Overview Report of

The Serious Case Review relating to

Child H

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Glossary of terms	
CAF	Common Assessment Framework
CAFCASS	The Children and Family Court Advisory and Support Services
CME	Children Missing from Education
CSC	Children's Social Care
DASH	Domestic Abuse, Stalking and Harassment
DVD	Digital Video Disc
ESCSC	East Sussex Children's Social Care
ESHT	East Sussex Healthcare NHS Trust
ESPS	East Sussex Primary School
EWO	Education Welfare Officer
FHNA	Family Health Needs Assessment
FSO	Floating Support Officer
GP	General Practitioner
GPS	Grimsby Primary School
HPCP	Health and Care Professions Council
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Review
LSCB	Local Safeguarding Children Board
MARAC	Multi Agency Risk Assessment Conference
NE Lincs CSC	North East Lincolnshire Children's Social Care
PCSO	Police Community Support Officer
PCT	Primary Care Trust
RSPCA	Royal Society for the Protection of Cruelty to Animals
SECAMB	South East Coast Ambulance Service

SUI	Serious Untoward Incident
TAC	Team Around the Child
TAF	Team Around the Family

1 INTRODUCTION

1.1 Background to the review

1.1.1 This review was called because the police were contacted by a neighbour expressing concern about a child in a neighbouring flat. When they visited the child, H was found to have extensive bruising over the body. The mother and her boyfriend have since been convicted of child cruelty and are serving significant prison sentences.

1.1.2 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake reviews of serious cases where *(a) abuse or neglect of a child is known or suspected; and (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.*[1] A Serious Case Review Panel meeting was held on 15th October 2012 and the conclusion was that that the case did not meet the threshold for a serious case review. Following the conclusion of care proceedings, when additional information was identified, a further Serious Case Review Panel meeting was held on 14th February 2013 which did consider that these criteria applied and recommended that a serious case review should be undertaken. The chair of the LSCB, Cathie Pattison confirmed that decision on 21st February 2013.

1.2 The Terms of Reference

1.2.1 This review was started on 6th March 2013 so was initiated and conducted in accordance with the guidance in Working Together to Safeguard Children 2010 which sets out the purpose of a serious case review as:

- to establish what lessons are to be learned from the case about the way in which local professionals and organisations worked individually and together to safeguard and promote the welfare of children;
- to identify clearly what those lessons were both within and between agencies, how and within what timescales they would be acted on, and what is expected to change as a result; and
- to improve intra- and inter-agency working and better safeguard and promote the welfare of children.

1.2.2 The specific terms of reference agreed for this review were:

- Were practitioners aware of and sensitive to the needs of the child in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare? Should the practitioners not have worked in this way, comment should be made about the reasons for this.
- When, and in what way, was the child's wishes and feelings ascertained and taken into account of when making decisions about the provision of children's services? Was this information recorded? If this work was not undertaken, the reason for this not taking place should be noted.

[1] Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, p245, DCSF Publications

- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- Did your agency consider that the threshold was reached for any relevant legal intervention at an earlier stage?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way, and if this was not the case, what was preventing this?
- Were concerns about this child shared between the relevant agencies in a timely manner, with appropriate communication and analysis? Should communications be reviewed between agencies, in order to identify if there were issues of concern that were not shared?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments? If appropriate actions did not take place, what was obstructing this?
- Were there any issues, in communication, information sharing or service delivery between those with responsibilities for work during normal office hours and others providing out of hours services?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability to the child and family, and were they explored and recorded?
- Were senior managers or other organisations and professionals involved at points in the case where they should have been? If this did not take place, what were the reasons for this?
- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards? If this was not the case, what was preventing this from happening?
- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
- Was there sufficient management accountability for decision making? If accountability was lacking, what would have assisted this in taking place?

1.2.3 The time frame of the review was from 18th July 2007 to 17th July 2012 and agencies were asked to provide a detailed chronology for that period. All agencies were also requested to provide a summary of all significant events and relevant family history outside the specific scope and timescale, where this would help to inform the overall analysis.

1.3 Review Process

1.3.1 Individual Management Review (IMR) reports were received from:

- East Sussex Healthcare NHS Trust (ESHT) community - school nursing
- East Sussex Healthcare NHS Trust (ESHT) acute – hospital
- NHS Sussex (PCT) – GP services
- East Sussex County Council (ESCC) – children's social care
- East Sussex County Council (ESCC) – education services
- Sussex Police
- Borough Council – Housing
- Homeworks
- Community Independent Domestic Violence Advocacy (IDVA) service

- North East Lincolnshire Council - children's social care
- North East Lincolnshire Council - education services
- North Bristol NHS Trust – health visiting
- Humberside Police

1.3.2 IMR authors from East Sussex were offered a briefing session and were provided with feedback on their reports following the panel discussions. Brief reports were also received from a number of agencies who had limited contact with the family during the relevant period but who had information that would assist the review. Reports were received from:

- The Children and Family Court Advisory and Support Services (Cafcass)
- South East Coast Ambulance Service

Northern Lincolnshire and Goole Hospitals and Humberside Probation Trust also confirmed that they had no contact with the family during the period of the review. Additionally on occasion members of the panel accessed directly agency records in order to resolve contradictions in information received from different agencies.

1.3.3 A health overview report was also produced by the Designated Nurse Safeguarding Children for NHS Sussex as commissioners in order to review and evaluate the practice of all involved health professionals, including GPs and providers, commissioned by the PCT area.

1.3.5 IMRs and the Health Overview Report were drawn up by officers who had had no previous involvement in the case.

1.4 Family Input to the Review

1.4.1 Consideration was given to involving the family in the review process and they were advised that the review was underway. The mother, father, maternal grandmother and maternal aunt were invited to contribute to the review. The Lead Reviewer met with the mother in prison; however, none of the other family members responded to the invitation, despite a number of attempts to involve them.

1.5 The Review Panel

1.5.1 The review group membership was as follows:

- Leighe Rogers, Director, Surrey and Sussex Probation Trust (chair)
- Designated Doctor, NHS Sussex
- Designated Nurse, NHS Sussex
- Sussex Police
- Head of Children's Safeguards & Quality Assurance, ESCC
- Legal and Interventions Co-ordinator, Children's Services, ESCC
- East Sussex LSCB Business Manager

Additionally, Fiona Johnson, the Independent Overview Writer, attended review Panel Meetings.

