices ensure significant information is available to Health Visiting services.

3.7 **The Domestic Violence Reported to A&E:** It is on the surface mystifying why what the father reported to A&E, and later that day to NAViGO, was not taken more seriously, and why no one checked in person the immediate safety of mother or any child. Describing the context in which the work was done may help others take a more family focussed approach in future.

3.8 The A&E nurse in question discussed his assessment at length with the Review- and did so not defensively but to learn. We explored why he had not considered the well-being of the mother, or check on the existence/well-being of any children, and the nurse explained the way his thinking had gone and the influences that were applying. He did not really understand why he did not inquire more, but identified four contributory factors. He faced a decision he had never faced before- that of a perpetrator arriving in A&E and owning up to an assault, so had no prior experience to fall back on. Secondly, the presence of the father's father and brother provided a reassuring influence. Thirdly the father saying he had 'tried' to do certain things to his partner gave an 'impression that he had not succeeded'. Fourthly, he felt his prime duty was to the patient in front of him, which narrowed his focus.

3.9 He simply did not think to ask about children (nor father's employment), and got the impression that the victim must be OK. Interestingly, the doctor (not seen by the Review) who then saw father also did not ask about children (or of he did it was not recorded), nor did the doctor take any steps to be sure of the victim's health. As 'children' did not come up, CSC were not contacted. The fact that the father agreed to be referred on to the mental health services and left to go straight there, the presence of relatives, and that he appeared keen to get help, dampened any sense of imminent danger. The father also said he had contacted the Police but this was not checked, and he had not.

3.10 It would have been appropriate for A&E to have alerted the Police to actions which were undoubtedly, as described, criminal. Indeed, the Trust's Head of Safeguarding told the Review that such a referral should have been made, but could see that the unusual circumstance of the perpetrator seeking help was off putting. He had no doubt that had the victim attended the police would have been called. The A&E nurse was less sure, and thought that mother's consent to refer may have been required.

3.11 The A&E nurse said he had safeguarding training to level 2. This case might suggest that level 3 would be better as even nurses focussing on adults can face, as in this case, issues potentially very child related. (The Review understands this is now the case – and level 3 is the required training for unscheduled care staff in the

'Safeguarding children and young people: roles and competences for health care staff: Intercollegiate Document'[1]).

3.12 The nurse who assessed the patient first and the doctor who then assessed him worked separately and the two never discussed the case. The nurse suggested to the Review that in some cases, and this might have been one, there are clear benefits in one worker seeing a patient through the whole A&E journey.

3.13 The Police advised the Review that had they had a referral that night either from A&E (or indeed NAViGO) they would have visited, and mother and child's safety would have been established. Also, they would have sought the father's stay elsewhere until a police domestic violence coordinator had met mother and assessed her situation. The father may have been arrested. CSC would have been informed or their visit. This would all have happened regardless of whether the mother said she was ok and did not want police involvement.

3.14 Had police been involved, even if had led to no formal action, it would have made it harder for any agency who heard about the incident later to regard the incident as being of low significance.

3.15 There are a number of learning points:

- A&E staff when faced with domestic abuse perpetrators or victims must inquire about the presence of children, and take necessary steps to ensure someone checks their safety.
- If a crime seems to have been committed in the context of domestic abuse the Police should be informed.
- Similarly, if an act of some severity is reported and there is no evidence of the victim's wellbeing, steps should be taken to ensure the victim is checked (e.g. police).
- A&E should not think that referring on to mental health services necessarily discharges their duties as in the two bullets above
- It is always important that staff working with adults 'think family'.
- When the assessment is about mental well- being and especially in a family context there should be at least an attempt to see the patient alone.
- When there is an assessment that involves (or should involve) risks to others, it would be good practice for staff who assess a patient separately to discuss their mutual findings to ensure the whole picture is clear.

3.16 It is not clear why the A&E discharge note was so misleading and sparse in content. GPs in one practice visited for this Review estimated that perhaps only 5% of such letters told them much more than their patient has been to A&E. It is understood some improvement work is underway.

[1] Royal College of Paediatrics and Child Health. Third edition: March 2014

- A&E discharge notes must tell recipients enough so that they can exercise proper judgement about their patients' needs.

3.17 **Mental Health Assessment:** As with the A&E assessment, the Crisis assessment by NAViGO seems not to have grasped the severity of what had been described by the father. Again the two relatives were present throughout. It is not clear from the records if A&E conveyed to the Crisis service the richness of what they had been told, and the assessing nurse cannot recall a briefing. Nevertheless, the mental health notes used phrases like 'nearly killed', so not the most minor of tiffs. The Review spoke to a manager who had worked in Crisis who said that workers in the night are singe handed so it is not practical to take time away from the patient to check with other agencies- and in any case their experience of any detail from CSC is small. (As it happens, CSC would have known nothing).

3.18 Had the assessment been in A&E (as it would once have been) there may have been more dialogue between the NAViGO assessor and the two clinical staff who saw father. The Review was told that restructuring and resource issues have led to the assessments now being done away from A&E.

3.19 NAViGO did appropriately check if A&E had referred to CSC and, discovering that they had not, did it themselves. It might have been assumed that CSC would visit quickly given the seriousness of the event, but it does not seem that the two agencies discussed what speed was necessary. CSC went four days after the incident, and relied solely on the paternal grandmother's day one phone view that all was well.

3.20 The assessor concluded that the father 'was pleasant in conversation, good eye contact and rapport established, and he showed willingness to access needed help. (The father) had no plans to harm himself or others'. He was said not to be clinically depressed or with any signs of psychosis. In the 'Risk' section it said 'risk of harm to others impulsively due to being unable to manage his stress and anger in a better way' and added 'risk of harm to himself due to frustration at the workplace, although he did not express any thoughts to harm himself, and no past history'. The fact that only 2 hours before the father spoke to the A&E doctor about 'thoughts of not wanting to be alive' (although denying any plans) was presumably unknown.

3.21 The plan was for the father to 'access' Open Door' for anger management and 'once therapy is completed access Open Minds' for stress management. There seems to have been no plans for review if he did not do this- and he never attended Open Door, and was not offered any outpatient appointment as a result. The notes of the assessment (and that of Open Minds two days later) were promptly sent to the father's GP, but not to that victim's or child's GP.

3.22 The father's relatives remained present throughout the assessment. The nurse told the review that if the father had wanted it he could have been seen alone, but often seeing the patient and relatives together creates less anxiety. The father's relatives

may well have wanted to play down the seriousness of the episode (or may not have understood its severity) and it is interesting that their assurances were behind the nurse not thinking it was necessary to take any steps about the partner's safety.

3.23 Asked about why there had been no check about the victim's well-being the nurse said that he understood the police were aware, and in those circumstances to make any other contact would have been in breach of patient confidentiality.

3.24 While it is not clear what could have been done had the assessor been more worried about risk, it is interesting that the inherent contradiction between being assured by his verbal assurances that he would get help etc. and the diagnosis that he become very angry 'impulsively' was overlooked. This Review concludes that there could have been a clearer analysis of risk. The mental health worker in Open Minds saw the Crisis assessment as being clear about their being little risk, and as a consequence seems not to have weighed up in depth what the father told her (but see below).

3.25 The learning points are:

- NAViGO should consider the implications of Crisis team staff working alone, and the degree to which this can limit proper inquiry.
- As with A&E, seeing patients only with relatives, especially when risk to self or others is involved, can risk a partial or influenced picture being formed.
- If a patient indicates they have informed the police, and if such a referral is appropriate, it should be verified.
- The implications of not following up the recommended treatment should be identified in the assessment.

3.26 Paragraphs 2.10-13 have already commented on the assessment at Open Minds. This was not planned to have happened before therapy for anger management had been completed, so the PWP concerned would have been wrong-footed. But as it is an "open service" the patient was assessed for suitability for the therapies which Open Minds offered. It was not a 'mental health assessment' in the sense that the Crisis assessment was. It was to assess suitability for stress management help. The father had in effect gone to the wrong place. He was assessed as would anyone else have been who self-referred, and pointed again at Open Door.

3.27 The PWP told the Review that especially with appointments made with little notice and her relatively high caseload, it was often not possible to scour old notes before commencing an assessment. This means that at the time of the interview the PWP may not have been aware that what the father said differed in many respects from what he said at Crisis. PWP's are not trained or expected to do in depth psychological assessments e.g. unravelling a patient's psychological history, and she knew that Crisis had done an assessment only two days before. The PWP's supervision discussion about the case was on the same day as the assessment interview so again there may not have been time to fully explore what father had said before.

3.28 It was also known that Crisis had referred to social services. Her supervisor also assured herself that NAViGO had made such a referral. However, if the PWP's role is considered it would have been unreasonable of her to have made a fresh and different diagnosis. The NHS website says a PWP "*They provide high volume, low intensity interventions for clients with mild to moderate depression, based on a cognitive behavioural model. They undertake patient-centred interviews, identifying areas where the person wishes to see change, make an assessment of risk to self and others, provide assisted self-help, liaise with other agencies and provide information about services. This work may be face to face, telephone or via other media. PWPs work under supervision and refer on those people, who require it, for High Intensity Therapy".* When this is taken together with the fact that the father had turned up there wrongly (or confused) this tends to explain what might on the surface seem a missed chance to spot more risk.

