Surrey Safeguarding Children Board

Report of the Serious Case Review regarding Baby KK

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1. Introduction

1.1 Why this case was chosen to be reviewed

The Local Safeguarding Children Board determined to conduct a Serious Case Review (SCR) because the circumstances of this case met the statutory criteria:

> *(a) abuse or neglect of a child is known or suspected; and*
> *(b) (i) the child has died*
> *(Working Together to Safeguard Children,* 2015 4:18 p 76*)*

1.2 Succinct summary of case

1.2.1 This review concerns services provided to Baby KK and the family. Baby KK was nine months old at the time of death and had lived in the community with mother and father. Baby KK was born prematurely and experienced a range of health problems requiring repeated admissions to hospital. Children's Social Care (CSC) were also working with Baby KK and the family as there were concerns about the care being provided by the parents and from the age of three months Baby KK and Sibling were the subject of child protection plans because of neglect[1]. The cause of Baby KK's death was unclear at the time however the post mortem identified the following causes: -

1a Hypoxic ischaemic heart failure following resuscitation from cardiac arrest
1b Chest Infection.

1.3 Family composition

Family member	Age at the time of the child's death
Baby KK	9 months
Sibling	2 years
Mother	20 years
Father	24 years

1.4 Timeframe

The time frame for the review was agreed as being from September 2014 when the family first moved into supported housing until 30th April 2016 when the baby was pronounced dead.

1.5 Organisational learning and improvement

1.5.1 Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including serious case reviews states that:

> 'Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into

[1] If child protection enquiries show that a child may be suffering or is likely to suffer significant harm, an initial child protection conference will be organised and if the conference decides that the child is suffering (or is likely to suffer) significant harm then the decision will be made for him/her to have a child protection plan. The aim of the plan is to try and stop any harm happening to the child and make things better for him/her.

programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children'. [2]

1.5.2 The Learning Together Review process requires that prior to starting the review the LSCB identifies broad research questions which go beyond the facts and issues in this case, to look more widely at their child protection systems. Specifically, it was felt that it would be useful to examine the following areas: -

- How effectively are agencies working together with families where children are on child protection plans because of neglect?

- How effective are professionals at achieving change with families where there is disguised compliance?

- How effective are professionals at using information and knowledge gained when working with older siblings in assessing risk for babies when all children are the subject of child protection plans?

1.6 Methodology

Statutory guidance requires SCRs to be conducted in such in a way which:

- 'recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings'[3].

It is also required that the following principles should be applied by LSCBs and their partner organisations to all reviews:

- 'there should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;
- professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith; families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process'.[4]

[2] Working Together 2015, 4:7 http://www.workingtogetheronline.co.uk/chapters/chapter_four.html
[3] WT 2015, 4:11http://www.workingtogetheronline.co.uk/chapters/chapter_four.html
[4] ibid

To comply with these requirements, the LSCB has used the SCIE *Learning Together* systems model[5]. Detail of what this has entailed is contained in Appendix 1 of this report.

1.7 Reviewing expertise and independence

1.7.1 The review has been led by Fiona Johnson, an independent social work consultant, and, June Hopkins, an independent health consultant, who are both accredited to carry out SCIE reviews and have extensive experience in writing serious case reviews. Both reviewers have had no previous direct involvement with the case under review.

1.7.2 The lead reviewers have received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

1.8 Acronyms used, and terminology explained

Statutory guidance requires that SCR reports: 'be written in plain English and in a manner, that can be easily understood by professionals and the public alike'[6].
Writing for multiple audiences is always challenging. In the Appendix 2 we provide a section on terminology aiming to support readers who are not familiar with the processes and language of the safeguarding and child protection work.

1.9 Methodological comment and limitations

1.9.1 There were some challenges to the smooth running of this review. Attendances at review team meetings was inconsistent, with GP attendance being particularly problematic. The first core group meeting between the review team and front-line professionals was also poorly attended with few health professionals being present. There was good involvement in both meetings however by CSC and housing staff. There were also pressures on the administrative support for the review.

1.9.2 Another difficulty was that it was not possible to involve the parents until late in the review because of civil and criminal matters separate from the serious case review. This meant that the parents' perspective was only known when the bulk of the analysis was complete and resulted in some significant re-writing of the report during the end stages.

1.10 Participation of professionals

The lead reviewers and the review team have been impressed throughout by the professionalism, knowledge and experience that the case group (the professionals involved with the family, from all agencies) have contributed to the review; and their capacity to reflect on their own work so openly and thoughtfully in the review process. All this has given the review team a deeper and richer understanding of 'what' happened with this family and within the safeguarding network and 'why' and has allowed us to capture the learning that is presented in this report.

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[5] Fish, Munro & Bairstow 2010. Fish, S., Munro, E., Bairstow, S., SCIE Guide 24: Learning together to safeguard children: developing a multi-agency systems approach for case reviews, Social Care Institute for Excellence (SCIE), 2009

[6] WT 2015, 4:11http://www.workingtogetheronline.co.uk/chapters/chapter_four.html

1.11 Input of the family

1.11.1 Mother was interviewed by one of the lead reviewers and a member of the review team. She was not willing to talk in detail about the services provided over the full review period and wished instead to concentrate on the support provided to Baby KK at the time of death.

1.11.2 Father was in prison on remand for the period of the review for offences separate from the matters in this case. He was advised of the serious case review and was invited to contribute which he accepted, and a video conversation took place.

2. The Findings

2.1 Structure of the report

2.1.1 Statutory guidance requires that SCR reports 'provide a sound analysis of what happened in the case, and why, and what needs to happen to reduce the risk of recurrence'.[7]

2.1.2 This section contains 8 priority findings that have emerged from the serious case review. The findings explain why professional practice was not more effective in protecting Baby KK. Each finding also lays out the evidence, identified by the review team, that indicates that these are not one-off issues, but are matters that if not addressed could cause risks to other children and families in future work, because they are issues that undermine the effectiveness with which professionals can do their jobs.

2.1.3 Immediately prior to the findings an overview is provided of what happened in this case. This clarifies the view of the review team about how timely and effective the help that was given to Baby KK and the family was, including where practice was below expected standards. This is then followed by the views of the parents.

2.1.4 A transition section of the report highlights the ways in which features of the involvement with Baby KK and the family are common to work that professionals conduct with other families; and, therefore provides useful organisational learning to underpin improvement.

2.2 Appraisal of professional practice in this case.

2.2.1 This section provides an overview of 'what' happened and 'why'. The purpose of this section is to provide an appraisal of the practice that is specific to the case and it therefore includes the review team's judgements about the timeliness and effectiveness of practice including where practice was below expected standards. Such judgments are made in the light of what was known and was knowable at that point in time. For some aspects, the explanation for 'why' will be further examined in the findings in section 4 and a cross reference will be provided.

2.2.2 This case was concerned with the challenge of working with parents who are not keen to engage with services, where neglect is an issue meaning they choose to live in conditions that can generate a considerable level of risk for their children but where evidencing that this is causing the children significant harm is difficult. In these circumstances it is essential that there is close working across all agencies and this review has identified some areas where the joint working between professionals in health and children's social care could be improved. It focuses on the relationship between professionals working in the community and those in the hospital and examines some differences in focus and approach that can present challenges for safeguarding children particularly in the context of neglectful parenting.

Relevant background history

2.2.3 The parents had been in a relationship for some time and had a child together (Sibling), born when mother was 17 and father was 20 years of age. Prior to the review period the parents had limited involvement with statutory services although the father

[7] http://www.workingtogetheronline.co.uk/chapters/chapter_four.html

had been known to CSC because of his mother's neglect of him and was known to the police for suspected violence against family members and had convictions for petty theft and criminal damage. Immediately prior to the review period the couple had lived with paternal grandmother and were re-housed because of the poor home conditions at her house. The mother was also known to have attended a school for pupils with learning difficulties.

Start of Review Period

2.2.4 At this point the parents had moved with the Sibling to live in a one-bedroom flat within a supported housing complex. Staff there were working with the parents to help them manage their finances and make benefit claims. Initially the flat was clean and tidy but following the death of the paternal grandfather staff noted a deterioration in the home conditions. They provided additional support, and because they thought the father was grieving, offered him bereavement counselling, which he refused.

2.2.5 Soon after the family moved into the accommodation CSC received a referral suggesting the Sibling had possible contact with a registered sex offender. A social worker (SW1) visited the family and was confident that the parents understood the risk and could protect the child. Therefore, the case was closed to children services. This assessment seemed to the review team to be thorough, and the response appropriate.

Hospital care during ante natal period

2.2.6 Within four months of moving into supported housing the mother was pregnant again. She accessed antenatal services in good time and at the initial booking visit was rightly referred to the teenage midwife service. At 17 weeks gestation, the mother was admitted to the antenatal ward with premature rupture of membranes (PROM). The hospital staff rightly explained the potential consequences of having PROM which included miscarriage, premature birth and disability of the baby if born prematurely. There was discussion with the mother about a termination of the pregnancy who was anxious to return home to Sibling. Hospital staff did not pursue this further with her and did not explore why she felt father was not able to care for the child. Staff also did not consider getting her consent to share information with other agencies in order that the family could be provided additional support as such discussions would usually only occur if the procedure (termination) occurred. Mother had almost daily access to hospital ante-natal services to support her with her decision and ongoing pregnancy. Staff in the hospital had routinely asked mother about domestic abuse at admission and on other occasions, which was good practice, but did not consider this specifically as a possible cause of the PROM at this stage or later when mother was re-admitted with abdominal pain reportedly caused by sibling kicking her in the stomach. Following this incident mother was admitted to hospital for bed rest however there was no communication with the GP, health visitor or community midwife about the PROM or mother's concern about the Sibling or her requests for a termination. **Findings 2 and 5 explore why aspects of the communication by hospital staff may seem less pro-active with regards to safeguarding.**

*Deteriorating home conditions and concerns reported to NSPCC***.**

2.2.7 Whilst mother was in hospital, a neighbour spoke to her health visitor about concerns for Sibling which included; unhygienic home conditions, the child being inappropriately dressed and being fed left over takeaway food. The health visitor advised her to report her concerns to CSC and passed the information on to the allocated health

visitor, however neither health visitor checked that the referral to CSC was made, which was poor practice. The first health visitor rightly considered that this was the responsibility of the allocated health visitor, and that worker has left health visiting practice meaning that the review team has been unable to find out why this information was not reported appropriately.

2.2.8 Three days after the neighbour spoke with her health visitor, CSC were informed of an anonymous referral made to the NSPCC raising similar concerns. Social workers attempted to visit but were unsuccessful, however they contacted mother by telephone and she agreed to 'checks' being made with other agencies. Following this the social workers spoke with the health visitor and discussed the concerns raised in the anonymous referral. The health visitor reported that she was due to visit to complete Sibling's one-year developmental check and agreed to check whether there were any concerns. The health visitor visited the next day and completed the developmental assessment which indicated that Sibling was developing within normal limits. The health visitor also recorded that the home conditions were poor. This developmental assessment contrasted with the views of housing staff who saw the child very regularly and who were recording and sharing with professionals their concerns about how the space available for the child (because the parents were choosing to live in one room) could adversely affect the child's development, particularly her motor skills and speech. Following the visit, a duty social worker contacted the allocated health visitor for feedback from the home visit. She was not available, and the social worker spoke with a colleague who referred to the electronic records. Although the records clearly recorded the poor conditions of the home, the precise details of the information exchanged between the two professionals are not known. The impression the duty social worker was given from the call, as recorded at the time, was that the flat was messy but not unsafe and 'that the visit had not identified any developmental concerns'. It has not been possible to gain a reason for this discrepancy. The consequence was that CSC took no further action regarding the NSPCC referral.