1.5.2 Dates of review Panel meetings were as follows:

- 12th March 2013

- 12th June 2013
- 10th July 2013
- 30th July 2013
- 4th September 2013
- 10th October 2013

1.5.3 The Chair of the Panel was Leighe Rogers who had no direct involvement with any of the professionals' work being reviewed. Leighe Rogers, MSc, Dip SW (Southampton University) is an operational Director with Surrey and Sussex Probation Trust. She has represented the Trust on Brighton and East Sussex LSCBs (2009-13) and is currently Chair of the Brighton LSCB SCR Sub Group advising their Independent Chair on cases suitable for further learning or independent review. Leighe is the Trust lead for Restorative Justice, Health and Well-being and Domestic Abuse.

1.5.4 The independent overview writer is Fiona Johnson, an independent social work consultant. Head of Children's Safeguards & Quality Assurance in East Sussex County Council between 2004 and 2010, Fiona qualified as a social worker in 1982 and has been a senior manager in children's services since 1997 contributing to the development of strategy and operational services with a particular focus on safeguarding and child protection. She is HCPC registered and has previously written overview reports for East Sussex, Brighton & Hove, Portsmouth, Southampton, Kent, West Sussex, Wandsworth, Surrey, Slough, Bracknell Forest, Kingston and Hampshire LSCBs.

1.5.5 The overview report was completed based on information provided in the IMRs and the additional reports. The overview author also had direct sight of some children's social care records and was also provided with executive summaries from previous serious case reviews held in East Sussex that were considered to be relevant. Specific information was provided about the Multi Agency Risk Assessment Conference (MARAC) process and a copy of the centile growth chart for H. With the consent of the court, the overview author was also given access to some relevant reports from the care proceedings. The author also saw the education records for the school in North East Lincolnshire; these were provided by the East Sussex Education Services.

1.5.7 The Panel considered at all stages how early learning could be shared with relevant agencies and staff. The recommendations and action plans will be shared with staff and implemented immediately where possible.

1.6 Parallel Processes

1.6.1 The criminal process was completed prior to the serious case review starting and mother and her partner were both convicted and are currently serving prison sentences. H was the subject of care proceedings that were completed prior to the serious case review being completed. NHS agencies are required to carry out reviews of 'Serious Untoward Incidents' (SUIs). For the NHS agencies involved, it was not considered that the case would meet the threshold for an SUI.

2 THE FACTS

2.1 The Family Structure

Name	Relationship	Age at time of incident	Ethnicity
H	Subject	Almost 5 years	White British
M	Mother	Aged 26	White British
F	Father	Aged 46	White British
S	Sibling	Aged 6 years	White British
MP	Mother's partner	Aged 38	White British
MGM	Maternal Grandmother	Aged 47	White British
A1	Aunt	Not known	White British
A2	Aunt	Not known	White British
SGU	Maternal Step-great-uncle	Aged 30	Not known

2.2 The Family Background

2.2.1 Both parents are White British and English is their first language. Little information is provided in IMRs about their socio-economic background but it would appear that they were in receipt of benefits for the period of the review and there was no knowledge of either of them having jobs. There was no evidence that the parents followed any established religion and there was minimal information provided about their cultural identity. When living in East Sussex, mother and the children were living in an area of relative deprivation; the school attended by the children was one where a large number of the pupils come from impoverished backgrounds.

2.2.2 Mother met the children's father when she was eighteen and he was thirty-seven. She lived with him for six years initially in Bristol and later in Grimsby. They had two children, born when she was nineteen and twenty-one years old. Maternal grandmother lives in East Sussex, as do mother's two siblings. It is also not known where father was living prior to Bristol and minimal information was provided about his background in the Individual Management Reviews (IMRs). It is known that there were allegations about sexual abuse within his wider family. Mother was also seen by Child & Adolescent Mental Health Services when a teenager and was not attending school at that time.

2.2.3 Mother's boyfriend is eleven years older than her and had a very troubled childhood. He witnessed domestic abuse between his parents and was partially brought up by his grandparents. He was very close to the grandparents and was distressed when his grandfather died unexpectedly when he was nineteen. His grandmother and brother died when he was in his twenties. There are reports that the boyfriend had anger management problems and had abused alcohol; he was

also involved in some domestic abuse incidents that required police involvement. He was married and had a number of children by previous relationships. He has lived at a range of addresses including Liverpool, East Sussex and Grimsby. Prior to the incidents that resulted in this serious case review, the only agency that had direct contact with the boyfriend was his GP. His first contact with mother was in December 2011 but he did not play a significant role in the children's lives until after mother moved into bed and breakfast in April 2012.

2.3 Agencies' Involvement with the Family - Bristol

2.3.1 While the family were living in Bristol the only agency involvement was with the health visitor and GP. The GP records indicate that both children received routine immunisations and experienced normal childhood illnesses. H had one incident of bronchiolitis when eighteen months old and was seen in hospital but nothing untoward was identified. The sibling was seen once with severe nappy rash and in a paediatric clinic because of a large head circumference which was thought to be familial; this child was also seen as a toddler with eczema.

2.3.2 The health visiting input to the family was also routine contacts. The older child was seen at six weeks, nine months and two years and no information was recorded indicating any issues of concern. H was also seen at six weeks and nine months and a comprehensive Family Health Needs Assessment (FHNA) was undertaken when the child was two and a half years old. H failed the new-born hearing screen and was not taken to follow-up appointments. When the FHNA was completed, both children's speech and language was described as the lower end of normal. There was no questioning or check regarding their hearing. At this visit the flat was described as 'cluttered and a little grubby' and that there was 'lots of warm interaction between mother and the two children'.

2.3.3 Sibling was nominally on a primary school roll from September 2010 until October 2010 but never attended the school as the family moved to Grimsby.

2.4 Agencies' Involvement with the Family - Grimsby

2.4.1 In September 2010, when the children were four and three, the family moved to Grimsby. The older child started at a primary school in Grimsby on 30th September and the family registered with a GP. There was no communication between the GP and health visitor which meant that there was no direct contact between the health visitor and the family while they were in Grimsby. S was known to school nursing services as that information was shared with the nurse by the school.