3.29 There is one exception to this. Firstly, the father told her he had not told the police- which challenged the Crisis understanding that he had, and related to this the new information that the partner had actually been hurt with symptoms of strangulation. The supervisor told the Review that had the father come in off the street before telling anyone else and said what he had said to A&E and Crisis the case would definitely have been reported to the Police. It seems this was not done on this occasion because of an assumption that CSC or Crisis would have done so (even if the father had not).

3.30 The PWP explored with the Review why there was not a greater sense of alarm about what was reported. Her description fits a pattern seen in other professionals who found themselves being reassured by the father's and his relatives' presentation. She said that, for example, the father talking about 'we went to A&E' gave the impression the mother went too, and this deflected her from considering the mother's well-being. She identified a range of factors which mitigated against high concern:

- Father voluntarily attending A&E to get help
- Saying 'we' attended A&E, implying this included the partner
- Appearing remorseful
- Creating an impression of the domestic violence being a 'one off'
- He had already been to A&E and Crisis, and been referred to children's social care to look at any safeguarding risk- so the impression gained was one of significant agency involvement already
- The previous point contributed to the need for a police referral not becoming a thought

3.31 The learning points are:

- NAViGO need to ensure staff have time to explore prior records when making an assessment

- Even if a colleague has undertaken a recent assessment, staff should be alert to the implications of new information they receive
- Staff hearing of injuries caused to a third party should report that to the police, unless certain they are involved already
- Supervisors should be aware that verbal reports from supervisees might be selective and should see the full assessment where there is risk to others, especially children
- Assessments, including those by PWPs, should have a clear narrative assessment or risks
- Think Parent-Think Child- Think Family

3.32 **Initial Assessment (IA) by Children's Social Care (CSC):** Both the CSC submission to the LSCB and this SCR identified weaknesses in the assessment and its process, and it is important that CSC examine their current practices to ensure such assessments, if not a one off, have improved. But it is important to note that this does not necessarily imply that a better assessment would have led to action which would have prevented the injuries. However, whether or not it made a difference, there is a lot to learn from this part of the case history. When looking at the comments below it should be borne in mind that the social worker had completed one week of post qualification practice, and had no prior experience of statutory social work., it was one of the first assessments the social worker had done,. It was the social worker's first case of domestic violence so no prior experience of assessing it.

3.33 Ofsted's safeguarding and looked after children inspection, published June 2012 (8 months before the assessment concerned) asked for 'immediate action' to 'ensure managers in referral and assessment services record on file clear management directions as to the level of assessment to be undertaken, the purpose of assessment, checks to be undertaken and the risk and protective factors that should be addressed' This was done in this case.

3.34 It also said the quality of assessments, decision making and planning was inconsistent and that In some cases Ofsted saw assessments that did not fully consider or record a child's situation or provide a good enough exploration of their family functioning. It added that analysis was not always robust and at times appeared superficial. It is possible therefore that the weakness in this assessment of the R family reflected an underlying problem within CSC at the time rather than individual responsibility. This family assessment was similar to that Ofsted had seen eight months before. It also showed in this case the inadequate checks with other agencies that Ofsted described in 2010-11. Each area of weakness in the assessment is discussed below and appropriate learning points raised for current consideration.

- CSC should assess the degree to which this case represented a pattern or an isolated illustration

3.35 It should be noted that the duty Principal Social Worker's written description of the level of work to be undertaken clearly noted the key points and had a helpful guide on checks to be done. It did not though suggest contacting the Children's Centre, NAViGO or GPs.

3.36 *Speed of Response:* The father had described a potentially fatal assault. There was no evidence that police knew or had attended, yet CSC did not visit the home for 4 days after referral, nor is there a CSC record of checks with any other agency to see if they knew mother and child were safe. (The Health visitor does note a call from CSC on the second day, but the health visitor would not have known about the family's current safety).The CSC out of hours worker receiving the call from the Crisis team noted that the grandmother would have T that night- but that does not necessarily mean T or mother were safe and unhurt. The social worker given the case does not recall that it was allocated with any sense of urgency, although guidance was given on how to address the assessment.

- Agencies should not assume victims or potential victims are safe especially on the word of perpetrators or a perpetrator's relatives
- CSC in similar situations should takes steps to ensure the child's immediate safety

3.37 *Seeing mother alone:* Given the very serious description of the assault, it should have been priority to see mother alone as by its very nature domestic abuse is likely to close down open communication with professionals To take until the third home visit before a lone interview minimised the chance of anything open being said. There is no record of the mother being asked about whether she was hurt/injured. The mother gave the social worker no indication that she had been hurt.

- Staff assessing safety in families where there is domestic abuse should say from the start that they are required to see parties alone
- The victim should be asked about the impact of the abuse

3.38 *Not consulting other agencies* Even the CSC submission to this Review said there was a multiagency assessment, but there is no evidence of this. It is possible that because it is common-sense to consult there was an assumption that it there were multiagency checks - but this needs to be checked and not assumed. In this case, there was no contact with either GP practice, the Children's Centre, and only a call with the health visitor 3 days before meeting the mother alone. The mother's/children's GP did not know any assessment was even being done, or indeed the case was open at all until the letter saying the case was closed. The father's GP was never contacted. The supervisor in this case told the Review that contact with health visitors was assumed to retrieve GP information. This is not an accurate assumption and needs to be checked clearly with the health visitor. (In any case the health visitor would have had no connection with the father's GP). The Children's Centre did not know, other than seeing the family on a list of open cases. The record of the decision to do an IA required checks 'with mental health services

and the referrer' - but there is no evidence this was done. Working Together 2010[2] the then statutory national guidance required the involvement and obtaining relevant information from professionals in contact with the family. There is no evidence that any other agency was invited to the closure meeting (as is procedurally required).

3.39 The IA summary says 'no other agencies have any concerns' – yet only one was ever spoken to, the father was not attending mental health services, and the Crisis assessment was father alone and not family

- Assessors must make inquiries of professionals involved in the family
- Supervisors should not assume multiagency checks have been made but be assured of this when signing off assessments
- There should be no automatic assumption that communicating with a health visitor leads to information held by GPs
- It is of minimal use to tell another agency a case is closed, without explaining why it was open, or better still letting them know an assessment is taking place and involving them in it

3.40 *Not consulting wider family:* Apart from one failed phone call to the paternal grandmother there is no record of any contact with the grandparents other than the call on the day of the referral when the grandmother said things were calm. The IA implied the grandparents were supportive, but the mother did not want her own mother to be contacted. (The maternal grandmother never knew the domestic abuse incident took place until after V's injuries nearly a year later). The IA said both sets of grandparents were supportive.

- Assessments about child safety cannot assume that parental report of grandparent support is accurate
- If support from relatives is deemed a protective factor in assessing no risk, there must be some evidence of this

3.41 *Rush to judgement:* Initial Assessments should be undertaken with an open mind. In this case, according to the health visitor, the social worker said she was told the health visitor the case would be recommended for closure ---- before the mother had even been seen alone, and before discussion with her supervisor. This suggests that the abuse incident was not seen that seriously and that conclusions could be reached without completing the assessment. Neither was correct. The social worker thinks it more likely that she said that from work to date it was looking like closure.

- Assessors should not convey conclusions on incomplete work – this can give false assurance to the recipient

[2] 'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children' HM Gov 2010

3.42 *Timeliness:* IA's had to be completed in 10 days. The record of the completed IA is dated on the deadline, although a supervision note of that day says 'IA to be completed'. As seen above, after the visit to the mother on the day the assessment is dated, the family had no contact at all for 46 days- either to check how things were going, or to implement the closure. It was good that the supervisor spotted the gap and required a home visit to meet the child in need visit frequency, although with such an inexperienced worker one would have hoped that the process of the case would have been spotted earlier. The formal closure meeting was another week later. The SCR was told there was 28 days to arrange a closure meeting- but even if that is appropriate, it is unreasonable for families to be left in the dark for nearly 2 months on something so important.

- CSC needs to have procedures requiring families to know the outcome of their assessment promptly
- Supervisors should agree the process of a case after a closure decision is confirmed in supervision

3.43 *Assessment Quality:* It is well known that some families or individuals can be convincing or engender sympathy, so taking assurances from parents without sufficient evidence should not be a surprise. This is why the supervision and management process is so important. It is of course difficult to read the IA now without hindsight, but this SCR has tried to assess the IA by what was known at the time. There was no evidence to support the following, or self-report proved inaccurate. IA statement in italics.