2.2.9 One week later, CSC received a further anonymous referral via NSPCC which repeated the previous concerns about the poor state of the flat and reported that Sibling had a bruised forehead which the parents said was accidental, but the referrer was unconvinced. Initially CSC responded positively by attempting to visit the family, but when they were unable to gain access, and, following contact with the housing staff, a manager made the decision instead to refer the family for a Team Around Family (TAF) meeting which would be attended by a CSC staff member. This wrong decision meant that the bruise was not seen by a professional and led to a delay in the initiation of the child protection process. CSC accept that this decision was incorrect and report that at this point the RAIS[8] teams were not functioning well and that changes since made to the services would reduce the risk of this recurring. **This is a matter on which the LSCB may wish to receive a report from CSC providing reassurance about the improved functioning of the Assessment and Intervention Service arrangements.**

2.2.10 The TAF meeting did not take place for four weeks which is usual practice where there are not seen to be immediate child protection concerns. The meeting was attended by a Family Support Worker (FSW) who then visited the flat and was shocked by the home conditions. He immediately shared them with his manager who asked the

[8] RAIS – Referral, Assessment and Intervention Service, the team within CSC that responded to referrals and undertook immediate assessment work.

SW1 who had previously been involved with the family to become involved again, which was good practice. SW1 visited and immediately identified that there had been significant deterioration. SW1 referred the parents to a children's centre for additional support, contacted the maternal grandfather to see if the family could assist and, when after two weeks there was little improvement in the home conditions, he initiated a strategy discussion[9] which agreed that the threshold was met for a section 47 single agency assessment[10]. This assessment was completed three weeks later and recommended holding an Initial Child Protection Conference (ICPC). This was an effective and timely response to the concerns raised.

2.2.11 Soon after this mother was admitted to hospital for to have the baby and when the social worker visited a week later there was a significant improvement in the home conditions, which was maintained for the next visit one week on. That week Baby KK was born but due to prematurity and infection required specialist neonatal treatment and was transferred to a tertiary hospital[11]. Mother was also ill with sepsis and followed Baby KK to the tertiary hospital but soon after transfer discharged herself from hospital against medical advice. It is of concern that the communication with the GP about this was only a routine discharge letter and there was no contact with the health visitor, although the community midwife was informed by the hospital midwife and she spoke to mother on day one of discharge from hospital. Other professionals in the community working with the family only realised how ill mother had, been during the review.

Initial Child Protection Conference

2.2.12 The ICPC was held on the 24th of July 2015. Both parents were present along with professionals from housing, the children centre, a social worker and the safeguarding midwife from the hospital. The health visitor was unable to attend in person and sent in a written report which was brief and did not capture the full picture of how poor the home conditions had been. The review team felt it was regrettable that a health visitor representative was unable to attend in person to contribute to the information regarding the home conditions.

2.2.13 The Chair at the ICPC gave a balanced summing up of the risks and was clear to the parents that if the recent improvements were not maintained then there would be a need for a further child protection conference. Significant weight was given, however, to the information provided by the children centre worker who had only recently started to work with the family and had only recently visited the home, compared with housing staff who had known and worked with the family on site on an almost daily basis for several months. Additionally, the social worker and family support worker were over-optimistic in their hope that the very recent change in the home conditions would be sustained. The social worker felt that the recent improvement meant that the children no longer met the threshold for child protection. This view was not shared by the housing support officer (HSO) and her manager who believed the threshold for child

[9] When there are concerns that a child may be at risk of significant harm, CSC will talk to partner agencies about the child and jointly decide if the threshold for a child protection investigation (see Section 47 below) has been met and who should carry out the investigation – CSC and the police (joint agency) or the police alone (single agency).
[10] A Section 47 enquiry is an investigation undertaken when social workers have 'reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm'. The enquiry will involve an assessment of the child's needs and the ability of those caring for the child to meet them. The aim is to decide whether any action should be taken to safeguard the child
[11] Once a patient is hospitalized, they may require highly specialised treatment and care within the hospital. Tertiary care requires professionals, usually surgeons, with specific expertise in a given field, to carry out investigation and treatment for the patient.

protection was met based on their knowledge of the family and the previous failed interventions tried with the family. They were left feeling angry, and that their work and opinions were undervalued by the chair and RAIS staff, when compared with the opinions of other statutory partners. **The issues of relationships between Housing staff and other agencies and how they are mutually viewed is discussed further in Finding 1.** The HSO and her manager were unaware that there was a formal process for recording their dissent to the outcome of a conference. If formal dissent had been raised, then there was a 'formal dissent group' who reviewed all conferences where a formal dissent was recorded. The 'dissent group' has now been dissolved but since this time there has been significant LSCB training regarding individual responsibilities to escalate concerns.

Child in Need plan

2.2.14 Following the ICPC meeting professionals from children services, health, housing and early help worked with the family. There was almost daily professional contact with the family. Within the home, there were repeated patterns of conditions improving slightly and then quickly deteriorating. All offers of help from housing to help tidy and clean the flat were declined and professionals observed parents failing to maintain basic hygiene including sterilising bottles. Within three weeks of Baby KK's discharge from hospital the baby was re-admitted with gastroenteritis and was also treated for both nappy rash and a urinary tract infection before being discharged home the next day. Whilst in hospital, the medical staff concentrated on his immediate physical presentation and expressed their concerns by sharing information with the GP and health visitor. Gastroenteritis can cause nappy rash and be associated with urinary tract infection however there was no apparent exploration as to whether unhygienic home conditions could also be a reason for his ill health. **Whilst it is understandable and right that the initial focus was on the medical presentation the reasons that medical staff did not explore further other possible causes is discussed in Finding 2.**

2.2.15 A month later Baby KK was taken to the GP for a belated developmental check and whilst at the surgery the GP noticed that Sibling was bleeding in the mouth which, on examination turned out to be caused by a torn frenulum, for which the parents had no clear explanation. The GP also thought that the children were not appropriately dressed. At this stage, the GP was unaware that the children were being supported via a child in need plan as the minutes of the ICPC had not been received by the previous GP. He contacted the duty health visitor as he thought that she was the most appropriate person to talk with. She told him about the child in need plan but even after this discussion he did not report the injury to the social worker or take any further action. The review team considered that this was a failure in practice, as even if the injury was accidental, it may have been a result of poor supervision or neglectful parenting and given the levels of concern about this family all such incidents should have been shared. **The issue of GP's not referring directly to CSC is discussed in finding 3.**

2.2.16 Throughout this three-month period there were frequent reports by different professionals of poor home conditions including dirty bottles strewn around with no clean bottles ready for use. On one visit the HSO asked about the steriliser and found it in a cupboard; there were plates of food with mould around the living area plus piles of empty food packaging. As a result, the HSO (with the parent's permission) took a photo of the home conditions and sent it to the social worker, this was sustained and consistent

intervention by these staff in raising concerns about the family. Despite such evidence of concern, it took three months of continued assessment and child in need work before a strategy discussion was held and a further ICPC organised. **The challenges facing professional when working in families where neglect is present are explored in Finding 4**

Second Initial Child Protection Conference

2.2.17 Three months after the first ICPC, a second ICPC was held and rightly decided that both children should be made the subject of child protection plans. The child protection plan that was agreed was explicit in detailing the strengths and weaknesses of the family and outlined in simple terms the professionals' concerns about the risks to the children. It also stated that change was needed within speedy time frames and that if this was not achieved then legal intervention should be considered. Following this conference, key worker responsibility was transferred to the Child Protection and Proceedings Team and SW2 was allocated to provide long term support for the family. This social worker recognised that mother could have a learning difficulty and immediately used methods such as pictorial instructions to aid communication with her.

2.2.18 During the month after the ICPC professionals noted ongoing concerns in the care being provided to the children including untreated nappy rash, poor sterilisation of bottles and Baby KK sleeping in a car seat. At the end of the month Baby KK developed bronchiolitis and was seen twice at the hospital where the baby was noted to be in dirty clothes and 'a bit smelly'. It is not unusual when a child is developing bronchiolitis that they are not admitted at the first attendance as admission only occurs when the child requires additional support. During this time the family would have had open access to the ward and the staff would check that mother had sufficient transport and would be given advice about when to return to hospital. The next day the baby was readmitted to hospital and was diagnosed with bronchiolitis and sepsis. Baby KK's condition deteriorated rapidly and full resuscitation support was required to keep the baby alive. Due to the level of intensive care that was required Baby KK was immediately transferred to a London tertiary hospital the same day. There was prompt sharing of information between both hospital safeguarding nurses and the social worker.

2.2.19 After 10 days in London, Baby KK was transferred back to the children's ward at the local hospital. A parent is expected to stay on the ward to care for their child's routine care. Father stayed with Baby KK, but nursing staff were concerned that he did not wake in the night to feed the baby who was also left in dirty clothes. These concerns were discussed at the weekly hospital safeguarding meeting. This meeting is an opportunity to discuss children who have been to the hospital and ensure information is shared with other agencies, including CSC. Whilst, the safeguarding nursing staff are regular attenders at these meetings, CSC are represented by a duty social worker from the local team which means there is a different professional attending each time who will not know the children discussed in person and may be unfamiliar with hospital systems and terminology[12]. The weekly safeguarding meetings are well established within the hospital, but routinely only the specialist safeguarding hospital staff attend in person and only occasionally the doctors in charge of Baby KK's care. There is a heavy reliance on the named nurse/safeguarding team being the main communication route in all safeguarding matters. **The potential shortcomings of this system are explored in Finding 5.**

[12] This has now been changed and the same social worker now attends those meetings

2.2.20 As Baby KK became medically fit for discharge the SW2 contacted the hospital named nurse and requested that the baby be kept in hospital for a couple of days longer as the home conditions were unsuitable. It is therefore surprising that although, this was known there was no formal discharge planning meeting involving community health and social work staff to ensure that community support was in place for the baby's health requirements and the review team has not been able to find an explanation for why this did not happen. It is reported, but not recorded, that there was telephone communication with community health professionals however this was a missed opportunity for hospital staff to meet with all professionals working with the family in the community to gain a mutual understanding of Baby KK's health needs and to plan jointly how best to manage and assess safeguarding risks post-discharge. **It is thought that the absence of this joint planning further reflects the issues raised in Findings 2 and 5.**

2.2.21 Prior to discharge, the parents were informed by the social worker that the local authority would be seeking legal advice in respect to the children, and asked them to sign a written agreement, this was good practice. Baby KK was discharged home just before Christmas and during that week there were two visits by social workers and it was noted that the poor home conditions continued, with dirty bottles, nappies and left-over food all over the living area. When a social worker visited soon after Christmas the condition of the flat had further deteriorated, and Sibling had a cold. Baby KK was seen to be sleeping in the car seat. Soon after both children were unwell and were taken to the hospital where Baby KK was admitted for tube feeding as the respiratory illness was making it difficult for the baby to feed. The parents raised the issue of mould as being the reason for the illness but there was no contact made with the social worker to discuss home conditions. Baby KK was discharged home on the 5th of January. When SW2 visited the next day, she was concerned about the home conditions and immediately asked her manager to see the property. At that visit it was decided that the living conditions were unfit for the children and it was agreed that mother and the children would be moved to a bed and breakfast accommodation for the weekend so that father could clean and tidy the flat. Whilst the provision of alternative accommodation for the family was a good intervention to allow father to sort the flat, in reality, he spent most of the weekend with mother and the children, however the result was some improvement in the home conditions.

Review Child Protection Conference and initiation of legal proceedings

2.2.22 The review child protection conference took place the next day and correctly decided that the child protection plan should continue. Some of the conclusions recorded in the minutes of the conference appear to contradict the professional contributions to the meeting, as the chair was very positive about the parents in his summing up. Despite intensive support there had been no real improvement in the care provided to the children and concerns were escalating with consideration being given to initiating legal intervention via the Public Law Outline (PLO) process[13]. This emphasis on the positive aspects of the parents' care minimised concerns from other professionals and reflected an over-optimistic stance that was taken by the chair of the review. This attitude is not considered to be representative of the whole service.