2.4.2 Soon after the family moved to Grimsby, there were two incidents involving H which might indicate a lack of supervision; a call was made to NHS Direct because the child had ingested fabric conditioner and had a sore tongue and there was an abandoned 999 call made by the child whilst mother was asleep.

2.4.3 Prior to December 2010, the Grimsby Primary School (GPS) had no major concerns regarding S's presentation however the child was seen to be clingy and over-affectionate and the school attendance was irregular (56%). A letter was sent to the parents in December suggesting a meeting at the school if attendance did not improve; at this point the child was not of statutory school age.

2.4.4 In December 2010 S returned to GPS after an absence of a few weeks with a bruise on the forehead and a cut finger. The child also seemed withdrawn and was wearing dirty clothes with unbrushed hair and smelling of urine. Father told the school that S had been ill but the child described shopping with mother for a Christmas tree and watching TV. The school staff were concerned and contacted North East Lincolnshire children's social care (NE Lincs CSC) and were advised to talk with S about the bruise and to contact the parents if the child did not attend school the next day. The explanation given by S was consistent with the injury and the child did not disclose any information of concern. The next day the mother was asked about the bruise and gave the same explanation as S; she also reported that she had just separated from the children's father and that they had been going through a 'tricky patch'. Three days later father contacted NHS Direct about H experiencing a head injury and was advised to contact the GP. There is no record that this contact was made.

2.4.5 In January 2011 a school attendance meeting was held at the school and mother was advised that medical evidence would be required for any further absences by S. The child's attendance was monitored closely for the next seven weeks and attendance was 100%. H started at nursery school in May 2011 and there were no concerns regarding attendance. S was seen by a nurse practitioner with earache and records report that the child was 'quite unkempt'. There is no evidence that this information was shared with any other professional.

2.4.6 In March 2011 mother made an application to a Council Housing Department in East Sussex to join their housing register which was not progressed as she failed to provide documentary evidence such as birth certificates and proof of address in East Sussex.

2.4.7 In May 2011 S's legs and feet were noticed by school staff to be dirty during PE. The same month the child was measured as part of the routine National Child Measurement Programme by the school nurse and nothing of concern was noted. In June 2011 S was again seen by school staff to have dirty legs and feet and to have unwashed hair and dirty unironed clothes. This was raised by the school teacher with mother who said the child had been 'playing out in sandals'. At a school medical, soon after, the school nurse noted that S had dry flaky skin on the scalp and was reported to be bedwetting.

2.4.8 On 4th July 2011 both S and H ceased to attend GPS, and after numerous attempts to contact the parents by phone on 4th July, they were both identified by the school as 'missing from school'. On 6th July the Education Welfare Officer (EWO) was notified and on 7th July an EWO attempted a home visit but could not gain access. EWOs undertook further unsuccessful home visits on 11th July and 12th July after which the school contacted NE Lincs CSC. They advised that there was nothing that could be done if the family had moved without leaving an address and suggested that if the school continued to have concerns they should contact the police. Later that day the school contacted the police who advised them to contact NE Lincs CSC. The school did so but was again told that there was nothing that could be done if there was no way to contact the family. The school then reported these actions to the EWO who recorded it in their records. Later that day the school contacted the local policing team and spoke to a Police Community Support Officer

(PCSO). He agreed to ask a colleague to attend the address to check if the house was occupied. On 13th July the school records record that a PCSO had visited the home but there was no response. The school record also says that the PCSO would be checking with colleagues about what further action could be taken. The school then rang the mother on the next three days leaving a voice message each time.

2.4.9 On 17th July 2011 the police, RSPCA and landlord attended the family home following a report to the RSPCA, from a member of the public, that a dog had been left unattended at the property. The police records of this incident identify that the dog was 'skinny' but well and that the RSPCA 'seized' the dog. The school record, quoting a report from the landlord, describes 'a dog left to die' and that the flat was 'in an appalling condition with animal and human excrement in the children's bedroom and on walls, with clothes and toys left everywhere'. Police records state that it appears the occupants had left the property. The next day the school recorded that there was further contact with NE Lincs CSC who advised further liaison with the police and to give them mother's previous addresses and email address. The school records then detail a further discussion with the PCSO who agrees to test the email address and that he would advise the school of any further developments.

2.4.10 The police contact with GPS was via telephone when the school was requesting advice. Humberside Police do not record such contacts when the request is purely for advice. Police records regarding the removal of the dog from the house have no record of poor home conditions. There are no NE Lincs CSC records of any contact with the school prior to September 2011 and this is reported as being because the telephone conversations with the school were classed as 'advice' rather than formal referrals and so were not recorded on the database.

2.4.11 During July and August 2011 there was no contact by any agency with the family and the only relevant actions were that the Health Visiting Service identified that the family had moved from Bristol to Grimsby and a health visitor was allocated on 25th August 2011. This health visitor attempted a home visit on 2nd September and was told by new tenants that the previous occupants had left. The health visitor then contacted the school nurse who was unaware that the family had moved and provided the health visitor with mother's mobile telephone number. The health visitor attempted to phone and left a message.

2.4.12 On 8th September 2011 GPS contacted NE Lincs CSC and reported that they had no contact with the children since 4th July and that the school and EWO had unsuccessfully attempted contact by phone and visiting. The school also reported that the landlord had told them that the house was in a terrible state after the family's departure (human and animal excrement smeared on walls) and that the police were aware that the family had gone missing. The advice given was to contact the police again and advise them that the children had not returned to the school and did not appear to have registered at another school and to follow the 'Missing from Education Protocol'. On 12th September the Children Missing from Education (CME) team checked with school medical records which confirmed that the children were still registered with a GP in Grimsby. On 23rd September the health visitor contacted NE Lincs CSC to advise them that the children were

missing and was told that they were aware and that the school had been advised to follow the 'Missing from Education Protocol'. On 30th September the CME team contacted a family friend who advised that the family might have gone to Norwich and an email was sent to Norwich's School Admissions and CME co-ordinator.