- '*Dad is willing to undertake any intervention required and is actively seeking support for his anger'*. He had not accessed this by the time the assessment was completed or by the official closure two months later. CSC even recorded that he found his one visit to Open Minds as 'not very good'
- '*The family have strong links to both sides of the extended family.. are a source of support'* Not fully evidenced
- '*Parents both state (they) "have accessed services to get* help". Only father had been once to a service he should not have gone to
- '*Parents need to access support services to be able to protect T.* See above, neither was accessing services at the point of the closure meeting
- "*Mother says she will call her parents if future abuse*. She never told her parents anything
- "*Mother will engage with the Women's Centre".* She had not done so by closure and never did
- *Concerns re mother's ability to protect T are minimal due to her stating that she will in future call the police…'* The 'due to' is a non-sequitur. It does not follow as it implies the next bad event will have happened before help is sought
- *'Father received support from Open Door and Open Minds after his discharge from hospital'.* He never went to Open Door
- *Concerns re fathers mental health and the domestic violence incident impacting on T's developmental growth and emotional /physical well-being are also now*

minimal as father is accessing support services for anger management and counselling for stress and anxiety'. He wasn't, and there was no process to monitor if he was actually taking these apparently protective steps

- *'Mother and father have the ability and support network in place so that they are able to protect T from harm'.* The word 'ability' is not demonstrated in any way- and in fact their inability to access help was clear at the closure meeting 7 weeks after the conclusion was reached
- In the "case synopsis" written a week after the closure visit it said '*both grandparents took father to hospital'.* It was the baby's grandfather and uncle

3.44 The assessment makes no reference to father going to A&E. There is nothing in the assessment or case notes about the parental relationship and the circumstances in which violence did or could occur. Although the assessment seems to be assuming the violence was a one off there was no evidence for this- only a guess. The IA makes no reference to mother's new pregnancy as that was only discovered at the closure meeting 7 weeks after the IA was completed, and no update was added. (CSC say updates are made in case notes, and the assessment itself is not amended). Maternity services were rightly informed of the reasons for CSC involvement.

3.45 The possible cause for the assessor's naivety are discussed later looking at inexperience and at overarching themes such as undue optimism, limited challenge etc. . There was an opportunity for this to be drawn out in supervision, and the supervisor did make sure he reviewed the assessment, instructed the additional visit and did go with the assessor on the closure visit. The problem was that the supervisor accepted the assessor's account of parental assurances without seeking the evidence, or asking the 'but how do you know' questions about the worker's conclusions. The learning points below may seem obvious but they are very frequently overlooked with convincing parents.

- If seeking help is fundamental to an assessment of low/no risk there must be evidence of that help being taken up
- Cases should not be closed in the face of evidence that support is not being accessed
- Especially where there is domestic violence the victims assurances cannot be taken at face value
- Assessments of child safety from domestic violence cannot be complete without some understanding of the parental dynamic
- Prior violence is a good predictor of future violence so assessments that it is a 'one off' (together with the false assurance this might give) are unwise
- Descriptions of violence that describe murderous intent, such as attempted strangulation, cannot be assumed to be of little consequence especially when there is no evidence of any change in the issues allegedly causing the perpetrator stress

3.46 *The impact of inexperience/workload pressure* In discussing this case with the Review and looking at the case papers, the social worker, now 19 months more experienced, could quickly identify where the assessment 'had glaring holes', and could also identify personal learning . Simply discovering how to do ones first assessments, with no experience of statutory work before, is hard and the worker said everything was taking a long time to do while processes were learned. Dealing with families where there is violence is difficult work. Learning to challenge self-report is something even seasoned professionals often struggle with. Knowing how to weigh up the safety of a child in a family with domestic violence is hard if you have never done it before. In the opinion of the Review, it would have been surprising if the worker had managed to do a good assessment without the most rigorous and close supervision.

3.47 The social worker said that in the first week of practice a case involving a suicidal teenager, a domestic abuse (non-violent) and a neglect case had already been given, and the caseload had got to 12 within 6 working days of starting practice. The worker described the team as having high turnover, low morale, and heavy workloads including for supervisors. Work, the social worker said, started getting behind straight away. Later she said she spoke to her supervisor about this and believing it was unsafe, and the supervisor emailed a senior manager about this. Another senior manager told the Review that the problem was not staffing up to budget, but that the increase of referrals was outstripping the staff capacity.

3.48 With very robust supervision the weaknesses in the assessment could have been challenged and the worker helped to do a more thorough job. It is likely that the high caseloads held by front line staff would make it difficult for supervisors have sufficient time to supervise in sufficient detail.

3.49 The social worker was on the government backed scheme. The Assessed and Supported Year in Employment (ASYE) which helps newly qualified social workers (NQSWs) to develop their skills, knowledge and capability and strengthen their professional confidence. NEL is one of the authorities which uses this scheme. It provides new workers with access to regular and focused support during their first year of employment. The worker thought that the scheme "should have been another line of defence for myself and service users" (the line manager should of course be the main source of development help) but did not feel there was sufficient capacity to provide the necessary degree of support The Review was told that the support person only worked two days a week and had nearly 30 newly qualified social workers to oversee. The social worker says there was an initial very brief meeting with the ASYE supporter, followed by a three month review which actually occurred after five months due to availability of staff - lasting 'around 5 minutes and was held in a public part of the office…there were no other meetings where arranged due to availability of the supporter and myself and external pressures'.

3.50 Whilst a better assessment may still have led to no further action by CSC, there is still much learning from the experience in this case.

- Newly qualified workers, especially if without any statutory experience, need protection from cases which may be beyond their current skill or experience and …
- …where they are given stretching cases must be subject to detailed supervision
- The council need to ensure the ASYE scheme runs effectively
- New workers are especially vulnerable to undue optimism and lack of challenge especially when parents appear compliant

3.51 **The pregnancy with V**: The author of the CSC analysis of the assessment, provided to assist the SCR, concluded that the increased stress factors post the pregnancy and increased family size 'could have been explored more fully' in the IA and that it could be argued that it should have been moved to a Core Assessment .

3.52 With regard to other agencies, other than points already made about the mother's Practice not being approached by any other agency, there is little to learn from the revelation of mother's second pregnancy. Her GP knew nothing to regard the request for termination as out of the ordinary. Mother did not reveal the recent violence or CSC assessment to the GP.

- A new pregnancy in the home were there has been domestic violence should be regarded as a major area to be assessed, rather than just acknowledging parental 'happiness'

3.53 **The blood shot eyes:** One was seen by a health visitor before the V's admission with pneumonia, the other by a paediatric nurse and doctor. None knew of the bruising to T, or that V's rib fractures had probably already occurred and the paediatric staff had no knowledge of the domestic violence. The fact that neither eye was described clearly in notes or drawn, and the medical view not recorded at all, means it is hard now to consider what the cause was. Although clinical staff will know that red marks or areas of the eye can indicate trauma such as shaking or throttling, this was not something that sprung to mind for the two nurses seen by the Review. The health visitor knew about the paternal violence but had formed an impression from low key reports from CSC that it was of no great consequence. The hindsight lesson is that such signs should be properly recorded as good practice, which at least would ensure some sort of history should there be future problems.

3.54 Nice Guidance[3] on the signs of physical injury in children has only one relevant sentence in 43 pages on eye trauma but it is an important one. "Suspect child maltreatment if a child has retinal haemorrhages or injury to the eye in the absence of major confirmed accidental trauma or a known medical explanation, including birth-related causes". The SCR has been advised that the need for an explanation is

[3] **NICE clinical guideline 89:** When to suspect child maltreatment
Issued: July 2009 last modified: March 2013

the key (there are a number of innocent causes) but in the absence of a clear cause further inquiries should be made. This is not a call to over react to every mark on a baby's eye but to treat it as, say, bruising where (especially on non-mobile babies) there needs to be a credible explanation. The medical expert at the Finding of Fact, from descriptions of the red marks and the absence of any confirmation of eye infection thought they had a traumatic (shaking) origin.

- Clinical staff should be reminded of the need to establish a cause for reddened eyes in babies and in the absence of such a cause make further inquiries
- Blood shot eyes should be drawn in clinical notes

3.55 **The admission with pneumonia and the chest X-ray** In terms of the baby's presentation at A&E, and then the GP out of hour's service- leading to admission there are no major learning points. Many families use A&E instead of the local GP practice, and the fact that the father mentioned finding blood in V's throat was not seen as exceptional due to the respiratory tract infection. The baby was admitted. The x ray confirmed pneumonia, appropriate medication was given. There was nothing to alert staff and the mother, the SCR was told, was very nice to staff and gave them a present.

3.56 The X-ray was seen by a consultant paediatrician and a staff grade doctor. Neither saw fractures, nor found it easy to see them when shown them as part of the Review. Para 2.33 noted that a specialist paediatric radiologist said the fractures "may be less evident" to a non-specialist consultant radiologist' .and so they would be even less evident to a non-radiologist. The Review found that some paediatricians found it hard to see some of the fractures even when pointed out. An A&E doctor who was shown the x ray during the Review could not see all the fractures even when knowing where to look for them.