2.2.23 Given the history of the family failure to sustain changes and the escalating risk

[13] PLO – Public Law Outline the framework within which court proceedings are initiated by the Local Authority under The Children Act 1989 – see glossary for more detail.

to the children it was appropriate that SW2 and her Manager initiated PLO proceedings. This decision was confirmed by the Service Manager in early January, who recommended a comprehensive parenting assessment, a family group conference and a psychological assessment of both parents to review their cognitive functioning. It was then almost seven weeks before the parents were given the letters of intent[14] to formally start the legal process. This was because there were significant delays in the local authority legal section authorising these letters. **This was a known problem that is now resolved however the LSCB may wish to receive a report from CSC about how well their legal processes are now working.** A PLO meeting was then convened appropriately within two weeks but as father had not obtained a solicitor to represent him this process could only be progressed with mother. To resolve this SW2 and HSO assisted father obtain a solicitor and a second PLO meeting was held a month later. **The extent to which the legal process can hinder effective safeguarding of children where there is neglect is considered in Finding 6.**

2.2.24 During this period, there were two significant events reported. There was an anonymous referral to the police that reported hearing the parents arguing and suspicion that a child may have been slapped. The police attended and spoke to mother alone initially. No allegations of physical assault were made. Both children were seen by police officers. Sibling was awake and appeared happy, Baby KK was fast asleep in the car-seat. The police correctly shared this information with CSC.

2.2.25 The second significant episode happened a month later when Baby KK was taken to hospital with a left arm injury. The parents reported to hospital staff that the baby's arm got caught in the cot bars. The Accident & Emergency registrar examined the baby and could find no evidence of bruising or swelling and concluded that it was an accidental pulled elbow that had spontaneously reduced. However, Baby KK was a child subject to a child protection plan with known safeguarding concerns who was under one year of age, and the protocols require that the registrar should have therefore referred the baby to a paediatrician for examination and consideration of immediate referral to CSC. The social worker would have known of Baby KK's history of sleeping in a car seat and therefore may have challenged the history of the baby reportedly being in a cot.

2.2.26 SW2, after being informed of Baby KK's injury, was also told by the children's centre of a possible assault against mother and immediately contacted her. Mother denied that the father had tried to hurt her but confirmed that Baby KK had an arm injury caused by getting it trapped in the cot bars. SW 2 was uneasy with this explanation and rightly contacted the hospital staff to question them about the presentation. The doctor remained adamant that they had no concerns regarding the mechanism of the arm injury, although it was noted that Baby KK was unkempt and possibly overweight.

2.2.27 Given the continuing concern about the mechanism of the injury, it is unfortunate that there was no consideration by the social worker or manager of contacting the LSCB Designated Doctor or the Named Doctor for safeguarding children at the hospital for further advice regarding escalating their concern. This was in part because they both assumed that the registrar, as the expert, knew best and they were unaware of the protocol requiring the child be referred to a paediatrician. It may also reflect a lack of knowledge by those staff about how to challenge medical staff judgement and a concern

[14] ''letters of intent' are the letters given to families at the start of the legal process of the public law outline indicating to parents that the local authority is starting court proceedings.

that such challenge would not be effective. **The reasons for professional reluctance in escalating concerns is further explored in Finding 7.**

2.2.28 At this time Baby KK's breathing problems were worsening resulting in frequent presentations at the hospital. Soon after, the hospital admitted Baby KK for observation and to check on whether mother was using the inhaler properly. It is routine practice that when a child is prescribed inhalers in hospital staff teach parents inhaler techniques and review these at every admission. This is conducted routinely and would only be documented if there were concerns about the technique. A pre-term infant with bronchiolitis can be expected to attend recurrently with wheeze and chest problems. Given that inhalers had been prescribed for almost five months the review team felt that this check was over-due. It was known that mother had attended a school for children with learning difficulties however it is unclear if hospital staff made any adjustment for her understanding. **This is an issue that is considered in Finding 8 which discusses the different professional approaches to giving advice and information to parents**. This point was also an opportunity to explore whether the wider social conditions were impacting on the parents' capacity to care effectively for a sick baby. Considering that this was Baby KK's ninth admission since birth the review team felt more consideration to the support required by the family in the community should have been considered before discharge. **The reasons this did not happen are discussed in Finding 2, 5 and 7.**

2.2.29 Three days later, on the 29th of April, Baby KK was admitted to hospital by ambulance after being found lifeless and floppy, he was transferred to a London Hospital, but sadly died the following day.

2.3 Views of the Parents

Interview with Mother

2.3.1 The lead reviewer met with Mother at a Housing Support Office. She was clear that she did not wish to discuss her relationship with the Father and felt that the focus of the interview should be on the professional interventions with regard to Baby KK. She said that there was mould in the bedroom within three days of them moving into the flat and that this meant that the 'house was a bit of a mess' because they were 'sitting and sleeping in the front room'. She also said that Father 'didn't do housework' so Mother 'had to do it even when she was meant to be on bed rest'.

2.3.2 Mother said that she felt supported by the Housing Support staff and also the children's centre however she was unhappy that she was pressurised by the social workers to attend the children's centre but that there was not similar pressure put on Father. Mother felt that SW1 was of assistance but that SW2 was less helpful although she admitted that she was probably doing her job. Mother said that she felt that even when they cleaned up the flat SW2 was 'never satisfied that it was good enough'. She said that Father 'got on okay' with SW1 but he was very angry and difficult with SW2. When asked if SW2 could have done anything to help manage Father, Mother replied that he 'was stubborn and he didn't do things or listen. If he doesn't like what you are saying he will argue back at you. He would kick off if he didn't agree and swear.' Mother did confirm that Father was violent towards her but admitted she had not told

any professional about this and said that she never felt safe to do so as she felt that Father was always watching her. She felt that professionals should have realised that Father was violent because of how he spoke to her.

2.3.3 Mother was asked about the support she got in hospital and said that when Baby KK was given an inhaler 'they showed us once, that wasn't helpful' she went on to say that it was 'really hard to use the inhaler, [the baby] would cry so much that Mother wasn't sure that [the baby] could take much in because [the baby] was crying too much'. Mother said she spoke to hospital staff who said that he should be okay. Mother said that at the time she thought that it wasn't working but that hospital staff said it was fine, it was working so she believed 'what the doctors and nurses say'. Some [of the hospital staff] were really lovely and Mother could ask questions, but some used 'really long words' that she didn't understand. Mother explained that she was dyslexic, she said that she googled bronchiolitis as she didn't know what it was or how it was caused but she was anxious about this as she knew that 'Google can't be relied on'. Sometimes Mother checked with nurses what the doctors had said and said that some were helpful but that others were less supportive. Mother was anxious to understand why Baby KK had died and felt that if he had been given oxygen not just an inhaler then he might not have died.

2.3.4 The Mother also provided information about the child death rapid response process which was shared with the Child Death Overview Panel as it was relevant but fell outside the scope of the serious case review.

Interview with Father

2.3.5 The lead reviewer spoke with Father via a video link. Father felt the professionals were not listening to their concerns that the poor home conditions and especially the mould was contributing to Baby KK's poor health. Father felt the mould was due to a fault with the building and not due to their lifestyle.

2.3.6 Father said that he understood that if he tidied the home and paid the rent arrears then the family would be moved to new accommodation. He said that whilst he did what was asked of him he felt let down that they were not moved.

2.3.7 Father admitted he hated working with social workers as he had experience of them as a child and in his view, they had not changed how they practiced. He also felt at times he was receiving mixed messages about how the professionals viewed the property, with some people at times saying it was good then in the same time-period others saying it was not good enough.

2.3.8 Father was asked about the support the family got from the hospital. Generally, he felt "they did their part", but just kept prescribing inhalers which had to be given four hourly. However, he felt strongly that at the last attendance at the local hospital Baby KK should have been admitted but wasn't and within 48 hours he had died.

2.4 In what ways does this case provide a useful window on our systems?

2.4.1 The LSCB agreed broad research questions at the start of the process, which go beyond the facts and issues in this case, to look more widely at their child protection systems. The questions are set out at in paragraph 1.5.2 and directly link to the areas covered in the appraisal of practice and the findings

2.4.2 A key area of research was how effectively agencies work together with families where children are the subject of child protection plans because of neglect. This review has identified that it is challenging for professionals to evidence significant harm where there is neglectful parenting and that this may cause delay in the progress of legal proceedings. It has also shown that closer working between hospital professionals and social workers could assist in identifying significant harm earlier and improve safeguarding of children in these situations.

2.4.3 One of the research questions was concerned with how effective professionals are at achieving change with families where there is disguised compliance. This review has highlighted the importance of understanding parents' capacity in determining whether they are deliberately failing to co-operate with professionals. In this case it was noteworthy that at the time of the review there was still a lack of clarity about how capable the parents were and whether they deliberately ignored advice or did not really understand what was expected of them.

2.4.4 The LSCB was also concerned to understand better how effectively professionals were using information and knowledge gained when working with older siblings in assessing risk for babies. This review has shown that whilst information was known and shared, the key challenge was in being able to interpret the effect on children of the parents' actions, and in particular, in judging whether this was causing significant harm.

2.5 Summary of findings

The review team have prioritised 8 findings for the LSCB to consider. These are:

	Finding	Category
1	There is a perception from partner agencies in part of the county that Child Protection & Proceedings teams have a better understanding of the relevance of supported housing input for safeguarding than Assessment and Intervention services, undermining joint working in early intervention.	Professional norms & culture around multi-agency working in assessment and longer-term work.
2	Do hospital professionals standardly take a medical and social history only to inform their treatment of the immediate presenting illness/injury rather than also assessing whether the health history raises safeguarding issues?	Professional norms & culture around multi-agency working in assessment and longer-term work.
3	Are general practitioners in the county reluctant to refer directly to Children's Social Care, preferring to consult with fellow health professionals?	Professional norms & culture around multi-agency working in assessment and longer-term work.
4	Does the fluctuating nature of neglect and the inconsistent ability of parents to maintain improvement undermine professionals' ability to see and respond to neglectful parenting?	Professional norms & culture around multi-agency working in assessment and longer-term work.
5	Seeing the task of hospital clinicians as to "*assess, treat, discharge, and where necessary refer on to specialist services*" works for most children but means there may be limited involvement of hospital professionals in on-going safeguarding work even when a child is being admitted repeatedly to hospital, undermining multi-agency safeguarding work to protect children.	Professional norms & culture around multi-agency working in assessment and longer-term work.
6	Does the nature of chronic neglect mean that evidencing that deteriorating conditions is increasing harm, make it hard for the current threshold in care proceedings to be met, risking leaving children for over-long periods in substandard care?	Patterns in human–tool operation.
7	Is there a culture in the area whereby constructive challenge is interpreted as personal and organisational criticism, fostering defensiveness between agencies and reducing the likelihood that escalation of safeguarding concerns happens when needed?	Patterns in human–management system operation
8	The routine method of communication used in hospital settings – namely verbal instructions - does not accommodate limitations to parental capacity to understand the information being given.	Professional norms & culture around multi-agency working in assessment and longer-term work.

2.6 Findings in Detail

Finding 1

There is a perception from partner agencies in part of the LSCB that Child Protection & Proceedings teams have a better understanding of the relevance of supported housing input for safeguarding than Assessment and Intervention services, undermining joint working in early intervention. Professional norms & culture around multi-agency working in assessment and longer-term work.

Introduction

Supported Housing staff have a key safeguarding role to play, alongside their colleagues in social care, health and the police. Published case reviews highlight that housing services often conduct regular inspections of family homes and have a unique insight into the lifestyles of their tenants. Therefore, housing have a potential wealth of knowledge regarding the family that should be an important source of information when assessments are being undertaken. This is particularly true of Supported Housing staff who mainly work with vulnerable families where there are identified support needs. The complex nature of child protection work means that dysfunctional relationships and poor communication between professionals and, also, the family often occur and can increase risk.