2.5 Agencies' Involvement with the Family - East Sussex

2.5.1 On 7th September 2011 mother applied for a primary school place for S and H. Mother's first two school preferences were full and there was delay in identifying and allocating school places for the children. On 30th September mother was sent a letter notifying her of places for the children at an East Sussex Primary School (ESPS). She contacted the school the following week beginning 3rd October and visited the school that week arranging that the children should start school on Monday 10th October.

2.5.2 On 12th October 2011 the ESPS contacted GPS and advised them that the children had enrolled at their school. Staff at GPS said they were relieved to hear that the children had been found and informed ESPS of their prior safeguarding concerns and the circumstances in which the family had left Grimsby. It is not clear exactly when ESPS requested that the school records be transferred however this happened on 10th November.

2.5.3 At some point between mid-October and mid-November the school held a meeting attended by the children's form teachers and the designated teacher for child protection requested that the children be monitored. There were no written records from this meeting, the date is unknown and there was no follow-up meeting to discuss the findings from the monitoring. On 18th November 2011 ESPS made a referral to East Sussex Children's Social Care Team (ESCSC). This referral reported the concerns noted previously by GPS (including the state of the house after they left) and identified that since the children had been in East Sussex they had worn oversized and second-hand clothes but had not appeared dirty.

2.5.6 A manager in East Sussex Children's Social Care Team (ESCSC) made a decision that prior to undertaking an assessment there should be contact with agencies in Grimsby. Duty workers contacted the health visitor who confirmed that there had been no direct contact with the family and that prior to the contact with GPS in July 2011 there had been no concerns about the children; they also confirmed that the Bristol health visitor had no concerns about the children. Duty workers also spoke to NE Lincs CSC who said that they had no contact or concerns about the family until the school contacted them in September 2011. Duty workers then tried to speak to the RSPCA to ascertain their perspective about the state of the house and the risks to the dog. It was difficult to engage the RSPCA and the duty team was not able to get a clear response until 2nd December when they confirmed 'that there had been an abandoned dog' but did not confirm 'neglect or harm'.

2.5.7 On 22nd November 2011 a practice manager at ESCSC made a management decision that CSC should take no further action (this was prior to receiving a response from the RSPCA) and that the school should be requested to initiate a CAF (Common Assessment Framework). A letter was sent to mother advising her of the referral by the school and including reference to asking the school to undertake a CAF, this letter was copied to the school. At the same time a standard

letter was sent to the school indicating that ESCSC would not be taking any further action. This letter does not mention the CAF; however, the school did receive a copy of the letter to mother and the social worker also discussed with the schools inclusion officer their recommendation that a CAF be started. On 2nd December 2011 following the final conversation with the RSPCA, a further management record was added saying that the RSPCA information meant 'no confirmed increased risk. NFA.' The school did not start a CAF but did not challenge the ESCSC decision.

2.5.8 Between October 2011 and January 2012 the children's attendance at school was relatively good with the occasional absence and late mark. The children were making good academic progress and presented as happy whilst at school. With hindsight, the school teacher reported that the children were unkempt with 'a look of poverty' and that H occasionally wet themself, seemed tired in class and was 'accident prone with occasional bruises on knees and cheeks and was covered in flea-bites'. None of this was recorded at the time and no information was passed to other professionals. On 9th November S had a new pupil health check at school which resulted in an unsatisfactory hearing test and it was recommended that it be retested in one month. On 21st November S was referred to a sleep support clinic because of night terrors, it is unknown which professional made this referral but it seems probable that it stemmed from the school health check. An appointment was offered for 9th January which was not attended; following this a phone call was made, and two letters were sent, to mother asking her to contact the clinic to make another appointment. When this was unsuccessful the clinic advised the school nurse regarding the non-attendance and asked her to make a re-referral if the service was still needed.

2.5.9 On 29th November 2011 Cafcass received a private law application made by father in Grimsby. Father was applying for contact with the children and disclosure of their whereabouts. Cafcass undertook checks with children's social care in Bristol and North East Lincolnshire (Grimsby), Humberside, Avon & Somerset and Metropolitan Police Forces. No significant information was identified. On 13th December mother contacted the IDVA service in East Sussex reporting historic domestic abuse in Grimsby and requesting support regarding father's application for contact.

2.5.10 On 15th December 2011 ESCSC received information from a nearby authority Public Protection Unit relating to a registered sex offender who was having contact with S and H. On 16th December the practice manager made a decision to undertake an initial assessment and on 20th December a home visit was done to maternal grandmother's house where mother was seen with the two children and their maternal grandmother and maternal aunt. The social worker discussed with the adults the contact between the children and the sex offender and was told that the meeting was with maternal grandmother's brother and was unplanned, brief and with the mother and grandmother present. There was a discussion between the social worker and the adults about the need to protect the children from the sex offender. Mother also told the social worker that she had left Grimsby because of domestic violence and that she had referred herself to the IDVA service, a local service for victims of domestic abuse.

2.5.11 Following this visit ESCSC had two conversations with the IDVA, on 30th December 2011 and 6th January 2012. The IDVA confirmed her contact with mother and that

mother had reported a past history of domestic abuse that had been witnessed by the children. The IDVA said that she had no current anxieties regarding the children but was concerned that father was applying for contact. On 12th January the family were discussed at a MARAC meeting attended by a wide range of agencies including police, housing and children's social care. The mother was referred to the MARAC because the IDVA was concerned about risks for her safety due to father's application for contact. The chair of the MARAC did not feel the circumstances warranted a discussion at a MARAC meeting but, once such a referral had been made, did not have the power to prevent the case being put on the agenda. The case discussion was brief and the action plan agreed was the minimum possible which was that all agencies would 'flag and tag' all parties with MARAC status (victim, perpetrator and children) and that the IDVA would advise mother to disclose her historic abuse to her solicitor. Following this meeting all agencies present were expected to record on their data-bases the mother and children as victims of domestic abuse and the father as a perpetrator of domestic abuse. After the meeting the social care, police and housing representatives added this information on to their individual databases.