3.57 The medical expert at the Finding of Fact said that a radiologist should see the fractures. The Chair of the British Society of Paediatric Radiology who was consulted by the author, said that where there was no suspicion of NAI, and the x-ray was being examined for other reasons, she would not expect a paediatrician to see the fractures in the first x ray. She would have expected a paediatric radiologist to have seen the fractures, but at the time of this x-ray there was no process in place for this to happen at the Trust. She would have expected the 4Ways Healthcare consultant to have seen them, but thought that the fact that that consultant did not see them supported the case for wider access to specialist paediatric radiologists. As noted in 2.33 the paediatric consultant who first saw the chest x ray said they would be 'less evident' to a no specialist radiologist, and would not expect them to have been seen. The conclusion of this SCR ,taking into account all views heard is that a non-specialist radiologist should see them but in practice may not, especially when looking at a routine x ray and asked for a view on something else with no recorded suspicion.

3.58 The analysis below of the delay in reporting does not necessarily imply that the delay made any difference to this case. This particular X-ray was not seen by a hospital consultant radiologist after the paediatric view as there had been longstanding gaps in the consultant radiologist establishment. The Trust's Diagnostic Imaging Reporting Policy (approved 18.4.13) requires 90% of routine reports to be done in 7 days, including bank holidays and weekends. However, backlogs were not uncommon and a private external reporting agency 4Ways Healthcare was engaged to assist the Trust with this. 17 days after the X-ray was taken, 4Ways was contacted about 600 X-rays including V's chest X-ray, and the Trust agreed to consultant reports within a further 11 days. (The deadline proved to be 6 days after V's admission with the head injuries). Had the report come on the last day of the deadline, it would have been 28 days after the X ray was taken. Clearly policy targets were not being met.

3.59 When V was admitted badly injured the hospital called 4Ways for the awaited report, found it had been done, but not yet sent back to the Trust. The report did not identify any rib fractures. 4Ways say it was likely that their reporting consultant did not examine the x-ray further having answered the presenting question as to whether there was an infection. Two consultant paediatricians and a 4Ways consultant radiologist had seen the X-ray but not the fractures.

3.60 The Northern Lincolnshire and Goole NHS Foundation Trust conducted a serious incident (SI) review into the incident. The review was undertaken using root-cause analysis, and identified a number of findings, leading to a seven-point action plan for improvement. Since three weeks after the baby's injuries, routine paediatric X-rays are now seen weekly by specialist paediatric radiologists from Sheffield Children's Hospital, which addresses both the speed of reporting and the necessary expertise. X rays that need an urgent paediatric radiology view can be seen by Sheffield more quickly that the weekly review. However X rays needing to be seen urgently are read by NLAG's general radiologists only, and do not have the paediatric radiology check. This should be considered. There is also a tighter system for identifying any x-ray reporting backlog within the Trust. The shortfall in Trust radiologists is on the NLaG Trust Board's Risk Register, and progress monitored monthly.

3.61 Given that not seeing the rib fractures (whether they could be seen by a non-specialist doctor or not) meant that later injuries were not prevented, there are learning points from this episode.

- Delays in reporting routine x-rays can have serious consequences.
- The Trust should consider if weekly review of routine X-rays by a paediatric radiologist is an appropriate wait, and also consider a paediatric radiology check of X-rays seen urgently by NLAG radiologists.
- Trusts need to be aware that paediatricians, and even non specialist radiologists, may not see less obvious rib fractures so should have appropriate access to paediatric radiology.

- Good practice is to study a whole X-ray and not just look to answer the presenting question.
- It may also be useful to look first without knowing the presenting question as that can narrow the focus.

3.62 **V's continuing illness, and weight***:* It is only in hindsight, and the later knowledge that by this point V had been injured at least twice, that V's ongoing illness after being discharged from hospital might lead to thoughts of other than illness. There are no learning points from that as such. However the weight loss between the two health visitors weighing's from the mid-point 50th centile percentile at 4 weeks old to the 9th centile at 9.5 weeks does need consideration. There is no comment or explanation in the notes about the lack of growth, and whilst there was still no obvious reason to suspect abuse, it would have been useful to indicate in the notes that such weight deterioration had been noticed and a presumed cause. To be fair, the hospital discharge summary which the health visitor received also said V's weight was at the 9th centile at 7.5 weeks so it may well have been assumed that this had been considered at consultant level. Hospital records would have shown that V's weight at birth was at the 50th centile level.

- It would be good practice to provide some explanation for significant weight loss in clinical notes, and to have a monitoring plan.

3.63 **Domestic abuse.** In this case several agencies did not refer to the police when told of abuse with an apparently fatal intent. A&E did not mention the domestic abuse when telling the father's GP about his visit to A&E. The Children's Centre that family attended, and the mother and children's GP were never told about the violent incident. There is a recommendation on this is section 5. It is very important that the LSCB makes clear its expectations of necessary intra and interagency communication and referral when there are cases of domestic abuse where there are children.

3.64 **Overarching Themes:** The themes here are not new and appear in many if not most SCRs. However they are fundamental to the identification and management of safeguarding concerns and can be illustrated from this case. The R family was not thought to be abusive but one can still learn from themes in this case.

- *A rule of optimism.* (Described in Brandon et al[4], as a "common and previously identified theme" in their biennial review of learning from SCRs).
- *Failure to revise judgements*. (Fish, Munro and Bairstow[5], say that 'One of the most common, problematic tendencies in human cognition … is our failure to

[4] 'New learning from serious case reviews: a two year report for 2009-2011' Brandon, H. et al. Department for Education, 2012

[5] Fish, S., Munro, E. and Bairstow, S. (2008) *Learning together to safeguard children: developing a multi-agency systems approach for case reviews*, London: Social Care Institute for Excellence.

review judgements and plans – once we have formed a view on what is going on, we often fail to notice or to dismiss evidence that challenges that picture').

- *Lack of challenge* of parents and fellow professionals (Brandon et al[6], describe numerous lessons from lack of challenge and critical thinking in SCRs).

3.65 The rule of optimism is where professionals wrongly assume positive outcomes for children. It rationalises evidence that contradicts progress – so even where the facts show that risk is on-going or increasing, professionals tell themselves that the opposite is true. The current national guidance, Working Together 2013[7], puts it well. "A desire to think best of adults and to hope they can overcome their difficulties should not trump the need to rescue children from …..abusive homes". The R home was not thought to be abusive but the principle is still relevant.

3.66 Related to this is a feature that E. Munro[8] describes as, "The single most pervasive bias in human reasoning is that people like to hold on to their beliefs". This leads to a failure to revise judgements whatever the evidence.

3.67 The third feature of these dynamics is a lack of challenge – both professional to parent and professional to professional. A dictionary definition of challenge includes 'summons to engage in a contest' and 'demand an explanation'. Often it can be the fear of coming over as engaging in a contest that stops professionals demanding explanations. This can apply to work with families (such as not challenging parents too much in case it lessens their motivation or impacts on relationships with staff). Also, it can be hard for any worker to challenge parents when certain of their answers might lead very threatening processes like a child abuse investigation.

3.68 Why do these overarching themes happen? One answer is that this is simply what happens in child care work. There is always a tendency or wish to be optimistic about making things better, to work in partnership with parents, and produce change, and to see maintaining the family as the first objective. This has been seen, in many SCRs, around a sense of sympathy for parents, giving them every chance, or a last chance and so on, and this had led to errors due to insufficient child focus as evidence of continuing or increasing risk is overlooked, as views become unchanging, and over optimistic, and challenge is held back.

3.69 There are a number of illustrations of these overarching themes:

- Assuming that the bruising to the baby T was as described by the parent and doing nothing more than recording a partial explanation

[6] op.cit

[7] Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children' HM Gov March 2013

[8] Munro, E. (2008) 'Improving reasoning in supervision', *Social work now*, 40 (August), 6.

- Assuming that the mother must not be injured after the father admitted trying to kill her
- Assuming that T did not need speedy assessment as a relative of the perpetrator implied T (and mother) were okay
- No one informing the police of the domestic violence in the home of a young baby
- Either not noticing or not giving sufficient weight to the additional material the second mental health assessment learned
- Not feeling the need to make checks with other agencies (bar one) when assessing the safety of T
- Completing an initial social work assessment based on unverified self- report- and not changing the conclusion when there was clear evidence many weeks later of self-reported commitments not being complied with ……and
- … not revising any part of the assessment when there was a second pregnancy very soon after the violence
- Assuming the violence was a one off without any real evidence.
- When the case was closed and records all concluded that, in effect there was not anything to worry about- nobody said words to the effect of 'hang on.. have you read what he *actually* said he did or tried to do? That was very serious'
- Not considering prior information of domestic abuse within the family when seeing an unexplained bloodshot eye

3.70 The bullets above are based on a belief that everything will be all right, that things are probably not as bad as they might seem, and that expressing a willingness to change is the same as actually changing. They are based on a good motive of wanting things to be better, and to show faith that parents want things to be better.