How did the issue feature in this particular case?

By the time the Initial Child Protection Conference (ICPC) was held in the July the Housing Support Officer (HSO) had been working with the family for over 9 months. In that time, the HSO had established a close working relationship with the parents, this was helped by the fact that the HSO saw the family frequently and at different times of the day. Initially the HSO focus with the parents was to support them with claiming benefits, but within a short period the general poor living conditions within the flat became a major concern.

The HSO attempted to support the parents to recognise and improve the home conditions and offered different methods of interventions which ranged from practical help to tidy and clean the flat to the suggestion of a referral for grief counselling for father, but all offers were declined. Over the nine-month period it was noticed by housing staff that there were occasional improvements to the home environment usually in response to an official warning, but, the improvements were never sustained.

Following the anonymous referrals to CSC, a strategy meeting was held in June and it was agreed that CSC would undertake a single agency section 47 enquiry. This resulted in SW1 and a Family Support Worker from the RAIS team being allocated to the family, who worked with the parents over a six-week period prior the ICPC being held. Initially there was little progress seen by CSC by the parents in improving the living conditions, and on completion of the section 47 enquiry on the 2nd of July SW1 concluded that sibling1 was experiencing harm and that there should be an ICPC.

However, when the ICPC was held three weeks later (10 days following the premature birth of Baby KK) SW1 felt that the recent improvement of the home conditions and willingness of the parents to engage with professionals meant that the need for a child protection plan for both children was not required and that a child in need (CIN) plan was sufficient. This view was supported by all the other professionals attending the conference including the Chair with the clear exception of the HSO and their manager. Interestingly, despite the HSO being the one professional present who had worked with the parents for the longest and had seen how changes made to improve home conditions had never lasted, the Chair appeared to give greater weight to the opinions of other professionals who had only started to work recently with the family, some of whom had never visited the home and seen the home conditions first hand. The HSO manager was so sure that the CIN plan would be insufficient to protect these children that she remarked to the Chair “see you back here in 3 months” which turned out to be the case.

How do we know it is an underlying issue and not something unique to this case?
The case group on discussion of this matter reported that other agencies also felt that there are closer working relationships and understanding of roles between workers from the Child Protection and Proceedings teams compared with the other early help and assessment teams. When exploring possible reasons for this it was felt that many factors came into play. These reasons could include:

- The initial assessment phase is a short-term intervention by a social worker compared with the longer-term work with families supported by child protection plans meaning there are ongoing relationships forged with other professionals working with the family;
- The assessment process may focus on gathering information from a range of professionals whereas longer-term work includes more face-to-face meetings and sometimes joint visits
- There is greater opportunity within this longer-term work for all agencies to be able to explain their roles and for professionals to gain mutual understanding of skills and knowledge.
- The Assessment & Intervention Service discussions with partner agencies are often focussed on determining thresholds for CSC intervention which may be conflictual whereas the involvement of the Child Protection & Proceedings teams has been determined by the child protection conference.

How common and widespread is the pattern?
This review only involved staff from one are within the area however the reasons given by professionals for the differences in working relations could apply across all of the county. There are other structures for delivering social work services that may ameliorate some of these issues by delivering services without separating assessment work from longer- term work.

What are the implications for the reliability of the multi-agency child protection system?

Effective practice with children and their families requires sound professional judgement based on evidence and the practitioner's knowledge and experience. If professionals working with a family do not have a clear understanding of each other's role and potential knowledge, then there is a risk that assessments will lack important information. This will in turn affect the quality of critical and analytical thinking that needs to take place and may influence the quality, effectiveness and timeliness of decision making.

Finding 1: There is a perception from partner agencies in part of the county that Child Protection & Proceedings teams have a better understanding of the relevance of supported housing input for safeguarding than Assessment and Intervention services, undermining joint working in early intervention.

One of the key aspects to effective interventions with families is the quality of partnership working relationships between different professionals. If the understanding of each other's roles is not clear for those working at the early help[15] stage, then opportunities for review and assessment of a child needs can be missed or delayed potentially leaving some of them at risk of significant harm.

Considerations for the Board and partner agencies

- Do the reasons given for this fully explain the issue?
- What lies behind this?
- Is it likely to apply to all the teams in the county?
- Do other agencies in the county divide their services between assessment and longer-term work?
- How does the Board think that the adoption of 'Appreciative Inquiry[16]' will change practice?

[15] Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years. Providing early help is more effective in promoting the welfare of children than reacting later." (Working Together 2013)

[16] Appreciative Inquiry (AI) is a change management approach that focuses on identifying what is working well, analysing why it is working well and then doing more of it. The basic tenet of AI is that an organization will grow in whichever direction that people in the organization focus their attention. If all the attention is focused on problems, then identifying problems and dealing with them is what the organization will do best. If all the attention is focused on strengths, however, then identifying strengths and building on those strengths is what the organization will do best.

Finding 2

Do hospital professionals standardly take a medical and social history only to inform their treatment of the immediate presenting illness/injury rather than also assessing whether the health history raises safeguarding issues? Professional norms & culture around multi-agency working in assessment and longer-term work.

Description

Child neglect can be multifaceted and enduring, and as such may be difficult to pick up from one single incident. It may involve a broader set of circumstances which can only be pieced together through the accumulation of evidence. Though neglect can affect any child, its impact particularly applies to infants and very young children who, among all the age groups, are at the highest risk of death and/or mental and physical damage. Whilst the immediate focus on the presenting illness/accident is essential it is also necessary for there to be adequate consideration of the impact of the home conditions on the health and general development of children.

How did the issue manifest in this case?

Even before the birth of Baby KK, there were known concerns about the poor home conditions and the parents' ability to fully acknowledge the impact this could have on their children. From the antenatal period, this knowledge was shared with hospital staff and information relating to safeguarding was completed in a specific section of Baby KK's medical records.

During the baby's lifetime Baby KK was seen and/or admitted to the local hospital on several occasions in addition to being seen for follow up appointments. The baby presented with a range of health problems including gastroenteritis, bronchiolitis, and an arm injury. Although these illnesses are not in themselves uncommon for babies to have, especially over the winter months and gastroenteritis can cause nappy rash and be associated with urinary tract infection, it appeared that other contributory factors were not explored in depth.

One example was when Baby KK was taken to hospital with gastroenteritis. When the child was admitted to hospital it was not documented that a possible cause was the lack of cleanliness and hygiene at home. Professionals in the community at that time were reporting observations of feeding bottles with mould and the bottle steriliser being found still in the cupboard. At the time staff in the hospital were unaware of these concerns despite SW2 approaching the hospital to ask if there could be a link.

Similarly, following an acute episode of bronchiolitis in the November, the causes of subsequent presentations to hospital with breathing difficulties were not explored beyond the immediate medical cause despite both parents and professionals suggesting that the poor home conditions may have been a factor.

A final example is that when Baby KK presented at Accident & Emergency with an arm injury. Even though there was a child protection plan because of neglectful parenting, the injury and the parent's explanation were accepted, and the other known risk factors were not considered. If this had happened, then he would have been referred to be seen by the paediatrician.

How do we know it is an underlying issue and not something unique to this case? (what other evidence is there?)

The case group reported that this is common practice and can be evidenced in different departments. Often the time-pressure on services results in reduced consultation times, therefore clinicians do not have the time to read about previous attendances, especially if they relate to another specialist or the information stored with the safeguarding section. Often history taking is focused on asking the parents to update and provide additional information.

The case group discussed with the review team there being "a culture of specialisms" in the health field with safeguarding being viewed as a specialist service. The danger of this approach for safeguarding is that clinicians identify their safeguarding responsibility as being purely to pass on information and not recognise their wider safeguarding role. They consider their function to be to refer to a specialist i.e. the safeguarding team rather than continuing to be involved and providing guidance and support to social workers in determining whether health problems are indicators of safeguarding concerns.

How common and widespread is this pattern?

This review concerned a child that was seen at the Hospital in the county and all the research was undertaken with professionals working in or with that hospital. However, practice that was undertaken was routine and similar to that in other hospitals and there is no reason to think that the underlying practice would be different in other hospitals across the county or probably the rest of England.

What are the implications for the reliability of the multi-agency child protection system?

All professionals working with children have a duty to safeguard and promote the welfare of children and contribute to the multi-agency safeguarding process. If health professionals do not adequately consider the impact that environmental conditions and neglectful parenting may have on a child's well-being then, opportunities to intervene on behalf of children are missed.

Finding 2
Do hospital professionals standardly take a medical and social history only to inform their treatment of the immediate presenting illness/injury rather than also assessing whether the health history raises safeguarding issues?

This review has identified that, in relation to acute presentations, there is may be a tendency to focus on the presenting illness/injury and not to consider other explanations and check records even when there are known safeguarding concerns. This potentially places some children at risk if all aspects of neglectful parenting are not fully explored. This is particularly true for acute short admissions (less than 24 hours) as hospital records may not be easily accessible.

Considerations for the Board and partner agencies

- Is this a known problem to the Board?
- Does the Board think that this finding would apply to other hospitals in the county?
- Is it known whether children with a known condition get a more consistent service and are better protected?
- Would a single electronic record improve identification of safeguarding concerns?

Finding 3

Are general practitioners in the county reluctant to refer directly to Children's Social Care, preferring to consult with fellow health professionals? Professional norms & culture around multi-agency working in assessment and longer-term work.

Description

General practitioners (GPs) and primary healthcare teams are best placed to spot the early signs of child abuse and neglect. They have an overview of issues affecting individual members of a family which, in combination, may impact on a child's welfare. They are also in a position to co-ordinate the work of different agencies supporting children and families. The RCGP/NSPCC Safeguarding Children Toolkit for General Practice identifies the following role for GPs in safeguarding and protecting children from abuse and neglect:

- 'The majority of children and their families in the UK are registered with a GP and general practice remains the first point of contact for most health problems.
- GPs and their practice teams have a key role not only in providing high-quality services for all children but also in detecting families at risk, supporting victims of maltreatment and providing on-going care and assessment while contributing to case conferences and care plans.
- Identification of child abuse has been likened to putting together a complex multi-dimensional jig-saw. General Practitioners and their Teams, who hold knowledge of family circumstances and can interpret multiple observations accurately recorded over time, may be the only professionals holding vital pieces necessary to complete the picture.
- It is important to acknowledge when there may be barriers to recognition of risk and taking action on child maltreatment and to overcome them. Child maltreatment is a costly societal and public health issue but is preventable and should not be tolerated'. [17]

How did the issue manifest in this case?

On the day that Baby KK was seen by the GP for the 8-week developmental check, Sibling was noted to be bleeding from the mouth, on examination the child was reported to have a torn frenulum[18]. There was no clear account of how this injury occurred. This caused the GP some concern, combined with the fact that both children were dressed inappropriately for the weather.

Although the GP was concerned enough to discuss with a colleague who was the safeguarding lead GP for the practice he did not contact CSC and instead decided to discuss the case with the health visitor. At this point the GP was unaware of the initial

[17] Safeguarding Children and Young People: The RCGP/NSPCC Safeguarding Children Toolkit for General Practice - http://www.rcgp.org.uk/clinical-and-research/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx

[18] Frenulum is a small fold or ridge of tissue which supports or checks the motion of the part to which it is attached, in particular a fold of skin beneath the tongue, or between the lip and the gum.

child protection conference held three months previously or that the outcome was that there should be child in need plans for the two children. The family only registered with this GP in September 2015 and although CSC have a record that the minutes of the ICPC were sent to the GP they were not found in the children's records and the Surgery have no record of that ICPC taking place or the minutes received. When interviewed for the review the GP with lead for safeguarding in the practice also reported that she did not routinely read conference minutes and therefore was not always aware of the current safeguarding concerns relating to children registered with their surgery. She suggested that this was usual practice for most GPs.