2.5.12 On 10th January 2012 mother applied to have her name put on the Housing Register. Following mother providing documentary proof of birth certificates and current address the application was assessed and she began bidding for properties on 23rd February 2012. From 9th January, following a referral from the IDVA, mother was supported by a Floating Support Officer (FSO) from Homeworks, an organisation that provides assistance to vulnerable individuals in housing need. The FSO provided support between 13th January and 14th March and assisted mother in making a 'Home Move Application', obtaining a birth certificate and getting a bed.

2.5.13 On 23rd January 2012 Cafcass provided a schedule 2 letter of information for the court hearing, regarding father's application for contact with the children. This report was based on telephone interviews with mother and father and contact with the duty social worker from ESCSC. The report identified that father denied that he had perpetrated domestic abuse and that he had no concerns regarding mother's care of the children. The report also informed the court about father's previous involvement with the police which did not include any offences of violence. Father also said that he had been having regular contact three or four times a week until mother took the children to Sussex. This arrangement was confirmed in the report by mother who said that prior to the separation she had been the victim of domestic violence on a weekly basis and that the children had witnessed this on three or four occasions. Mother also claimed that father was a heavy drinker and said that she was not stopping him having contact with the children but that she was not willing for them to stay with him overnight until he reduced his 'drinking'. The outcome of the hearing on 23rd January was that the matter was transferred to an East Sussex court pending further safeguarding information being provided by the Metropolitan Police Force; Cafcass involvement formally ceased on 18th April 2012.

2.5.14 On 24th January 2012 ESCSC completed the initial assessment and closed the case. The final summary said that the reason for the referral, which was the contact between the children and a registered sex offender, was resolved as the contact had been accidental and limited, and mother was now fully aware of the risks and was able to protect. The report also noted that mother had moved to the area

because of domestic abuse but that she was being appropriately supported by a range of other agencies.

2.5.15 On 2nd February 2012 the school nurse saw both S and H in school. The school nurse undertook a baseline assessment on H which recorded weight and height and noted H presented as a cheerful child 'who was a little scruffy but had eaten breakfast'. The class teacher had reported that H was possibly pigeon-toed and the nurse noted this. Following this assessment the school nurse rang mother on 22nd February and advised her that H had a possible squint and told her that the child should be seen by an optician and reassessed within six months by the school nurse with regard to his gait. She also told mother that S did not need a further hearing test as there had been a recent change in thresholds. Mother confirmed that S did not appear to have any hearing problems.

2.5.16 From early February 2012 both children's school attendance began to deteriorate and H was recorded as absent for a week from February 6th. The school made repeated attempts to contact mother by text on 6th and 7th February and eventually a letter was sent to the home on 8th February. During February and March mother disengaged from the services provided and the IDVA service and Homeworks both ended their involvement by 21st March.

2.5.17 On 16th April 2012 mother went to the local housing department and made an application as a homeless person saying that she had been staying with her mother but had been asked to leave due to overcrowding and friction. Mother and children were placed in bed and breakfast accommodation from 19th April. The school nurse was advised of this change of address and informed ESCSC and the school on 24th April. At this point ESCSC considered whether it was necessary to undertake a further assessment. The practice manager decided that this was not necessary and suggested that the school nurse should be provided with information about housing support services and advised to start a CAF. According to East Sussex Social care records, this information was shared with the school nurse by telephone on 27th April 2012; however, this is not recorded in the school nursing records. On 1st May, after ESCSC had been advised by the housing department of the family being placed in temporary housing, there was a telephone conversation with a housing worker about the reasons for the family leaving the grandmother's home. During this conversation, the social worker shared with the housing worker the previous concerns about the family arising from the state of the property in Grimsby. The housing worker agreed to refer the family to ESCSC if any concerns arose during the homelessness assessment. On 2nd May 2012 the case was again closed to ESCSC.

2.5.18 Between April and June 2012 both children were late or absent from school on a number of occasions. On 15th May 2012 H was admitted to hospital following a referral from the GP because of possible meningitis. H was discharged home the same day following assessment on the ward. It is noteworthy that at this time the GP records include mother's boyfriend's address and he is described as H's stepfather.

2.5.19 In late June 2012 H was absent from school for eight consecutive days returning to school on Monday 9th July. This absence was recorded as unauthorised by the

school and there are no written records that there was any attempt to contact mother. During this time S also had two periods of absence, for one and two days. On Friday 13th July H was found asleep in class and when questioned said that they had stayed up late watching a DVD.

2.5.20 On Saturday 14th July 2012 the police were called to an address because of concerns by neighbours about a child who was thought to be being assaulted by the male occupant of the flat. When the police visited the address they found H standing in a bucket with a black bin liner taped to the body and with significant bruising to the body including the face, body and genital area. S was also present but appeared uninjured apart from many insect bites. Mother was also in the flat. Both children were taken to hospital under police protection and mother and boyfriend were arrested for offences of suspicion of causing grievous bodily harm and child neglect. When in hospital H told hospital staff that 'daddy' hits me and S reported that H sometimes urinated on the floor and that was why the child was hit by 'daddy'. H presented in hospital as withdrawn and did not say much whereas, initially, S requested to return home.

2.5.21 Between 14th July and 17th July 2012, there was a series of strategy discussions between agencies to plan how to legally protect the children. The boyfriend was charged with grievous bodily harm and was remanded to prison whilst mother was released on bail. The children remained in hospital until 17th July 2012 when a short notice interim care order was granted to the Local Authority and the children were placed in foster care. While in hospital, the children disclosed further information about their abuse when they were in the care of mother and boyfriend and S asked not to return to the mother's care.

2.6 Additional information gained following the Police investigation

2.6.1 Following the police investigation it became apparent that injuries to H had been noticed by the maternal grandmother and aunt at some point in June 2012 when the child was in the bath. These injuries included bruising to the genital area. The maternal grandmother had also at an earlier date seen a bruise on H's back. Maternal grandmother did not discuss the bruising to the genital area with mother but said that mother had reported that earlier bruising to H's back had been accidental.

2.6.2 Bruising to H's forehead and face was also reported to the police retrospectively by the manager and a receptionist from the bed and breakfast. Both noticed the bruises but assumed at the time that the injuries were accidental.