3.71 The tendencies described above need management. David Jones, the vice chair of the English Association of Independent LSCB Chairs said[9] "If you need to help people as a social worker you have to be optimistic, but you also have to be realistic, which means you have to hold the possibility that people are playing games with you, or there is deception going on. Holding that together is really quite complicated which is why it is essential to have supervision. The key thing is having someone outside the situation who can talk it through and take another perspective". The principle of having someone to talk to applies to other professions whether 'supervision' is part of their arrangements or not, and the LSCB should ask its members to ensure that there are good arrangements for all staff to have the opportunity to discuss cases like this, and their feelings about them, with someone more distant from the direct management of the case. This needs to include discussing potentially worrying marks on babies with someone else.

3.72 There is a further overarching theme that the staff group wanted emphasised, which is the need to 'think family' when dealing with adults. This case showed how easily this can be overlooked.

[9] Professional Social Work (Nov 2013)

3.73 The summary learning points are:

- The need for all agencies to expect there to be a tendency towards optimism, fixed views, and insufficient challenge in child protection cases and...
- … to ensure that there are sufficiently robust processes of supervision and case review in place
- Verbal compliance is not the same as active compliance, and that seeking evidence is not confrontational but expected professional behaviour.
- Superficial compliance can mask resistance to accepting help
- The need for 'challenge' to be accepted part of professional and agency culture, and modelled by senior staff
- The need for a sceptical and challenging mind-set, especially around any suggestion of children being at risk

4 Conclusion

4.1 This is not an easy case to review as in some respects the family did not stand out, related well to professionals and helping services through the birth and beyond of two children. When there was domestic violence both parents indicated they would do the right thing, including getting specific help with anger and stress or about domestic abuse from the Women's Centre, and indeed father owned up to what he had done when it could have been hidden (although this deflected staff from the severity of the incident).

4.2 Paragraphs 2.43-54 looked at whether the injuries could have been prevented. The conclusion was that other than if rib fractures had been seen on the first x ray, there is no certainty that the injuries could have been prevented. The summary is reproduced here, showing that 'might' is the operative word when looking at whether different practice would have made a difference.

4.3 It is more a matter of 'increasing the chance' of some different thinking. For example:

- Had the bruising to the 11 week old T been reported to CSC (and there was in NEL no formal requirement for this) then it might have affected the CSC assessment of risk
- Had anyone made immediate face to face checks on mother's safety, or the incident been referred to the Police, the extent of the assault might have been clear and might have led to a more concerned diagnosis of father
- Had the incident been reported to the Police, this might have led to action against father, or at the least some additional assessment of risk – which may have led to the incident being seen more seriously.
- Had the second mental health assessment realised it was hearing new information from the father it might have led to a rethink about the risks
- Had CSC checked with both GPs when it assessed risks it might have led to more doubt about the assurances CSC was receiving- had the bruising to T been identified from the records.
- Had the health visitor not been given the impression that the domestic violence was of no great concern, it might have led to more thought about the eye
- Had the hospital known about any of the above (and there was little reason for them to do so) the red eye might have caused more concern, and the x ray looked at more closely. (Even if it had, fractures may not have been seen)
- Depending on which sort of doctor saw the x-ray and how quickly, the fractures might have been identified in time for protective action
- Had the x- ray have been reported in the normal timescale by a consultant radiologist , the fractures might have been seen and protection instigated
- Had the x ray been seen before the major injuries by a paediatric radiologist they would have been identified and it would have led to formal inquiries and protective action

4.4 What this SCR shows is not inexplicable errors directly linked with the later injuries, but that practice could have been better, with better practice leading to a greater chance of at least a different assessment of risk. Also, because the family seemed normal to many, or of low risk to others, that is no reason for not following or accepting other than the best practice.

4.5 However, there are enough examples in this Review of practice which did not met the best standards for there to be major learning across agencies, regardless of the extent to which a difference could have been made in this case.

4.6 The Learning Points listed in the Review (and collated in Appendix1) offer pointers of agency and professional consideration. Many may seem obvious but all have come from what happened in this case.

5 Recommendations

5.1 The SCR recommendations are around a number of key areas which cross agencies. *They are in addition to the 'learning points' (collated in App 1).* The recommendations are all addressed to the Safeguarding Board for work with member agencies, and are there to assist the Board have the necessary degree of ongoing assurance about areas highlighted in this Review.

5.2 The LSCB has the responsibility for being assured progress is made in these areas

i. The LSCB should consider the introduction of a policy of mandatory reporting for bruises on non-mobile babies, and monitor its implementation.

ii. The LSCB should commission a further update report from NLAG on radiology capacity, the ability of non-specialist radiologists to identify signs of fractures to children, and progress with the new scheme of regular access to paediatric radiology

iii. The LSCB should seek assurance from member agencies that staffing in key staffing groups is at a level to ensure quality safeguarding work, and that includes adequate support for newly qualified staff.

iv. Training around domestic violence should be reviewed to ensure that staff are aware when and where to report it, the significance of attempted strangulation, and that there are not naïve assumptions about violence being a 'one off'

v. The LSCB should be satisfied that expectations of staff around intra and interagency communication on domestic abuse where there are children are clear

vi. The LSCB should seek assurance from its members that the principal of 'think family' when dealing with adults is fully embedded

vii. The LSCB, being aware of the risks, should ask for a review of the inter connectivity of primary/community care client/patient databases to maximise the ease of sharing information

viii. The LSCB should work with member agencies on a culture of greater challenge to support assessments of risk so that staff have greater confidence to challenge for evidence, for example in the face of apparently compliant self-report.

ix. The LSCB should seek assurance that assessments of risk to children are done with full multiagency consultation

5.3 The SCR was concluded sometime before publication was possible due to the criminal proceedings not having concluded. Appendix 3 provides an update from the LSCB on progress on the recommendations.

APPENDIX 1 COLLATED LEARNING POINTS

Introduction: The learning points collated here come from the Review. They provide more detailed guidance or suggestions than in the formal recommendations. They are for Board and agency consideration, and do not imply that each represents something not yet addressed. They can be tested against current practice and key lessons prioritised for action.

From the bruising to the first child

- All staff who examine non mobile babies must be aware of the significance of marks and seek an explanation
- That explanation should not be accepted by one worker alone, and should be discussed with a colleague, manager or safeguarding advisor
- Bruises on non-mobile babies should be medically examined
- Such marks should always be drawn , and described in detail in notes (Practices need to make arrangements for drawings to be made alongside the electronic record)
- Consideration should be given to how GP practices ensure significant information is available to Health Visiting services

From the attendance at A&E following the domestic violence

- A&E staff when faced with domestic abuse perpetrators or victims must inquire about the presence of children, and take necessary steps to ensure someone checks their safety.
- If a crime seems to have been committed in the context of domestic abuse the Police should be informed.
- Similarly, if an act of some severity is reported and there is no evidence of the victim's well-being, steps should be taken to ensure the victim is checked (e.g. police).
- A&E should not think that referring on to mental health services necessarily discharges their duties as in the two bullets above.
- It is always important that staff working with adults 'think family'.
- When the assessment is about mental well- being and especially in a family context there should be at least an attempt to see the patient alone.
- When there is an assessment that involves (or should involve) risks to others, it would be good practice for staff who assess a patient separately to discuss their mutual findings to ensure the whole picture is clear.
- A&E discharge letters must be in sufficient detail to properly inform recipient professionals.

From the mental health assessments

- NAViGO should consider the implications of Crisis team staff working alone, and the degree to which this can limit proper inquiry
- As with A&E, seeing patients only with relatives, especially when risk to self or others is involved, can risk a partial or influenced picture being formed

- If a patient indicates they have informed the police, if such a referral is appropriate it should be verified
- The implications of not following up the recommended treatment should be identified in the assessment

- NAViGO need to ensure staff have time to explore prior records when making an assessment.
- Even if a colleague has undertaken a recent assessment, staff should be alert to the implications of new information they receive.
- Staff hearing of injuries caused to a third party should report that to the police, unless certain they are involved already.
- Supervisors should be aware that verbal reports from supervisees might be selective and should see the full assessment where there is risk to others, especially children
- Assessments, including those by PWPs, should have a clear narrative assessment or risks
- Think Parent-Think Child- Think Family

From the Initial Assessment by Children's Social Care

- CSC should assess the degree to which this case represented a pattern or
- an isolated illustration
- Agencies should not assume victims or potential victims are safe especially on the word of perpetrators or a perpetrator's relatives
- CSC in similar situations should takes steps to ensure the child's immediate safety
- Staff assessing safety in families where there is domestic abuse should say from the start that they are required to see parties alone
- The victim should be asked about the impact of the abuse
- Assessors must make inquiries of professionals involved in the family
- Supervisors should not assume multiagency checks have been made but be assured of this when signing off assessments
- There should be no automatic assumption that communicating with a health visitor leads to information held by GPs
- It is of minimal use to tell another agency a case is closed, without explaining why it was open, or better still letting them know an assessment is taking place and involving them in it.
- Assessments about child safety cannot assume that parental report of grandparent support is accurate
- If support from relatives is deemed a protective factor in assessing no risk, there must be some evidence of this
- Assessors should not convey conclusions on incomplete work – this can give false assurance to the recipient
- CSC needs to have procedures requiring families to know the outcome of their assessment promptly