Although the GP and health visitor discussed the injury and general appearance of the children, the focus of the conversation was on ensuring the family were receiving support. The opportunity to highlight the incident as a safeguarding one was not addressed by either professional. It is difficult to understand why when the GP learnt of the ongoing safeguarding concerns for the children and that they were the subject of child in need plans, the responsibility to contact CSC was not recognised.

How do we know it is an underlying issue and not something unique to this case?
On talking with case group members, previous examples were given where a GP had contacted CSC for advice on a case and the response they had received had dissuaded them from making contact with CSC in another incident. They said they felt more comfortable discussing concerns with a fellow health professional especially one who had a lead in safeguarding. Research has identified that a GP often will consult a fellow GP or other health professionals for further discussion rather than refer to CSC in the first instance (Hilary Tompsett et al 2009).[19] In part this may be because GPs view themselves as supportive as opposed to challenging and want to keep their relationship with the patients.

Members of the review team wondered if GPs could lack confidence in dealing with child protection concerns and feel that other professionals had a greater knowledge base and expertise than GPs. The nature of general practice is that the GP needs to know "a bit about a lot", as generalists they may struggle to feel that they are experts in that area. One suggestion is that GPs are generally very aware of their safeguarding responsibilities, but may need guiding through the process, particularly if they have not had recent child protection involvement in a case.

Interestingly the perception held by many professionals that GP's are the hub for all the health information is not one that is shared by many GP's who expressed concern that people thought that the allocated GP would hold all the information about any registered patient.

[19] DfES/DH Research Project The Child, the Family and the GP: Tensions and conflicts of interest in safeguarding children May 2006 – October 2008

How common and widespread is this pattern?

Research conducted by Hilary Tompsett et al in 2009[20] found that half of the GPs consulted expressed a preference for seeking early advice and support from a paediatrician or other health colleague, rather than children's social care services. In addition, two thirds of GPs rated the health visitor as highly significant to refer to, where there was concern for a child. GPs on the whole would prefer a model of referral that allows more stages of consideration, discussion and consultation before 'raising concerns'.

It has not been possible to determine how many children could be involved as data on how many children with child protection plans are held at each GP practice is not known. The arrangements described at this GP practice may also not be representative of other GP practice therefore further research may be needed to determine the extent of this problem.

What are the implications for the reliability of the multi-agency child protection system?

The majority of children and their families in the UK are registered with a GP and general practice remains the first point of contact for most health problems. GPs and their practice teams have a key role not only in providing high-quality services for all children but also in detecting families at risk, supporting victims of maltreatment and providing on-going care and assessment while contributing to case conferences and care plans. If GP's do not share safeguarding concerns relating to a child they are treating then the opportunity to intervene and share information with CSC will be missed, potentially leaving children at risk of harm.

Finding 3: Are general practitioners in the county reluctant to refer directly to Children's Social Care, preferring to consult with fellow health professionals?
Considerations for the Board and partner agencies • Is this a known problem to the Board? • Is it known how often GPs refer to CSC? • What is known about why GPs may be inhibited from referring? • How is the LSCB assured that GP's recognise their roles in safeguarding and are confident in making referrals to CSC when required? • How is the LSCB assured that when child protection conference minutes are circulated that they are routinely reviewed and considered by GPs? • Are the present arrangements for liaison between GP practices and health visitors the best way of safeguarding children with specific health care needs? • Do GPs receive relevant information in a timely manner? • Should there be data collected indicating how many children with child protection plans are held at individual GP practices?

[20] DfES/DH Research Project The Child, the Family and the GP: Tensions and conflicts of interest in safeguarding children May 2006 – October 2008

Finding 4

Does the fluctuating nature of neglect and the inconsistent ability of parents to maintain improvement undermine professionals' ability to see and respond to neglectful parenting? Professional norms & culture around multi-agency working in assessment and longer-term work.

Working Together 2015 defines Neglect as: [21] The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or

ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs

Neglect is notoriously difficult to define, partly because it is cumulative and difficult to measure. In addition, neglectful parenting can fluctuate and often the underlying impact on children in the long term is not analysed. There is a tendency to focus on physical symptoms which are easier to evidence. Often professionals find it harder to agree something as neglect when it is not seen as a deliberate act. One of the difficulties in identifying children who are being neglected is that there is no set standard about what is 'acceptable care'. This makes it very difficult for professionals to evidence when care falls below an acceptable standard and makes the decisions about when the quality of care is so low as to warrant decisive action more difficult.

How did the issue manifest in this case?

During the 10-month period that CSC worked with the parents both social workers considered the detrimental impact to health that the poor living conditions could be having on the health and wellbeing of both children, but especially in relation to Baby KK.

Whilst both social workers had concerns, they did not have the expertise to evidence that the neglect contributed to the health problems experienced by Baby KK. When they appropriately sought the backing of medical staff to support their observations that the poor home conditions could be causing an adverse effect on the children the response they were given was that they could not prove a definite link to enable them to take protective action.

When Baby KK was admitted with gastro enteritis SW1 asked the hospital what they thought the cause could be and could it have been due to the poor unhygienic home

[21] Working Together to Safeguarding Children 2015 HMG

conditions? The hospital's response was that they felt that the parents were probably not to blame and that Baby KK probably had a propensity to stomach disorders which are not uncommon in premature babies.

SW2 contacted the hospital after Baby KK had been seen for breathing difficulties to explore further if the home conditions were a contributory factor to his health problems, especially as the parents were clear that it was the mould causing Baby KK's ill health. The hospital responded by saying that yes, it could be a result of home conditions, but it could also be because of a range of other medical reasons.

Although in the community there was a wealth of evidence of extremely poor home living conditions, it is apparent that hospital staff did not understand the extent of the actual living conditions for these children and the term "poor living conditions" a common umbrella term used did not convey the true nature of the problem. Additionally, due to his prematurity and known medical history it was understandable that these factors were given more importance and the impact of the home environment was lost. Overall, the lack of substantive, consistent evidence of neglectful parenting causing significant harm to the children influenced the decision not to make the children subject to a child protection plan at the first ICPC.

How do we know it is an underlying issue and not something unique to this case?
Neglect is a multi-faceted issue, which can include dimensions such as emotional, supervisory and medical neglect, as well as neglect of physical care (Horwath, 2007).[22] In order to understand whether neglect is occurring, therefore, a range of factors must be considered including emotional and developmental needs as well as the immediate need for an adequate diet, warmth and safety. This case has suggested the focus on trying to improve the living conditions, and lack of evidence to link home conditions with physical health or development at times meant that two young children remained living in a neglectful environment.

Discussions with the review team indicated that when there appears to be a physical effect on a child of the parents' actions or inactions (i.e. a failure to gain weight) it is easier to evidence neglect leading to safeguarding action. Action was immediately taken by both the health visitor and the social worker. This was discussed with case group members who confirmed that in the absence of clear detriment to the child as a result of parents' actions it was hard to clearly identify that their behaviour was intentionally neglectful parenting. Review of the 'Neglect Strategy' is underway and has already identified a varying capacity to sustain improvement with families. Audits of neglect in the county have also identified that this as an area of difficulty.

Discussions within the review team confirmed that this was likely to be repeated in other circumstances, and that it was in part why the medical assessment of a child was

[22] Horwath, J (2007) Child Neglect: Identification and Assessment, Basingstoke, Hampshire: Palgrave Macmillan

deemed to be such an important facet of the child protection investigation, as it provided the opportunity for concrete evidence. Research has also shown that the cases that are most likely to catch the attention of the frontline practitioner are those that present the clearest evidence of harm. Research on biases in human reasoning finds that recall is stronger for very vivid or emotive material, such as visible injuries to children.

How common and widespread is this pattern?

There were 26,761 children in the UK on child protection registers or the subject of child protection plans under a category that included neglect on 31 March 2016 (or 31 July 2016 in Scotland). This equates to 46% of all the children on child protection registers or the subject of child protection plans according to the NSPCC (NSPCC, 2016). In the county data collected over a seven-month period in 2017 indicates that 65% of children with child protection plans have neglect as the primary criteria and a further 27% have it as a secondary criterion.

National research regarding neglect has highlighted that it presents a significant challenge to professionals: 'Numerous factors have been identified as potential obstacles to effective action. Firstly, professionals may have concerns about neglect, but they may lack the knowledge to be aware of the potential extent of its impact. Secondly, resource constraints influence professional behaviour and what practitioners perceive can be achieved when they have concerns about neglect. Thirdly, a number of additional 'mindsets' hamper professional confidence and action'.[23]

This research explored the observable risk factors that could be identified in neglectful families and suggested that 'Systematic assessment of these factors and the interrelationships between them, using a conceptual framework such as Glaser's tiers of concern should lead to more timely action and fewer missed opportunities'. [24]

This review was conducted in one area of the county however discussions with the review team and findings from County-wide audits would suggest that this finding is applicable across the whole LSCB.

What are the implications for the reliability of the multi-agency child protection system?

For children to be effectively protected professionals need to be confident in their understanding of **all** aspects of neglectful parenting including the impact of poor home environments and understand the long-term effects on children and babies if intervention and change does not occur in a timely way.

[23] Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? Research report November 2014 , Marian Brandon, Danya Glaser, Sabine Maguire, Eamon McCrory, Clare Lushey & Harriet Ward – Childhood Wellbeing Research Centre

[24] ibid

Finding 4: Does the fluctuating nature of neglect and the inconsistent ability of parents to maintain improvement undermine professionals' ability to see and respond to neglectful parenting?

Identifying and assessing child neglect can be difficult, and evidencing progress over time – or lack of it – can be even trickier. Yet this is crucial for making the right decision about a child's welfare. This review has identified that without hard evidence professional struggle to ensure the long-term effects on young children and risks are recognised.

Considerations for the Board and partner agencies

- What does the Board know about this problem?
- What are the barriers to professionals being able to identify and respond to neglect?
- What does the Board know about how well the 'Neglect Strategy' recognises this challenge for staff?
- What does the Board know about how well the tools available to professionals across agencies help in identifying risk factors for neglect?
- Do professionals across agencies in the county apply consistent and comparable standards in determining the risks presented by the environment that families live in?
- Has a focus on obtaining the views of the child meant that other assessment tools are less used?

Finding 5

Seeing the task of hospital clinicians as to "assess, treat, discharge, and where necessary refer on to specialist services" works for most children but means there may be limited involvement of hospital professionals in on-going safeguarding work even when a child is being admitted repeatedly to hospital, undermining multi-agency safeguarding work to protect children. Professional norms & culture around multi-agency working in assessment and longer-term work.

Description

Healthcare professionals are in a key position to be able to identify vulnerability within families and act upon concerns when it is thought that an infant, child or young person may need 'early help' or be 'at risk of harm'. To do this successfully, it is essential that each individual service recognises its own responsibility in identifying concerns, sharing information and taking action where necessary. Within all services staff who come into contact with children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding issues, including child protection. In England, all NHS trusts, foundation trusts, and public, voluntary sector, independent sector, social enterprises, and primary care organisations providing health services, must have a named doctor, named nurse, and named midwife. [25]

Hospitals by their very nature operate in a different way to community services. Within a hospital, safeguarding is viewed as a specialism led by the 'named professionals' with every staff member being trained and aware of their safeguarding responsibilities to refer appropriately to the safeguarding specialists. The practice of referring to a specialist is common practice in hospital and so the expectation that safeguarding work is led by the 'named professionals' and not the clinician who is treating the child is the norm and a partnership is maintained between the safeguarding team and the clinician in order to get the best outcome. The safeguarding team provide a consistent overview and supervision and inform changing medical and nursing teams.

How did the issue manifest in this case?

On several occasions throughout his life Baby KK was seen and admitted to the local hospital. From before the birth there had been safeguarding concerns around neglect that had been shared with the hospital. CSC communicated on a number of occasions with hospital staff, initially through the named midwife then the named nurse but not usually directly with the doctors who treated Baby KK, the exception being on one occasion when the baby attended with an arm injury.