3. VIEWS OF FAMILY MEMBERS

3.1 The overview author met with mother in prison and asked her about how H was harmed. Mother advised that she had been unaware that H was being harmed until the final incident and said that MP had never harmed her. She described however a relationship where he became increasingly controlling and separated her from her friends and family. Mother advised that the boyfriend encouraged her to leave her mother's flat saying that she would only be re-housed permanently if she moved into bed and breakfast. He also discouraged her from moving into a refuge when

the IDVA suggested this as an option and encouraged her to cease working with the IDVA and Homeworks.

3.2 Mother said that MP encouraged her to leave H with him and that the child liked playing on the playstation at the flat. Mother said that after these visits H started bed-wetting and that MP encouraged mother to keep the child off school until the bed-wetting was resolved. Mother denied that H was kept away from school because of bruises and denied any knowledge of bruising to the child's genitalia. Mother confirmed that she had seen bruising to the child's back and forehead but accepted MPs explanation that these had happened accidentally.

3.3 When asked if there were any actions that professionals could have taken that would have prevented H being harmed, mother suggested that if she had known MP's full criminal record she would not have become involved with him. Mother said that MP discouraged her from telling professionals about him and that she now thought that this was because of his criminal record. Mother confirmed that no agency ever asked her whether she had a partner once she had moved to East Sussex and said that the GP only had MP's details because she asked them to contact him when she had to take H to hospital because of the suspected meningitis.

3.4 Mother also said that the school in East Sussex did not contact her when H was not at school. Mother compared this with the arrangements in Grimsby when the school made contact and organised a meeting when S had poor school attendance. Mother said that there was no professional in East Sussex whom she trusted sufficiently to talk about concerns and that after she moved into bed and breakfast she felt very isolated and dependent on MP.

3.5 When asked about the conditions in the flat in Grimsby and her actions in abandoning the dog, mother said that a friend was supposed to be collecting the dog and that she did not think that the flat had been in that bad a state. Mother explained her departure as being because she needed to get away from her ex-husband who had persisted in being difficult and kept visiting the flat and being threatening. Mother also described how in her own childhood she had moved with her mother and siblings between East Sussex and Bristol because of maternal grandmother's boyfriends.

3.6 Mother described her marriage as being punctuated with repeated violence and said that MP had seemed very different because he was not violent; however, she now realised that he had been manipulating and controlling her. Mother also reported sexual abuse in childhood and that this had affected both her relationship with her mother and with men.

4 KEY THEMES IDENTIFIED BY THE REVIEW PROCESS

4.1 Difficulties of working with mobile families

4.1.1 This case has highlighted the challenges associated with working with mobile families who move around the country and do not tell agencies about their plans. This mobility presents agencies with difficulties in transfer of information and leads to delay in services being provided. This has been identified in research about serious case reviews as a recurring theme and can lead to 'a significant lack of clarity among professionals….key information….was not transferred from one agency to another…and at one stage the children 'disappeared ' from all professional monitoring following a move.'[2] This was evident with regard to health visiting support for H in Grimsby where, due to weaknesses in the notification systems, a new health visitor was not appointed for a year by which time the family had moved to East Sussex.

4.1.2 There was no East Sussex professional in contact with the family during the summer of 2011; however, if there had been, it is unlikely that they would have been able to gain any useful background information from agencies in Grimsby. The main record of the concerns about the state of the house that the family left in Grimsby were held in school records which were not accessible during the holiday time although some information was held by the Education Welfare Service which was operational during the summer vacations. It is probable that agencies from outside of Grimsby would have made first contact with CSC or the school. This was mainly because of the weaknesses in the NE Lincs CSC recording systems but exemplifies the difficulties of information sharing when local organisational structures and procedures are not known.

4.1.3 A further aspect that needs to be considered is whether the decision of a family to move in a hurry without planning is a factor that needs to be taken into account throughout the assessment process. In particular, the impact of the move on the children should be assessed; they had moved at least six times over a three-year period which meant for S, attendance at three schools before the child was six. Whilst there may have been good reasons for these moves, it is clearly unsettling for young children for whom stability is an important factor.

4.1.4 Finally, the review showed the importance of good documentation when families move. Even at the time of the review, there was significant variation in recording by a number of agencies in Grimsby about what was known and what was done following the family's move. This is particularly significant when agencies from outside the area make contact asking for information and can lead to confusion about the level and nature of the risks.

4.2 The Common Assessment Framework as a tool for safeguarding

4.2.1 One feature of work with this family was that there was very little evidence that alone would meet the threshold for intervention by children's social care. There was, however, some indication that the children's needs were not being fully met and that when mother was under pressure some aspects of their care may have been neglected. In these circumstances, it is crucial that agencies providing

[2] Page 92, Analysing child deaths and serious injury through abuse and neglect: what can we learn? Brandon, Belderson, Warren, Howe, Gardner, Dodsworth and Black DCSF 2008

universal services work to develop trusting relationships through which the care provided to the children can be monitored. The CAF is the tool that has been identified nationally as a mechanism whereby families can be encouraged to accept support from a range of agencies.

4.2.2 In this case there was no use by any agency of the CAF despite it being recommended as a way forward on a number of occasions. There was some effective early intervention by the school in Grimsby who liaised with NE Lincs CSC because of safeguarding concerns and did closely monitor S within school. They did not initiate a CAF however, which was unfortunate, as, if this had happened, it is possible that this could have led to the health visitor becoming aware of H at an earlier date.