- Supervisors should agree the process of a case after a closure decision is confirmed in supervision
- If seeking help is fundamental to an assessment of low/no risk there must be evidence of that help being taken up
- Cases should not be closed in the face of evidence that support is not being accessed
- Especially where there is domestic violence the victim's assurances cannot be taken at face value
- Assessments of child safety from domestic violence cannot be complete without some understanding of the parental dynamic
- Prior violence is a good predictor of future violence so assessments that it is a 'one off' (together with the false assurance this might give) are unwise
- Descriptions of violence that describe murderous intent, such as attempted strangulation, cannot be assumed to be of little consequence especially when there is no evidence of any change in the issues allegedly causing the perpetrator stress
- Newly qualified workers, especially if without any statutory experience, need protection from cases which may be beyond their current skill or experience and …
- …Where they are given stretching cases must be subject to detailed supervision
- The Council needs to be assured that the ASYE scheme runs effectively
- New workers are especially vulnerable to undue optimism and lack of challenge especially when parents appear compliant

From the pregnancy after the domestic violence

- A new pregnancy in the home were there has been domestic violence should be regarded as a major area to be assessed, rather than just acknowledging parental 'happiness'

From the bloodshot eyes

- Clinical staff should be reminded of the need to establish a cause for reddened eyes in babies and in the absence of such a cause make further inquiries
- Blood shot eyes should be drawn in clinical notes

From the rib fractures not being seen on the first x-ray

- Delays in reporting routine x-rays can have serious consequences
- The Trust should consider if weekly review of routine x-rays by a paediatric radiologist is an appropriate wait and also consider a paediatric radiology check of X-rays seen urgently by NLAG radiologists
- Trusts need to be aware that paediatricians, and even non specialist radiologists, may not see less obvious rib fractures so should have appropriate access to paediatric radiology
- Good practice is to study a whole x-ray and not just look to answer the presenting question.

- It may also be useful to look first without knowing the presenting question as that can narrow the focus

From the weight loss

- It would be good practice to provide some explanation for significant weight loss in clinical notes, and to have a monitoring plan

From the overarching themes

- The need for all agencies to expect there to be a tendency towards optimism, fixed views, and insufficient challenge in child protection cases and...
- … to ensure that there are sufficiently robust processes of supervision and case review in place
- Verbal compliance is not the same as active compliance, and that seeking evidence is not confrontational but expected professional behaviour
- Superficial compliance can mask resistance to accepting help
- The need for ‘challenge’ to be accepted part of professional and agency culture, and modelled by senior staff
- The need for a sceptical and challenging mind-set, especially around any suggestion of children being at risk.

APPENDIX 2: AGENCY UPDATES ON PROGRES

Agencies were asked to provide a brief narrative in their own words on what is different since the injuries or as a result of learning from participation in the Review. The following were provided in October 2014 and updated to in June 2015 where further progress has been made.

North East Lincolnshire Council

(i) ***Children's Social Care***

The Multi Agency Safeguarding Hub (MASH) has been in operation since April 2013. The purpose of the MASH is to ensure timely sharing of information and intelligence, which will improve decision making at the point of referral into the children's safeguarding team. MASH is staffed by 5 Principal Social Workers, a Police DS, a health professional, a worker from Integrated Services and a Parenting Advisor with links to the Children's Centres. These workers are able to access their own data base of information, enabling speedy sharing of relevant history on the child and their family. We have also developed virtual links with housing, Fire and rescue service, Drug and Alcohol agencies and YPSS.

The Principal Social Worker in MASH is the key decision maker on all new referrals to the service. Extensive work has been undertaken in ensure that they clearly record on all referrals management directions as to the level of assessment required, the purpose of the assessment, checks that still need to be undertaken and the risks and protective factors that should be addressed by the social worker when completing the assessment.

We are also undertaking a series of visits to partner agencies, particularly focusing on adult services, to make additional virtual links to the MASH to ensure that referrals to CSC are timely and thorough and that there are key partners involved in the decision making of a case from referral through to closure. This is to strengthen our already strong links with partner agencies.

Allocation of cases from the MASH are made by the management team from the MASH and Children's Assessment and Safeguarding Service (CASS) on a daily basis. The CASS social worker remains with the case from the point of allocation to the point of closure, whether that is step down to CAF or universal service or through to adoption.

CASS has had a significant level of financial investment enabling us to employ additional social workers and managers over the last year. This has in turn significantly reduced caseloads for social workers across the service. Caseloads continue to decrease as social workers start with the service. We have now appointed against all posts and will be fully staffed with social workers in the near future.

We have developed a robust transfer process of cases where the worker is leaving the authority. Cases are identified for transfer prior to the worker leaving the authority and handover visits and case file audits are undertaken prior to all transfers. Cases are never left unallocated. Newly qualified workers have a protected case load and are provided with a through induction programme in their first 6 months. They are not allocated the first case until at least two weeks into employment and they are fully supported by their PSW, including joint visits, observations and regular supervision.

The Local Authority has a well-developed programme of support and continued training and development for newly qualified social workers.

Every social worker has a named PSW who is their supervisor. They have between 6 and 7 staff to supervise which is usual across LA's. We have a supervision framework in place which includes weekly supervision for the first 6 weeks for new staff members and then fortnightly after for the first 6 weeks.

The ASYE PSW is in a separate training role, who oversees the ASYE programme of training and support, and is in addition to their case supervision. The ASYE focuses on the professional development of the social worker and not the case supervision. The ASYE programme is very structured we offer a high level of "back to basics" training for social workers and bespoke specialist training. It is a very well structured and productive programme of support for ASYE. Social workers have also been able to access bespoke training on assessments and analysis. In addition to the LSCB Domestic Violence training that all social workers undertake as part of their induction, we will be commissioning bespoke training specifically for social workers in the area of Domestic Abuse.

On 3rd September 2014 we launched the use of the Single assessment. This gives a maximum of 45 working days for completion but with built in reviews of progress at 10 days and 25 working days. These reviews are undertaken by a manager. This ensures that assessments are thorough but remain timely to avoid drift and delay with clear managerial direction.

Our electronic social care system has been upgraded to include the new single assessment. The upgrade, although new to staff, is already enabling improved quality of recording in assessments and in the case files in general. Social workers have also been provided with social work guidance, using the Signs of Safety (SoS) framework, to assist them to meet the expectations of quality within their recording. QA Audits throughout the last year demonstrate that case file recording is improving within the service.

We began a 3 year implementation of the Signs of Safety Framework in January 2014. This approach is based on the use of Strength Based interview techniques, and draws upon techniques from Solution Focused Brief therapy (SFBT).It aims to work collaboratively and in partnership with families and children to conduct risk assessments and produce action plans for increasing safety and reducing risk and danger by focusing on strengths, resources and networks that the family have. Many studies have identified substantial benefits that the SoS approach delivers, and these

benefits form the over-arching objectives of what we aim to achieve through SoS implementation within North East Lincolnshire including:

Better outcomes for families:

- Increased safety and permanency
- Improved relationships between practitioners and families
- Increased family involvement in identifying solutions to improve safety for children
- Improved organisation, efficiency, and standardisation in children social care practices
- Increased practitioner clarity and decision-making
- Improvement in frontline staff morale
- Improved partnership-working and collaboration between child protection and other professionals
- Contribution to a longer-term reduction in the local Looked After Children population
- Reduction in the duration cases are open to Children's Social Care
- Improved identification, management and support for children and young people at risk of sexual exploitation
- Improved identification, management and support for children and young people at risk from domestic violence

(ii) *Child Health Service*

The Named Nurse, Safeguarding Children has, between March and June of 2014, delivered to each of the health visiting and school nursing teams a presentation, "Record Keeping, Report Writing and Statements" which aimed to deliver key messages about the importance and quality of record keeping and what constitutes a good report. 86% of staff have attended to date with further dates booked in order to deliver the same training before the end of 2014 to those who were unable to attend initial sessions and for the cohort of newly qualified health visitors who have recently taken up their posts.

Included within these sessions was a reminder to staff of the importance of identifying and recording significant events and the recording of any observed clinical symptoms which may have relevance to a child's health and development in the future. Staff were also reminded of their responsibility for sharing appropriate information with relevant professionals working with children and their families. A reminder has also been disseminated to all health visiting and school nursing team staff advising of the importance of sharing information with GP's where another electronic recording system is used and alerting GP's appropriately if entries are made within SystemOne.

This training has continued past the end of 2014 and has now incorporated those nursery nurses working within Children's Health Provision and has encouraged the need for nursery nurses to record their observations and analysis of contacts with

families and to seek three way safeguarding supervision with the case-holding health visitor where appropriate.

Level 3 Intercollegiate training in safeguarding children, delivered by the Safeguarding Children Health Team has recently been updated to incorporate messages from local and national serious cases so will reinforce the messages to health staff as given at the team events described. The impact of domestic violence and the potential vulnerability of very young babies is addressed in all levels of safeguarding children training delivered by the Safeguarding Children Health Team.