[25] Safeguarding Children and Young people: roles and competences for health care staff INTERCOLLEGIATE DOCUMENT March 2014 Published by the Royal College of Paediatrics and Child Health 2014 on behalf of the contributing organisations. *https://www.rcn.org.uk/nursing/survey-of-designated-nurses-for-safeguarding-c...*

At one point the social worker wanted to explore if the repeated breathing problems experienced by Baby KK could be due to the poor home environment. She raised these issues with the named nurse who liaised with the paediatrician involved in the case. The response was appropriate and explored different possibilities i.e. that poor home conditions were 'one of a number of factors that could be relevant'. The paediatrician responded to the question but may have had a different view if he had spoken directly with the social worker who could have provided detailed information about the home conditions. Overall the focus of safeguarding responsibility within Hospital1 was on sharing information about any concerns that had been observed but not analysing and exploring if there was a link between the known poor home environment and limited parenting capability with the presenting medical symptoms.

On another occasion Baby KK was ready for discharge following a Paediatric Intensive Care Unit admission with bronchiolitis. Although hospital staff knew the condition of the home was poor and had agreed to delay the discharge, a discharge planning meeting was not held. However, discharge 'discussions' occurred, and hospital staff liaised with the social worker and they agreed that the baby could be safely discharged. The hospital staff were satisfied that CSC had organised a "big package of care" although there was no record of the care being provided. The accepted norm that hospitals generally do not play a part in ongoing safeguarding work was also accepted by CSC who did not approach the hospital to be actively part of the safeguarding process for Baby KK and no hospital staff, including the named nurse, were invited to the core group meeting that was held two days before discharge. A discharge planning meeting could have been incorporated into the core group meeting.

How do we know it is an underlying issue and not something unique to this case?
This case has suggested that because hospital staff were not an integrated part of the safeguarding work being undertaken in the community, the opportunity to protect children at an earlier stage was delayed. By the very nature of how hospitals operate, patients are not usually seen by the same staff when presenting for a variety of health illnesses or accidents. The reason for presentation will indicate which department will treat them and unless they are under the care of a specific consultant then generally each admission is treated as a one off with the expectation that the patient will not need to return. This makes it difficult then to identify a single person who can be part of the safeguarding process for a patient over a period of time. Attending conferences and being a core group member is part of the safeguarding responsibilities of hospital staff and they do attend if invited and are able to do so. If they cannot attend they will send a report. Baby KK had an allocated consultant as a result of his Neonatal Intensive Care Unit admission and was offered outpatient follow-up and ongoing care. However, this was not known by the social work staff, and despite a number of contacts being made with the hospital, it was never suggested that the hospital was available to attend such meetings.

This review has identified that this approach of delegating safeguarding to specialist professionals who are not directly seeing the patient may lead to a dilution of the information being discussed. It also may lead to hospital professionals seeing their main responsibility for safeguarding children, already known to CSC, as being to share information about specific concerns rather than analysing or exploring the child and family presentations in relation to known safeguarding risks which in this case were around the home environment and poor parenting.

How common and widespread is this pattern?

This review concerned a baby seen at a county hospital and all of the research was undertaken with professionals working in or with that hospital. That being said, the practice that was undertaken was routine and similar to that in other hospitals and there is no reason to think that the underlying practice would be different in other hospitals across the county or probably the rest of England.

All hospitals are required to have named professionals who are their organisations specialist in child protection and often are the key people who act on the behalf of health professional in overseeing and managing safeguarding work. Data relating to the number of children with child protection plans and child in need plans who are treated at hospital in the county is not collected. However, it is known that Hospital1 shared information with CSC on 189 occasions during September 2016 to September 2017, this cohort would include children with child protection plans, child in need plans and looked after children.

What are the implications for the reliability of the multi-agency child protection system?

Effective safeguarding relies on professionals working closely together. If professionals only see their role as being to assess, treat, discharge, and where necessary refer on to specialist services then there is a danger they will only focus on the presenting problem and miss the wider picture which could identify child protection risk factors. With the 'New Deal and Working Time Regulations[26]' for junior doctors there is increased changeover of doctors.

There is also a danger that this leaves hospital professionals taking a passive role and not being proactive in safeguarding children. If health professionals just address medical problems and do not work closely in partnership with social workers, especially where there is neglectful parenting, there is a danger that children will be cared for by inadequate parents for longer than is necessary.

[26] www.bma.org.uk/advice/employment/contracts/junior-doctor-contract

Finding 5: Seeing the task of hospital clinicians as to "assess, treat, discharge, and where necessary refer on to specialist services" works for most children but means there may be limited involvement of hospital professionals in on-going safeguarding work even when a child is being admitted repeatedly to hospital, undermining multi-agency safeguarding work to protect children.

All agencies who have any contact with children or work with parents and carers for children have safeguarding responsibilities. Effective safeguarding systems are those where all professionals know about how to protect children and there are good partnership arrangements that enable joint collaboration. This review has identified that a potential flaw in the multi-agency system is the extent to which frontline hospital professionals are fully engaged with safeguarding work. This is because they see this as the responsibility of a specialist safeguarding team and do not fully understand their ongoing role in safeguarding work.

Considerations for the Board and partner agencies

- Does the Board think that this finding would apply to other hospitals in the county?
- Are there any examples where there is greater involvement of frontline professionals in safeguarding work in the community?
- What does the Board think would assist professionals to consider wider factors when working with children were there could be child protection concerns?
- What does the Board know about the frequency and effectiveness of discharge planning meetings?
- Is the board confident that discharge planning meetings are routinely held in all situations?

Finding 6

Does the nature of chronic neglect mean that evidencing that deteriorating conditions is increasing harm, make it hard for the current threshold in care proceedings to be met, risking leaving children for over-long periods in substandard care? Patterns in human–tool operation.

Description

When social workers are concerned about the welfare of a child, they may be thinking about taking the case to court so that they can ask the court to make orders to protect the child. In most cases the Public Law Outline[27] requires the social services department to arrange a meeting with the parent(s) to see if it is possible to reach agreement about what needs to happen to protect the child from harm, so that court proceedings can be avoided. The hope is that the parents will come to the meeting with a solicitor. The solicitor will be able to help the parents to negotiate an agreement with the social services department to try to avoid the need to go to court. This formal meeting is often known as a “pre-proceedings meeting” or “PLO meeting”. In some cases, the social workers may feel that the risk of harm to a child is so great, or the case is so urgent, that the case should go straight to court. In these cases, no meeting takes place at all and the discussions about whether care is good enough take place in a court environment.

How did the issue manifest in this case?

CSC commenced legal proceedings in January 2016, and it was not until the 2nd of March that the FSW and SW visited the family at home to deliver the letters of intent. Although mother got a solicitor immediately, father did not. The PLO meeting with mother and CSC took place on the 15th of March but it could not go ahead for father as he still did not have a solicitor of his own. It was not clear if this delay was because father was being difficult and wanted to delay the process or just that he did not see the need for having a solicitor. However, SW2 was so concerned that father would not contact a solicitor without firm encouragement that she visited on the 20th March and did not leave until father had contacted one. The PLO meeting was arranged and held on the 27th of April. The threshold for initiating the PLO was deemed to be met in early January therefore it took almost four months for the initial process to be achieved during which time Baby KK and Sibling were experiencing neglectful parenting that in the views of professionals constituted significant harm. It was also evident that during this time the home conditions were deteriorating, and the pressure experienced by the parents was leading to disagreements between them with verbal arguments, possible domestic violence and possible physical abuse of Baby KK.

[27] 'The Practice Direction Guide to Case Management in Public Law Proceedings' [2008] 2 FLR 668, more commonly known as the 'Public Law Outline' or 'PLO' has been revised with effect from 6 April 2010. The revised PLO has three main features: elaboration of the 'Timetable for the Child' principle, reducing the burden of documents required at issue of proceedings, and streamlining the PLO forms.

How do we know it is an underlying issue and not something unique to this case? (what other evidence is there?)

Conversations with case group members indicated a degree of frustration with the time taken to achieve the threshold for care proceedings with some families. There was a lack of understanding of how the process worked but a feeling that there was better intervention when there was immediate progression to court intervention because of risk of physical injury. Review team and case group members agreed that the legal processes worked well if a child had made a disclosure and there was clear evidence of significant harm but felt that they did not work well with neglect cases where the incidents were cumulative.

'The PLO brings important benefits in terms of clarifying expectations of parties to proceedings and setting aims. However, one of the PLO's main aims, reducing delays in proceedings, is not being met, and is unlikely to be met without holistic investment in the family justice system. Merely tackling burdensome paperwork will not be enough to truncate the long timescales of care and supervision proceedings because there are problems which need to be tackled that run much deeper into the family justice system: problems such as delays in the appointment of guardians, underfunding, and ineffective inter-agency co-operation'. (Familylawweek.co.uk)

Research about pre-care proceedings has identified that while pre-care proceedings are valued by social workers, their managers, and parents and sometimes they can enable enough change in a family for a proportion of children to remain with their parent(s), however, the process may delay decisions for children who eventually have to enter care[28].

How common and widespread is this pattern?

As of 31st March 2017, there were 870 looked after children in the area however the majority of these children would probably not be subject to a legal order. Nationally the number of children looked after under a care order has increased by a third, from 7,550 children in 2016 to 10,130 in 2017. 31% of all children starting to be looked after were looked after under a care order in 2017, up from 23% in 2016[29]. It has not been possible to access data detailing the numbers of care proceedings in the area with breakdown of how many children become the subject of care orders and how many are resolved by children remaining with parents because this data is not currently collected. The Local Authority is considering whether this data should be collected in the future.

[28] Masson, Judith M. and Bader, Kay and Dickens, Jonathan and Young, Julie, The Pre-Proceedings Process for Families on the Edge of Care Proceedings: Summary Report (April 3, 2013). Available at SSRN: https://ssrn.com/abstract=2281153 or http://dx.doi.org/10.2139/ssrn.2281153

[29] Source: SSDA903 https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2016-to-2017

What are the implications for the reliability of the multi-agency child protection system?

By focusing on obtaining evidence as part of the PLO process, a lack of evidence should not be assumed to be positive. The way the PLO process works and the thresholds for intervention operating in the county courts has the potential to leave children, especially those at risk of neglect, in substandard care for long periods.

Finding 6: Does the nature of chronic neglect mean that evidencing that deteriorating conditions is increasing harm, make it hard for the current threshold in care proceedings to be met, risking leaving children for over-long periods in substandard care?
This case has identified that where there is chronic neglect and it is hard to evidence immediate risk of significant harm, the time that it takes to meet the current threshold for care proceedings risks leaving children in risky situations for long periods. The current legal arrangements do not easily include other agencies meaning that professionals may not be aware of the reasons for the apparent lack of intervention. Parents may also contribute to delay by not co-operating with the PLO processes such as accessing legal advice. The effect of this may lead to there being significant time before intervention to remove children from risky environments. **Considerations for the Board and partner agencies** • Are the current legal processes effective at protecting children when in a neglectful situation? • What does the Board know about the timeliness of the current legal process? • What is the understanding of agencies outside of CSC of the current legal processes including PLO? • How involved are agencies in contributing to planning for children once PLO is initiated?

Finding 7

Is there a culture in the county whereby constructive challenge is interpreted as personal and organisational criticism, fostering defensiveness between agencies and reducing the likelihood that escalation of safeguarding concerns happens when needed? Patterns in human–management system operation.

Description

In order for children to be protected, professionals need to work well together and part of a healthy working relationship is the ability to discuss and constructively challenge each other. Without challenge and analysis, risks may not be fully understood and outcomes for children may not be in their best interests. This case has suggested that when challenged staff from different agencies can take the criticism personally and become defensive, this in turn can lead to staff avoiding challenge such as escalating concerns.

How did the issue manifest in this case?