4.2.3 The school in East Sussex was advised to initiate a CAF but did not do so because of a perception that there were insufficient resources to make it worthwhile. This approach failed to identify one of the key strengths of the CAF which is that it engages the parent in a positive partnership on behalf of the child. It is clear that there were increasing concerns about the children's well-being throughout their year at the school but there was no evidence that the mother was engaged in a purposeful dialogue about them. Eileen Munro in her recent review identified the challenge for professionals working with families. 'There is a tension in providing support to parents. For most, the right approach is to offer services with families making a voluntary choice to receive them. There are families whose level of parenting raises some concern and the relevant services make more strenuous efforts to make them aware of the help available and to gain their co-operation, and a complicating factor is that parents who voluntarily engage with support services tend to make more progress while a more coercive approach can deteriorate into an adversarial relationship which blocks progress.' [3]

4.2.4 Effective early intervention undoubtedly is the best option for any child and evidence has shown that this may be about accessing good early years services but also can include targeted support for vulnerable families when problems occur. In this case there were a number of services offered to mother when she arrived in East Sussex and a range of professionals identified that she was a vulnerable parent. There was however little co-ordination of these support systems and the school referral to social care and the IDVA referral to MARAC may suggest that professionals were identifying a need for inter-agency working but were utilising mechanisms with higher thresholds than was warranted. It is noteworthy that the agency promoting the CAF most strongly was children's social care, the agency with least direct involvement in the CAF process. The recommendation to use the CAF was appropriate as the services required could be managed within this structure. The absence of a CAF meant that early signs of neglect were not shared and when mother withdrew from agencies this was not identified as a possible warning sign. 'There is always the risk that a sign that is fairly benign might occasionally be the surface appearance of serious harm. There is also the risk, for example, that parents who are neglectful may become more harmful.'[4]

[3] Page 21, The Munro Review of Child Protection Interim Report: The Child's Journey Professor Eileen Munro Crown Copyright 2011
[4] Page 25, The Munro Review of Child Protection Part One: A Systems Analysis Professor Eileen Munro Crown Copyright 2010

4.3 Avoiding Tunnel Vision

4.3.1 When undertaking a serious case review it is important not only to understand what professionals did but also why they took the actions they did. A factor in this case was that most professional intervention was because of relatively low level concerns and interventions were focussed purely on the expressed need. Therefore for many agencies mother was a victim 'fleeing' domestic abuse and this therefore predetermined the nature of the assessment and services provided. The reason for this approach by an individual professional is a facet of human cognition processes. One of the most persistent and important problematic tendencies in human cognition is a tardiness to revise a view of a situation or problem. Once people have formed a view on what is going on, there is a surprising tendency to fail to notice, or to dismiss, evidence that challenges that picture. As Eileen Munro has described it, 'Becoming fixated on one assessment despite an emerging picture that conflicts with it becomes a significant source of cognitive error.' [5] This is further described as a '*garden path'* problem where professionals find it hard to revise their initial view because 'early cues strongly suggest [plausible but] incorrect answers, and later, usually weaker cues suggest answers that are correct'. [6] In this case there was comparatively little evidence of mother being a victim of domestic abuse, except as reported by her, yet this self-description became accepted and acted to dissuade professionals from challenging her about the state of the house in Grimsby.

4.3.2 Similarly, when the social worker became involved, it was because the children had contact with a registered sex offender. The focus of the assessment was on mother's capacity to protect the children from that man. The worker reported that the duty service was busy and that there was an expectation that for routine work one visit should be enough. When working under pressure, people tend to narrow down their focus. 'This is referred to in the 'risk literature' as 'tunnel vision', whereby practitioners tend to make the task manageable by seeing an increasingly narrow portion of their work environment. This has the benefit of allowing them to stay well focused on one thread in the case but has the weakness of making them slow to notice issues arising outside that narrow focus.'[7] In this case, the social worker talked with mother about her capacity to protect against the specific sex offender but did not ask her about any relationships she might have developed since leaving the children's father and crucially did not explore with her why the house in Grimsby was in such poor condition or what arrangements she had made for the care of the dog when she left.

4.3.3 The nature of supervision being provided to professionals is crucial when addressing cognitive issues. There are certain types of erroneous thinking and decision making that will not be picked up by the individuals themselves. The role of the manager and supervisor is to provide an opportunity for reflective thinking and to challenge the worker to consider whether the assessment process has been sufficiently broad and robust.

[5] Page 53, A review of safety management literature, Eileen Munro, London School of Economics. SCIE 2008
[6] Page 53, A review of safety management literature, Eileen Munro, London School of Economics. SCIE 2008
[7] Page 69, Learning together to safeguard children: developing a multi-agency systems approach for case reviews, Dr Sheila Fish (SCIE Research Analyst) Dr Eileen Munro (Reader in Social Policy, LSE) and Sue Bairstow (SCIE Associate)

4.4 Invisible men – the risks to children

4.4.1 A feature of this review is that the injuries experienced by H were committed by mother's boyfriend who was unknown to all agencies apart from the GP. This is despite a number of assessments being undertaken by professionals and a range of services having been provided. Mother became involved with the boyfriend in December 2102 and he is recorded on GP records as H's step-father in May 2012. There is no evidence that any professional asked mother about current relationships and she now says that if she had been provided information about his criminal record this would have affected her willingness to become involved.

4.4.2 Mother also now says that MP discouraged her from advising professionals about his presence however it also reflects a pattern previously recorded in serious case reviews of agencies failing to take account of the role of male carers within the family process. 'There were instances of 'unknown' males in some households at the time the child was killed. There appeared to be a minimalist "need to know" attitude to sharing information about the appearance of new men in a household....these men became invisible to practitioners working with the family or child.'[8] This reflects a wider issue about the lack of involvement by health and welfare professionals with men despite their significant involvement in children's lives.

4.5 Role of the community in protecting children

4.5.1 A feature of this case was that there was limited professional involvement with the family and there were few concerns raised about the direct care of the children. In East Sussex there was direct involvement with the family because of historic domestic abuse by the children's father and an unplanned meeting between the children and a registered sex offender. Neither of these incidents related to the injuries that H was later to experience and there is no evidence that any professionals saw bruises on H prior to July 2013.

4.5.2 Significant bruising to the child's genital area was seen by H's grandmother and aunt, which was not reported, and which mother says was not fully discussed with her. The reasons for this are not known but it is probable that if they had reported concerns then later injuries to the child may have been prevented. Similarly bruising was seen by the manager of the hotel and the receptionist and this was also not discussed with mother or reported elsewhere because it was assumed that the injuries were accidental.

4.5.3 It is noteworthy, however, that the eventual police involvement occurred because neighbours reported their concerns to the police and it is probable that this conscientiousness may have saved the child's life and definitely ended the abuse. Child protection is a process that requires a partnership between professionals and families and the community.

[8] Page 52, Understanding Serious Case Reviews and their Impact: Brandon et al DCSF 2009

5 ANALYSIS

5.1 Were practitioners aware of and sensitive to the needs of the child in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare? Should the practitioners not have worked in this way, comment should be made about the reasons for this.