The Safeguarding Children Health Team have developed training for Routine Enquiry for all health visitors and nursery nurses (this is in 3 parts). Part 1 has recently been delivered to all staff, and is viewed as mandatory training with updates required every 3 years. Part 2 is the electronic recording of Routine Enquiry which is complete. Part 3 is the supportive literature which the team are currently working through. It is hoped that the literature and all health visitors offering 'routine enquiry' will be complete by Summer 2015.

Questionnaires are used to record core contacts for the Healthy Child Programme with ante-natal mothers and pre-school children on the SystmOne record. These have now been adapted to incorporate mandatory questions (Routine Enquiry) in relation to Domestic Violence and will be in use from the end of July 2015.

The Safeguarding Children Team are also hoping to develop a programme of training for school nurses in respect of identification and support of teenagers whom are in or suspected to be in an abusive relationship. It is envisaged that all of the school nurses will be trained by Summer 2016

The Named Nurse, Safeguarding Children has also undertaken a systematic audit and review of the standards of record keeping across the service and is currently preparing feedback sessions for staff to share her findings. Some individuals have been contacted as part of the process to discuss findings that required immediate attention and an action plan has been produced to address issues that affect the wider workforce. This includes an action within the safeguarding supervision process, to review the supervisee's standard of record keeping within the supervision session. The implementation of actions will be monitored and ensured by the Safeguarding Children Health Group which meets quarterly and has a separate, operational safeguarding group, which will ensure that operationally, issues raised from the audit are addressed.

Humberside Police

Humberside Police are committed to working with partner agencies in response to safeguarding concerns of children and young people. Humberside Police have seconded a Detective Sergeant to work alongside partner agencies within the Multi Agency Safeguarding Hub (MASH) in Grimsby. This role is supported by dedicated administrative support. The Officer ensures that effective information sharing is

undertaken, which facilitates a timely assessment of risk, vulnerability, harm reduction and the identification of early offer of help to meet safeguarding needs.

In responding to incidents of Domestic Abuse we follow a national framework of risk assessment, and work with partner agencies in addressing those cases of concern through information sharing, Multi Agency Risk Assessment Conferences (MARAC's) and referrals for children and young people.

NAViGO

All NAViGO's assessment and review paperwork prompts staff to explore what caring (and parenting) responsibilities the service user has, as well as any impact of adult issues on parenting capacity. This includes consideration of where service users may come into regular or significant contact with children, e.g. partner's children.

NAViGO has a new Lead for Safeguarding Children who is a Health Visitor, with a strong "Think Family Focus ". She is meeting with all teams to feedback learning from Serious Case Reviews and offer on-going support to Practitioners who are working with families. She has also offered additional LSCB Safeguarding Children Awareness training days to ensure all staff can attend in a timely manner. She has also set up regular sessions with the two other named Safeguarding Children's leads in NAViGO to see how practice can be continually improved. She is also attending several Safeguarding multi agency forums i.e. MACE, and the LSCB Health group.

The LSCB Parental Mental Health and its impact on children training, has been re-written and submitted to the LSCB, by the new Safeguarding children's lead, to be delivered when approved.

All staff have been reminded of the importance of this "thinking family" approach when undertaking mental health assessments. Work is on-going to ensure this is embedded in practice, via inclusion in Safeguarding Children training delivered in the organisation.

NAViGO have made links with the MASH and a meeting has been held to improve joint agency understanding and working. The new Safeguarding Lead is working to create a robust relationship with other agencies involved in Safeguarding children, especially Children's Social Care.

NAViGO have played a role in the creation of a new North East Lincolnshire Domestic Violence Pathway and Policy. Internally this has been shared with NAViGO's Acute Managers and with the Senior Management Team, it will be further disseminated to front line staff as part of the training plan.

GP Practices/Clinical Commissioning Group

As reflected in paragraph 3.5 of the report, the GP practice where the children (and mother) were registered now require all bruises on non-mobile babies be discussed with a GP. The Designated Nurse and Named GP for Safeguarding have shared the issues arising from this case with other GP practices to allow consideration of changes in individual practice policies.
The Designated Nurse and Named GP will be working within North East Lincolnshire Clinical Commissioning Group, and alongside NHS England (as commissioner of primary medical services) to explore appropriate responses across primary medical care settings to the other issues arising from the episode of bruising seen in the GP practice, i.e.

- How “drawings” of bruising patterns can be included on the different clinical Information Systems used,
- Robust practicable solutions for ensuring other key health professionals are aware of significant information held within different primary care clinical information systems.

The Named GP will also take a lead role in responding to this serious case review from a primary medical care perspective, and working with the Designated Professionals (as the statutory strategic professional leads for all health services in the locality) will ensure an integrated approach with other health services.

North Lincolnshire and Goole NHS Foundation Trust (NLaG)

Domestic violence update: NLaG provides training to all staff employed within the trust in relation to safeguarding children of which domestic violence is a key component. At the time of this incident A+E staff received safeguarding training at level 2. However, since the release of the new training plan in June 2014, staff are now required to attend training at level 3. Additionally cases of domestic violence are discussed in supervision sessions with all clinical staff to ensure that there is a greater understanding of domestic violence and the need to ‘do something’ whether or not children are involved. Attendance at safeguarding training and more recently supervision is recorded on the trusts electronic learning system which allows us to identify staff who are non-compliant and follow up as appropriate.

Staff are encouraged to contact the safeguarding team if they have concerns whilst the client is in A and E or they use the ‘safeguarding concerns diary’ to alert the safeguarding team to the fact that a domestic violence case has been through their department.

Within the training and supervision, the areas of think family and maintaining ownership of cases (following referral on) is discussed and reinforced.

The process of referring domestic violence cases into the Multi-Agency Risk Assessment Conference (MARAC) system has also been reinforced.

When clients are seen within the triage setting and there are concerns expressed there is an expectation that staff will have discussion with the professional who will next see the patient. This scenario is covered within the clinical supervision sessions held with A+E staff.

Discharge letter / GP letter update: Discharge letters from A+E are currently dependant on the information placed on the system by clinical staff. A project plan is in place and over the last few months work has begun to develop the system functionality / electronic record further which will allow for greater detail to be added to the GP discharge letter so that there is greater clarity with regards to reason for attendance and any follow up require. Work / training as also began with clinical staff to ensure that the quality of data added to the system is improved.

Children's X-ray: From the 6th February 2014, NLaG have developed a service agreement with Sheffield that a paediatric radiologist will attend Scunthorpe general hospital and review any non-urgent paediatric x-rays / scans weekly. This means that all non-urgent films are reviewed within 7 days as a maximum. Urgent films are reviewed by our own radiology team (in working hours) so that the reporting for urgent films is now available within hours of being taken. An x ray that is deemed to need urgent specialist paediatric radiology pinion can be seen by Sheffield paediatric radiologists.

APPENDIX 3: LSCB PROGRESS AGAINST RECOMMENDATIONS

The findings and recommendations from the R Family Serious Case Review were accepted in their entirety by the North East Lincolnshire LSCB in November 2014.

The Board had commissioned the LSCB Serious Case Review in order to develop and implement an action plan in response to the recommendations, to embed learning and to inform practice. Progress and impact against the action plan has been overseen by the LSCB's Leadership Board. In addition all agencies involved within the Serious Case Review have submitted regular reports to the SCR sub group as evidence of the extent to which learning points relevant to their organisations have been embedded.

i. <u>The LSCB should consider the introduction of a policy of mandatory reporting for bruises on non-mobile babies, and monitor its implementation.</u>

A Virtual Task and finish group was formed and a Northern Lincolnshire protocol has been developed that clarifies the expectation that no individual will make a decision around bruising without consulting another professional. Final consultation has taken place and there is multi-agency agreement to the protocol. An implementation plan has been developed whereby, once ratified the protocol will go to all agency leads who will then confirm dissemination to the LSCB Operational Board. The protocol will be published on the LSCB Website by the end of July 2015.

ii) <u>The LSCB should commission a further update report from NLAG on radiology capacity, the ability of non-specialist radiologists to identify signs of fractures to children and progress with the new scheme of regular access to paediatric radiology</u>

Assurance has been provided to the LSCB SCR Sub Group through reports submitted by NLAG on the revised paediatric X ray arrangements. Lessons from the SCR have been discussed in supervision with paediatrics, A&E and Emergency Care Centre staff to disseminate the learning. A Paediatric reporting action plan has been implemented and a paediatric imaging policy developed making expectations explicit. A suitable trigger point has been agreed with the Clinical Lead Radiologists to alert the Radiology Departments for the need for additional support in paediatric reporting.

The Diagnostic and Therapeutic Management team have secured a service level agreement with Sheffield Children's Hospital to provide Specialist paediatric reporting Monday-Friday 9am-5pm by request and Specialist paediatric reporting on Thursdays at Scunthorpe General Hospital 9am-5pm that will ensure the reporting of any outstanding unreported paediatric imaging. Radiology capacity is sufficient.

iii) The LSCB should seek assurance from member agencies that staffing in key staffing groups is at a level to ensure quality safeguarding work, and that includes adequate support for newly qualified staff.