Following Baby KK's attendance at the Accident & Emergency department with an arm injury reportedly caused by the baby's arm becoming trapped in the cot, SW2 was not comfortable with the diagnosis made by the doctor that this was accidental injury. Based on the social worker's background knowledge of this child, namely that the child spent much time in a car seat and had never been seen in the cot by a professional, the story of the baby being in a cot appeared unusual.

The social worker rightly questioned the presentation with the A&E registrar, but the registrar was clear that the stories of both parents matched, there was no delay in presentation and that the injury matched the suspected mechanism. The doctor acknowledged that the baby was unkempt and possibly overweight and was aware that CSC were working with the family. SW2 did not challenge the registrar as to why he had not referred Baby KK to a paediatrician in line with the procedure for injuries in babies under one year of age, especially when they are subject to a Child Protection plan because she was not aware of this protocol. Still uneasy with the decision of the registrar SW2 discussed the injury with her manager. The matter however was left there and there was no consideration of escalating their concerns and asking for a review of the case by either the named doctor in the hospital or the Designated Doctor for the county who could have reviewed the case notes.

How do we know it is an underlying issue and not something unique to this case?

The Review Team and Case Group reported that many staff including managers were not ready or confident to escalate issues when there is difference of opinion. People were too polite to challenge each other but were left uncomfortable with the outcomes. Staff have witnessed constructive challenge being interpreted as personal criticism, which leads to defensiveness. This defensiveness can occur at all levels within organisations.

A previous SCR of Child X carried out in the LSCB found:

> "*Sometimes staff feel that 'challenge' is too confrontational, rather than seeing it to be simply requiring good answers"* Alan Bedford 2013.

The most recent Ofsted inspection process identified that although the LSCB was able to challenge practice 'it was often issue-specific and reliant on the individual authority of the independent chair, rather than as part of a consistent exercise of the board's role as critical friend'. It also praised the child protection conference dissent group as 'an effective venue for challenging decision making and planning at conferences to ensure that children have plans that meet their assessed needs and risks' however this body has now been disbanded. The report concluded that the board's 'influence on key partnership agencies is not as strong as it could or should be'.

How common and widespread is this pattern?
This review was conducted in one part of the county however Review team members did not think that this was an issue that was specific to the area but was representative of practice throughout the county.

There has been significant work done on developing the levels of need document since the Ofsted inspection and it is thought that the work associated with this may have enabled professionals to have greater confidence in the escalation processes however this has not yet been evidence through practice.

Since the initiation of the MASH system there have been examples in practice where decisions have been challenged however there are currently no systematic records kept of challenges.

Similarly, although the Section 11 audit[30] requires agencies to evidence that staff are aware of escalation processes there is no requirement for agencies to keep records about numbers of challenges or their outcomes.

What are the implications for the reliability of the multi-agency child protection system?
If opportunities for challenge are missed due to a professional's previous experience this is a chance to re-evaluate a situation that is lost and allows a perpetuation of potentially flawed 'fixed' thinking. This can lead to the professionals missing critical and significant information about the nature of relationships within a household, as well as the nature of the care being provided to the children.

[30] The LSCB assesses the effectiveness of local safeguarding arrangements in various ways, including Section 11 safeguarding self-assessments. This is where all local agencies and organisations who provide services to children and young people are asked to self-assess the extent to which they meet the safeguarding requirements and standards as set out in Section 11 of the Children Act 2004. The LSCB has formally adapted and developed the Section 11 Audit Tool and Guidance based on Board priorities.

Finding 7: Is there a culture in the county whereby constructive challenge is interpreted as personal and organisational criticism, fostering defensiveness between agencies and reducing the likelihood that escalation of safeguarding concerns happens when needed?
Critical challenge between professionals should be regarded as something that is both healthy and productive in developing a strong and healthy safeguarding system. If there is defensive thinking and mutual self-protection there is the possibility that children will be left at risk. **Considerations for the Board and partner agencies** • What knowledge does the Board have of this issue? • How has the introduction of 'Signs of Safety[31]' and 'Appreciative Inquiry[32]' changed the culture in the county? • How does the Board and its member agencies consider the degree to which 'challenge' is encouraged as an important part of professional work, and valued as something in the interests of children? • How does the Board know if escalation policies are sufficiently understood and applied in cases where there is professional disagreement? • How can the Board evidence that there is sufficient training around escalation policies and that it has changed practice? • What does the Board know about the barriers to professional challenges to each other, particularly around decisions made at child protection conferences?

[31] The Signs of Safety model is a tool intended to help practitioners with risk assessment and safety planning in child protection cases. Its purpose is to enable practitioners across different disciplines to work collaboratively and in partnership with families and children. https://www.nspcc.org.uk/services-and-resources/.../signs-of-safety-model-england

[32] Appreciative Inquiry (AI) is a change management approach that focuses on identifying what is working well, analysing why it is working well and then doing more of it. The basic tenet of AI is that an organization will grow in whichever direction that people in the organization focus their attention. If all the attention is focused on problems, then identifying problems and dealing with them is what the organization will do best. If all the attention is focused on strengths, however, then identifying strengths and building on those strengths is what the organization will do best.

Finding 8

The routine method of communication used in hospital settings – namely verbal instructions - does not accommodate limitations to parental capacity to understand the information being given. Professional norms & culture around multi-agency working in assessment and longer-term work.

Treating sick babies and children is dependent on a collaborative approach between professionals and parents. Often the day to day care for a sick child will be the responsibility of the parent who will need to maintain the health regimes initiated by staff in the hospital setting when the child returns to live in the community. Generally, hospital staff show parents how to do the treatment and then watch them as they do it to check they understand the process. This advice is often supported by the parents being given leaflets that explain in more detail the advice given.

How did the issue manifest in this case?

Hospital staff had contact with the family throughout Baby KK's life. Most professionals in the community working with the family were aware that the mother had some learning difficulties and were careful to check her understanding and SW2, in particular, was using visual aids to assist in this process. It is unclear however how much awareness there was by hospital staff of mother's limitations.

Following the near fatal episode of Bronchiolitis in December, Baby KK was prescribed an inhaler. Although routine instruction was given to the parents there is no evidence that the hospital staff provided any additional guidance or assessed the mother's capacity to understand and use the inhaler. There are no records of what advice was given but normal practice is that when a child is prescribed inhalers in hospital staff teach parents inhaler techniques and review these at every admission. This is conducted routinely and is only documented if there were concerns about the technique.

Mother has reported to the lead reviewer that when Baby KK was first prescribed an inhaler, she was shown once how to use it and she described this as not being very helpful. Baby KK was seen at the hospital and admitted with breathing difficulties on several occasions yet there is no record that staff checked to see if parents had understood how, why and when they should use the inhaler. Mother reported that it was "really hard to use the inhaler, Baby KK would cry so much that she wasn't sure that her baby could take much in because [the child] was crying too much". It was not until the April that Baby KK was admitted with mother to the hospital to specifically address training on how to administer inhalers which was five months after they had first been prescribed.

Mother has dyslexia[33] which meant that she struggled to understand medical terminology and said that doctors routinely used long words which she did not understand. She described being told that Baby KK had bronchiolitis and having to look up the word on the internet to find out what it meant. Mother reported that whilst some nurses supported her by explaining the meaning of some of the words used by the doctors this did not happen all the time. There was no attempt to communicate in a different way such as by using pictorial aids as a way of instruction, a method SW2 had adopted.

How do we know it is an underlying issue and not something unique to this case?

Hospital staff like many other health professionals tend to approach teaching and informing patients/parent using instructive methods often supported by leaflets which works well for many individuals, but not all. It can be a challenge for staff to know what exactly a client has understood if they do not themselves indicate that they have not fully understood something. Professionals in the case group who were not hospital staff confirmed that it is not unknown for their clients to be unclear about what they have been told in hospital even though it is reported that processes have been explained to them. It was also reported that on occasion patients nod in agreement even if they haven't understood what is being said to them.

It is not uncommon for people with dyslexia to adopt strategies to manage the effects of their condition, making it harder for professionals to realise that if they have a difficulty.

Research has identified that '40-80% of medical information provided by healthcare practitioners is forgotten immediately. The greater the amount of information presented, the lower the proportion is correctly recalled; furthermore, almost half of the information that is remembered is incorrect'. There were three explanations for patients forgetting information 'first, factors related to the clinician, such as use of difficult medical terminology; second, the mode of information (e.g. spoken versus written); and, third, factors related to the patient, such as low education or specific expectations'[34]. This research concluded that 'Memory for medical information is often poor and inaccurate, ... Patients tend to focus on diagnosis-related information and fail to register instructions on treatment. Simple and specific instructions are better recalled than general statements. Patients can be helped to remember medical information by use of explicit categorization techniques. In addition, spoken information should be supported with written or visual material. Visual communication aids are especially effective in low-literacy patients'.

[33] Dyslexia is a common learning difficulty that can cause problems with reading, writing and spelling. It's a "specific learning difficulty", which means it causes problems with certain abilities used for learning, such as reading and writing. Unlike a learning disability, intelligence isn't affected.

[34] Patients' memory for medical information, Roy P C Kessels, PhD, Journal of the Royal Society of Medicine, Royal Society of Medicine Press, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC539473/

How common and widespread is this pattern?

It is estimated that up to 1 in every 10 to 20 people in the UK has some degree of dyslexia[35] however the issues raised would apply to any individual with literacy difficulties or problems with cognitive functioning. This review concerned a child that was seen at the Hospital and all the research was undertaken with professionals working in or with that hospital. However, practice that was undertaken was routine and similar to that in other hospitals and there is no reason to think that the underlying practice would be different in other hospitals across the county or probably the rest of England.

What are the implications for the reliability of the multi-agency child protection system?

If parents are to safely provide ongoing health treatments in the community to their children, there must be confidence that they understand how to administer such support. To achieve this understanding, staff in hospitals need to be enabled to provide guidance and support to parents in a way that is customised to the specific needs of the parents. Without this there is the potential for parents to misunderstand or ignore guidance about the provision of treatment to their children having an adverse impact on their health and possibly causing direct harm to them. Specifically, if the parents of babies and children with health problems are not given sufficient support in understanding how to manage their conditions well in the community they will keep returning to hospital which is an inefficient use of resources.

[35] Source NHS Choices

Finding 8: The routine method of communication used in hospital settings – namely verbal instructions - does not accommodate limitations to parental capacity to understand the information being given.

The current systems in Hospitals for advising parents about diagnosis and treatment of their children are not sufficiently customised to accommodate parents with literacy problems or other learning difficulties. If health interventions for babies that rely on parental delivery are to be effective, there needs to be reliable mechanisms to check that the parents understand what it is they need to do, when they need to do it and why. Without this, some failures are inevitable.

Considerations for the Board and partner agencies

- Is this a known problem to the Board?
- Does the Board think that this finding would apply to other hospitals in the county?
- What are the barriers to health professionals in enabling them to communicate in more effective ways for patients with learning difficulties?
- Is there enough/the right health support in the community for families with known learning difficulties who have children requiring medical treatment such as inhalers?

Appendix 1 – Methodology

1. This SCR has used the SCIE Learning Together model for case reviews. This is a 'systems' approach which provides a theory and method for understanding why good and poor practice occur, to identify effective supports and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high-risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and CP work (Munro, 2005; Fish et al, 2009). National guidance in the 2015 revision of *Working Together to Safeguard Children* (2015) now requires all SCRs to adopt a systems methodology.

2 The model is distinctive in its approach to understanding professional practice in context; it does this by identifying the factors in the system that influence the nature and quality of work with families. Solutions then focus on redesigning the system to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.

3 Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.