The Police, Children's Health Provision and Children's Social Care were required to submit an individual report to the SCR subgroup providing assurances that:

- staffing is sufficient to meet need and
- ensure quality safeguarding work
- Including support for newly qualified staff

Police - Sufficient staffing – On April 15th 2015 Humberside Police redesigned the force into a one force model. Within the new structure the Protecting Vulnerable People Team (PVP) has lead responsibility for all child safeguarding issues. The team is a force wide team, based at two bases, Brigg Police Station and Clough Road Police station in Hull.

North East Lincs safeguarding is primarily based at Brigg, but by operating a one force model resources can be moved across the force to cover demand as required. The team is headed by a Supt, currently has five DCIs with two predominantly working from Brigg, and nine DIs, with three based at Brigg.

While cuts in Public Finance has affected many areas of policing, Humberside Police has increased investment in PVP.

Ensure quality safeguarding work – It is now a requirement for those working in the PVP dealing with more serious cases involving children to be fully qualified detectives (hold an ICIDP qualification).It is also a requirement that these staff to acquire SSAIDP and SCAIDP status for dealing with investigations involving serious sexual assaults and children.

There is a robust weekly data dashboard which monitors the quantity and type of work being carried out by the police involving children and safeguarding matters. This is used as the basis for Sgts to audit each staff members work at least once every 28 days. Senior Managers audit the Sgts are carrying out the work.

Humberside Police is also fully committed to working alongside our partner agencies to Quality Assure safeguarding work through a series of multi-agency audits, implementing changes as recommended.

Humberside Police are also a key agency in the Multi Agency Child Exploitation meetings making sure all agencies are engaged in the safeguarding of children at risk from exploitation. We support Children's Services for the victims meetings and are the lead agency for offender meetings.

The quality of policer work within the Case Conference arena is now monitored centrally by an experienced Det Sgt, making sure we work to one standard across the force area.

Support for newly qualified staff – The expansion of staff within the team has meant specific courses have been identified for new staff to become VVO trained. As the police are aiming to have all staff trained to be Detectives with SSAIDP and SCAIDP qualifications, again specific training courses have been identified for staff at the earliest opportunity.

Training for all supervisors regarding safeguarding Decision Making was made mandatory and has now been completed. New and inexperienced staff are given a qualified Tutor Detective to work alongside until they achieve a portfolio of work to the required standard.

Children's Health Provision

Sufficient staffing

Health Visitor caseloads have been monitored since a review in 2011 that highlighted high caseload numbers, due at that time to a significant number of vacancies. The action plan included: recruiting 12 WTE HV to fill the vacancies, and monitoring of caseloads in terms of numbers of children and complexity of needs (as reflected by the level of deprivation for each given post-code, with the top 10% most deprived communities). More recently HV teams have been restructured to fit with the newly formed clusters. The Health Visiting service was fully established on 30th March 2015 with all vacancies filled. The service is workforce planning to ensure posts remain filled.

Support for Newly Qualified Staff

Safeguarding Supervision & Mentorship of newly qualified Health staff has been addressed following previous SCR and is now a robust part of the CHP (Children's Health Partnership) support to staff.

Children's Social Care

Investment has led to the establishment of additional PWS and SW posts with all but 2 substantive SW posts recruited to. 2 remaining fixed term PSW double post have been advertised and will be appointed to shortly. Caseloads have reduced and the Signs of Safety approach is being implemented. Both of these measures will have a positive impact in terms of achieving better outcomes for families and increased safety and permanency. A package of support is in place for newly qualified staff as part of the ASYE (Assessed Supported Year in Employment). There is a robust Quality Assurance Framework in place which measures the quality of work and impact on practice.

iv) Training around domestic violence should be reviewed to ensure that staff are aware of when, where and how to report it, the significance of attempted strangulation and not making naïve assumptions about violence being a 'one off'

The LSCB SCR Sub Group commissioned the Learning and Development Sub Group to conduct a training needs analysis of Domestic Abuse and review adequacy of LSCB training on referral making and Domestic Abuse. Level 1

Domestic Abuse Awareness training has been reviewed to incorporate the lessons from the SCRs. A review was completed by LSCB training Officer and Women's Aid trainers. Aspects updated included:

- Reinforcement of the referral process in respect of DV Contact telephone numbers added re both Police and Women's Aid
- Local Services updated so participants are aware of which services can be contacted for help
- Learning from the Serious Case Reviews where DV has been an issue being incorporated into slides and also highlighted as a feature throughout the DV safeguarding training within discussions and exercises
- Group exercises on the effects on children and young people being updated to include age groups. This will highlight the significant risk to the unborn baby and the significantly heightened risk to the mother during this time.
- As part of this training, participants are introduced to the MARAC process via DVD's so they have an awareness of what this is and how it works.

Level 2 Domestic Abuse (DA) Training will be reviewed in July 2015. The Learning and Development sub-group will endorse the changes and oversee the impact. The revision to the training will ensure that practitioners are clear how to recognise and respond to DA, the referral pathway, the risks associated with strangulation and the danger in making assumptions that incidents are '*one-off*'

There are a number of clusters (Family Hubs) in NEL, each cluster has a nominated 'lead' for domestic abuse and these would link in with families identified as at risk or experiencing DV. Clusters 1,3 and 4 have identified domestic abuse as a key priority as a significant target group. Each of the clusters. There are a number of activities across the clusters related to domestic abuse. These include programs on positive relationships, Domestic abuse awareness raising courses, visual displays on how to recognise if you're are a victim of domestic abuse and how to get support.

The Safer and Stronger Communities Team are leading on the One System Approach to address of Domestic Abuse across NEL. A One System Strategy and Action Plan has been developed and will approved by the to the 4 theme boards in August 2015.

v) <u>The LSCB should be satisfied that expectations of staff around intra and interagency communication about domestic abuse where there are children are clear</u>

The expectations around communication in respect of Domestic Violence Level 1 has been reviewed and is made explicit. Serious Case Review Practice Forums were delivered to two hundred and twenty inter agency practitioners in May 2015. Expectations around assessment of risk, appreciative enquiry and effective inter agency communication in respect of domestic Abuse were made explicit. Please See iv)

vi) The LSCB should seek assurance from its members that the principal of *'Think Family'* when dealing with adults is fully embedded

The LSCB Quality Assurance Sub audit tools and audit programmes incorporate the evaluation of the application of a 'Think Family' Approach. Think Family and Early Intervention are key elements within the LSCB interagency audit tool. SCR practice forums were delivered to two hundred and twenty practitioners in May 2015. The need for agencies to *Think Family* was reinforced in terms of assessment of risk and need which was direct learning from this review. The *Think Family Principle* is embedded within the LSCB Child Concern model and safeguarding procedures.

vii) The LSCB, being aware of the risks, should ask for a review of the inter connectivity of primary/community care client/patient databases to maximise the ease of sharing information

The LSCB Health Sub Group was commissioned to undertake a survey of systems in use and the ability for health professionals to share and access information. This survey identified there are more systems in use than initially known. The systems are designed for different purposes and as such no one single system is able to meet the needs of all health services. There are a number of initiatives locally to improve the way systems link. However, even if it were possible to have a single system it would not be an effective substitute for timely direct information sharing. This is a national issue although a task and finish group will be formed locally to develop the awareness initiative.

viii) The LSCB should work with its member agencies on a culture of greater challenge to support assessments of risk, so that staff have greater confidence to challenge for evidence, for example in the face of apparently compliant self-report

The Quality Assurance Sub Group programme 2015/16 will include a multi-agency audit in respect of assessments of risk, focusing on evidence sources used, consultation and professional challenge. The QA Coordinator will provide a report to the September SCR sub on the findings from audits in respect of risk assessment and escalation. The QA performance framework and audit calendar has been revised. There is a comprehensive audit programme in place and all themed audits have a specific focus on assessment of risk and need and formal escalation processes. The need for challenge by professionals to service users and between agencies coupled with the use of escalation processes was reinforced at the SCR practice forums delivered to two hundred and twenty practitioners in May 2015. The *Signs of Safety* approach being implemented within and across NEL is a model that is designed to identify and manage risk.

ix) The LSCB should seek assurance that assessments of risk to children are done with full multi-agency consultation

The Quality Assurance Performance Framework and audit calendar has been revised during 2014/15. There is now a comprehensive audit program in place

with all themed audits having a specific focus on assessment of risk and need and escalation.

Audits undertaken have evidenced that almost invariably assessments of risk are undertaken within a multi-agency consultation framework. The recent Child Protection Decision-Making Audit gave assurances that agencies felt and were involved fully in assessments of risk. The Signs of Safety approach which is being implemented locally will strengthen the identification and management of risk. In addition there is multi-agency training in assessing Neglect and use of the Neglect Risk Assessment tool. There are a number of designated risk management panels in place including CSE and a forum for challenge of MASH decisions regarding threshold of risk at the referral stage. There is also an ongoing audit of the Multi-agency Case Conference challenge with regard to assessment and evidence of risk regarding decision-making and planning at conference.