4 The basic principles – the 'methodological heart' – of the Learning Together model are described in summary form below:

- **a.** **Avoid hindsight bias** – understand what it was like for workers and managers who were working with the family at the time (the 'view from the tunnel'). What was influencing and guiding their work?
- **b.** **Provide adequate explanations** – appraise and explain decisions, actions, and in-actions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it
- **c.** **Move from individual instance to the general significance** – provide a 'window on the system' that illuminates what bolsters and what hinders the reliability of the multi-agency CP system.
- **d.** **Produce findings and questions for the Board to consider**. Pre-set recommendations may be suitable for problems for which the solutions are known but are less helpful for puzzles that present more difficult conundrums.
- **e.** **Analytical rigour**: use of qualitative research techniques to underpin rigour and reliability.

5 Typology of underlying patterns

To identify the findings, the Review Team has used the SCIE typology of underlying patterns of interaction in the way that local child protection systems are functioning. Do they support good quality work or make it less likely that individual professionals and their agencies can work together effectively?

They are presented in six broad categories of underlying issues:

1. Multi-agency working in response to incidents and crises

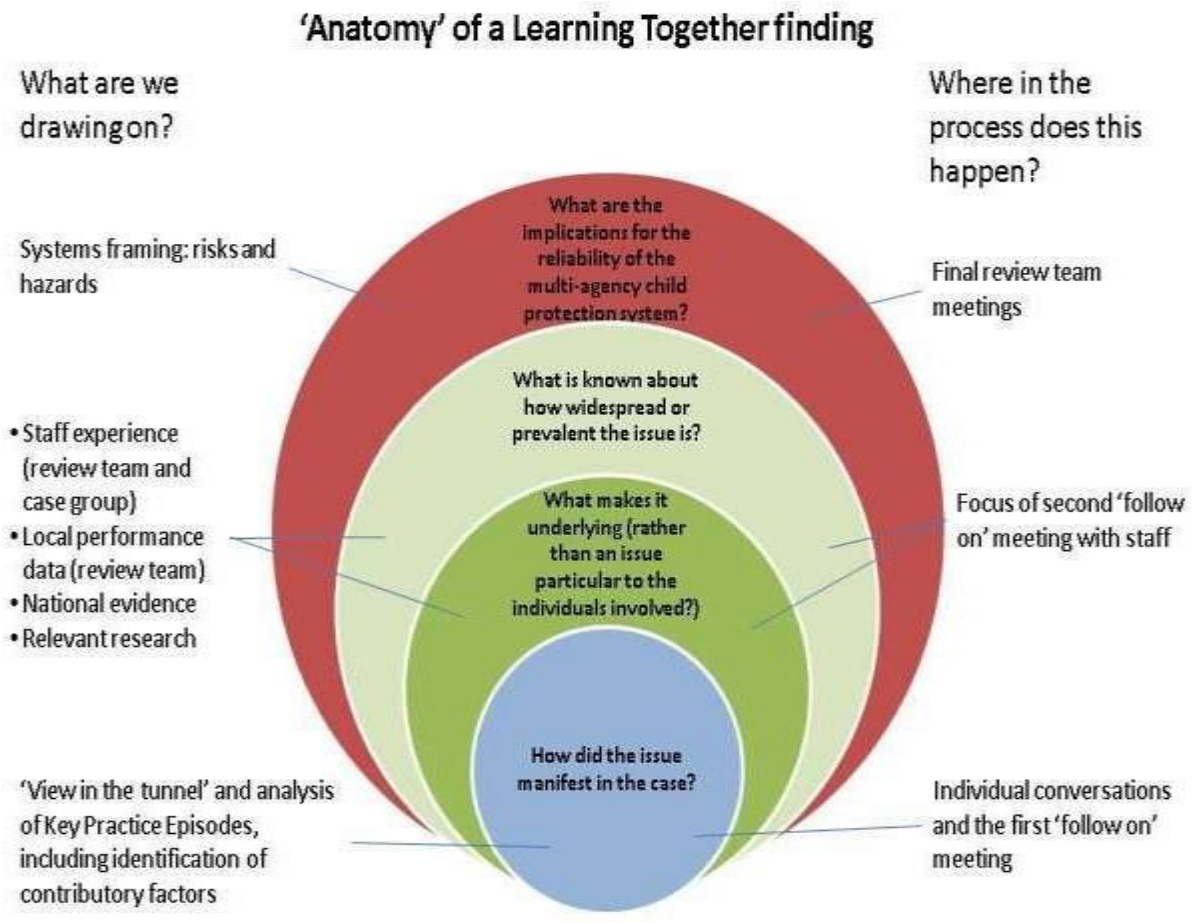
2. Multi-agency working in longer term work
3. Human reasoning: cognitive and emotional biases
4. Family – Professional interaction
5. Tools
6. Management systems

Each finding is listed under the appropriate category, although some could potentially fit under more than one category.

6 Anatomy of a finding

For each finding, the report is structured to present a clear account of: -

- How the issue manifests itself in the particular case?
- In what way it is an underlying issue – not a quirk of the particular individuals involved this time and in the particular constellation of the case?
- What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?
- How the issue is usefully framed for the LSCB to consider relative to their aims and responsibilities, the risk and reliability of multi-agency systems. Illustrated below.



7 Structure of the Review

There were three main groups who worked together to complete the review: -

7.1 **The review team** comprises senior managers from the agencies involved in the case, who have had no direct part in the conduct of the case. Led by two independent lead reviewers, they act as a panel working together throughout the review, gathering and analysing data, and reaching conclusions about general patterns and findings. They are also a source of data about the services they represent: their strategic policies, procedures, standards, and the organisational context relating to particular issues or circumstances such as resource constraints and changes in structure. The review team members also have responsibility for supporting and enabling members of their agency to take part in the case review.

Review Team Members
Fiona Johnson, SCIE Independent Lead reviewer
June Hopkins SCIE Independent Lead reviewer
LSCB Partnership & Support Manager
County wide Deputy Designated Nurse Safeguarding Children
County wide designated GP for safeguarding children
Named Nurse for Safeguarding Children, Community Health Service Provider
Service Coordinator, Child Protection Conferences Children and Families
Principal Social Worker
Detective Chief Inspector Public Protection Local
Head of Housing Advice at Borough council
Safeguarding Advisor Safeguarding & Health Team Early Help & Family Services

7.2 **The Case Group** are the professionals who were directly involved with the family. The Learning Together model offers a high level of inclusion and collaboration with these workers/managers, who are asked to describe their 'view from the tunnel' – about their work with the family at the time and what was affecting this. In this case review, the Review Team carried out individual conversations with 17 case group professionals, and up to 19 professionals were invited to attend the case group meetings which discussed the practice in this case and agreed the findings.

7.3 Review process

A Learning Together case review reflects the fact that this is an iterative process of information-gathering, analysis, checking and re-checking, to ensure that the accumulating evidence and interpretation of data are correct and reasonable. The review team form the 'engine' of the process, working in collaboration with case group members who are involved singly in conversations, and then in multi-agency 'Follow-on' meetings. The report will be received by the Serious Case Review Sub-group and the GSCB Executive who will have oversight of the final report and response plan.

The sequence of events in this review is shown below:

Date	Event
05/04/17	Introductory meeting for the Review Team at this meeting the Governance group was identified as required and formed
08/05/17	Introductory meeting for the Case Group – to explain the Learning Together model/method, and the case review process which they will be part of.
24/05/17 – 26/05/17	Three days' conversations with members of the Case Group (individual sessions of about 1.5 hours with each member of the Case Group; normally conducted by two members of the Review Team)
12/06/17	First Review Team analysis meeting
27/06/17	Second and third Review Team analysis meeting
14/07/17	First Follow-on meeting (Review Team and Case Group) In this meeting, the group works together on • identifying Key Practice Episodes (KPEs) in the case which affected how the case was handled and/or the outcome of the case • appraising the practice in these KPEs • considering what was affecting the work/workers at the time (the 'view from the tunnel')
05/09/17	Fourth Review Team analysis meeting
28/09/17	Second Follow-on meeting (Review Team and Case Group) At this meeting, the group were provided with a draft report which sets out the emerging underlying patterns and findings and were asked to consider whether these are specific to this individual case or pertain more widely and form a pattern.
13/10/17	Fifth Review Team meeting – to consider the draft final report
	Final review team meeting - to consider final draft report
18/10/17	SCR Sub-Group meeting – to consider the draft final report
13/11/17	LSCB meeting – to consider the draft final report
	Final report, fit for publication, to be submitted to Department for Education (DfE)

7.5 Scope and terms of reference

Taking a systems approach encourages reviewers to begin with an open enquiry rather than a pre-determined set of questions from terms of reference, such as in a traditional SCR. This enables the data to lead to the key issues to be explored.

7.6 Sources of data

7.6.1 Data from practitioners

- Conversations, as described above, with members of the Case Group; these were recorded and discussed by the whole Review Team.
- Members of the Case Group have also helpfully responded to follow-up queries and requests from the Lead Reviewers and the Review Team for clarification or further information, where this has been needed.

7.6.2 View from the Tunnel and Contributory Factors

The data from the conversations with the Case Group translates into their 'view from the tunnel' which enabled us as reviewers to capture the optimum learning from the case. Case Group members are also an invaluable source of information about the why questions – an exploration of the Contributory Factors which were affecting their practice and decisions at the time.

7.6.3 Participation

The Lead Reviewers and the Review Team are grateful for the willingness of the professionals to reflect on their own work, and to engage so openly and thoughtfully in this SCR. Everyone has contributed very fully in the process. Individual practitioners all have participated responsively in conversations, which have recalled their role in this story, and in group discussions which have at times been very difficult and challenging. All this has given the Review Team a deeper and richer understanding of what happened with this family and within the safeguarding network and has allowed us to capture the learning which is presented in this report.

7.6.4 Data from documentation

The Lead Reviewers and members of the Review Team reviewed the following documentation:
Children's Services records
Midwifery records
Hospital records
Police records
Community Health Records/ GP records

7.6.5 Data from family, friends and community

As in traditional SCRs, the Learning Together model aims to include the views and perspectives of family members as a valuable element in understanding the case and the work of agencies.

Appendix 2 Glossary

A&E	Accident and Emergency department of hospital.
CIN	Child In Need
CP	Child Protection
CSC	Children's Social Care
LSCB	Local Safeguarding Children Board
CSC	Children's Social Care General
GP	Practitioner
HMIC	Her Majesty's Inspectorate of Constabulary. Independently assesses the effectiveness and efficiency of police forces – in the public interest.
LSCB	Local Safeguarding Children Board
MARF	Multi Agency Referral Form
MASH	Multi Agency Safeguarding Hub. The Multi-Agency Safeguarding Hub (MASH) is a partnership between The County Council, The Constabulary, and health agencies working together to safeguard children, young people and vulnerable adults.
NHS	National Health Service
NSPCC	National Society for the Prevention of Cruelty to Children
Ofsted	Office for Standards in Education, Children's Services and Skills. They inspect and regulate services that care for children and young people, and services providing education and skills for learners of all ages.
SCR	Serious case review
Single Assessment	Single Assessment process is the assessment process used in children's social care which replaced initial and core assessments
SCIE	Social Care Institute for Excellence. The Social Care Institute for Excellence (SCIE) improves the lives of

	people who use care services by sharing knowledge about what works. They are a leading improvement support agency and an independent charity working with adults', families' and children's care and support services across the UK.
Strategy meeting / discussion	A strategy discussion is held when there is reasonable cause to suspect that a child has suffered or is likely to suffer significant harm. This may be following a referral and initial assessment or at any time during an assessment where a child is receiving support services if concerns about significant harm to the child emerge. The purpose of the strategy discussion is to enable the Children's Services' department, Police and other relevant agencies (e.g. health services, schools) to share information, make decisions about initiating or continuing enquiries under s. 47 of the Children Act 1989, what inquiries will be made and by whom, whether there is a need for action to immediately safeguard the child, and what information about the strategy discussion will be provided to the family. Decisions will be made regarding the provision of any medical treatment, how to handle inquiries in the light of any criminal investigation and whether other children affected are in need or at risk.
TM	Team manager

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