5.1.1 Prior to the family's move to East Sussex the agency with greatest contact with the family was the school in Grimsby who seemed aware of the needs of the child S and were alert to possible safeguarding concerns. They raised these issues with NE Lincs CSC who advised monitoring and following the appropriate process when children were missing from education. When the family moved the school acted quickly and liaised appropriately with other agencies. There seemed to be some confusion between the police and NE Lincs CSC as to what action could be taken when children go missing as the school were advised by CSC to contact the Police who then advised them to talk to CSC. The police are clear that if the children had been formally reported as missing they would have taken action but that in fact the school asked for advice. It is unclear whether the school appreciated this distinction. As the children went missing at the end of term they were missing from education for a comparatively short period although they were out of contact with any agency for two months. It is surprising however that there was no consideration by any agency (including the school) to contacting the children's father who may have known about their whereabouts and probably knew that maternal grandmother lived in East Sussex.

5.1.2 An issue that the Serious Case Review Panel considered at length was the condition of the house when seen by the RSPCA, police and landlord, after the family had moved. It is definite that the landlord considered that the property was in a very poor state, as this is recorded in the school records at the time, and was confirmed when he was contacted by the Serious Case Review Panel in October 2013. It is clear that neither the RSPCA nor the Police recorded anything about the property and this may be because their primary concern was the dog. It would also have been difficult for them to know to what extent the conditions were the responsibility of the previous tenant or may have been caused by other people. At the time of the visit the property was unoccupied and it was unclear as to when the family had left or if provision had been made for the welfare of the dog.

5.1.3 The police however did know that children had been living at the accommodation as they saw a letter from the school concerning the children's non-attendance and this was recorded. The PCSO, a member of the police service, also had information about when the family had moved as he had provided advice to the school. The police are clear that this matter was not one that required any further action as it was purely a request to remove an abandoned dog. This would seem to disregard the research regarding animal cruelty and child protection and may indicate a lack of awareness regarding safeguarding responsibilities. It may however also be an example of the tunnel vision, discussed earlier, whereby the staff involved focussed on the presenting issue (the abandoned dog) and did not consider wider safeguarding children implications. Similarly, although the school records indicate that Grimsby CSC were advised about the state of the property, this did not trigger for them consideration of a need to take any further action. The systems in place

within Grimsby whereby neither police nor CSC record details of families when they are providing advice to other agencies meant that the only agency in Grimsby that had a record of the state in which the property was left was the school.

5.1.4 Once the family moved to East Sussex the school was slow to report concerns to ESCSC and when advised to initiate a CAF failed to do so or to challenge the advice given. One explanation given for this is that professionals working within the school had become accustomed to accepting a level of poor presentation and development by pupils because it was the norm in that geographical area which had high levels of deprivation. Certainly the school did not refer these children to any other agencies despite some evidence of poor school attendance. With hindsight, the professionals described the children as presenting as neglected and impoverished although this was not recorded at the time. This explanation was one the panel discussed at length because a previous serious case review had identified a similar pattern and this had resulted in a recommendation that 'the LSCB should consider commissioning research to determine whether there are differential responses being applied by agencies in the context of social deprivation in geographical areas'. [9] This recommendation has not yet been implemented. When discussed, it was concluded that it would require a significant piece of research and that there was a lack of capacity within the LSCB.

5.1.5 The social work assessment of the family when there was known contact with a sex offender was prompt and addressed the immediate presenting problem effectively. It was unfortunate that the worker did not use this opportunity to explore more about why mother had left Grimsby so precipitately and without making suitable arrangements for the dog. As the mother was living in the maternal grandmother's accommodation, the social worker was not able to fully judge mother's capacity regarding hygiene and cleanliness in the home. This made it even more important that there was discussion about the state in which the property in Grimsby was left. There was also no discussion with mother about current relationships.

5.1.6 The Cafcass assessment was proportionate and the practitioner undertook appropriate checks and identified some safeguarding concerns requiring further investigation prior to the court making the final decisions regarding father's future contact with his children. Given that the children were resident in East Sussex, the transfer to a local court was correct.

5.1.7 The assessment undertaken by the IDVA seemed limited and the review panel was surprised that there was no exploration with mother of whether she had a new partner given that previous experience of domestic abuse is a risk factor for later relationships. This was particularly puzzling when according to mother there had been discussion about the possibility of moving into a refuge which would indicate some assessment of immediate risks. The IMR reported concerns about the discrepancy between the levels of risk identified and the IDVA decision to refer the matter to MARAC. One possible explanation is that mother's presentation indicated a level of abuse not evident in her description of the ex-husband's actions. It is unfortunate that the assessment process was not sufficiently robust to enable mother to discuss her relationship with MP.

[9] Page 5, East Sussex Local Safeguarding Board; Serious Case Review (SCR) J Action Plan - 5.10.10

5.1.8 When the children were in East Sussex the school's response to H's repeated absences was insufficient and did not meet the expected standards. This was a marked contrast to the actions of the school in Grimsby and was surprising given that school records from there would have identified that attendance had been an area of difficulty. It is noteworthy that mother identified the differences in approach by the two schools. It is also probable that some of these absences coincided with times when H had bruises as the school has no records of observing any marks on H despite family members and bed and breakfast staff seeing them.

5.1.9 Another area of discussion within the panel was the degree of responsibility for safeguarding children that can be expected from staff within bed and breakfast accommodation. These are private providers of accommodation but in this case were providing the rooms within an arrangement facilitated by the Housing Department. These providers are given a tool kit/briefing sheet which covers a number of issues that Housing consider relevant, and includes reference to safeguarding issues but are not provided with specific safeguarding training.

5.1.10 The final investigation following the neighbours raising concerns about H showed good inter-agency working with all professionals showing good understanding of safeguarding processes and acting promptly to ensure the safety of both children.

5.2 When, and in what way, were the child's wishes and feelings ascertained and taken into account of when making decisions about the provision of children's services? Was this information recorded? If this work was not undertaken, the reason for this not taking place should be noted.

5.2.1 There were a limited number of agencies who had direct contact with the children. The Housing Department, Homeworks and the IDVA service worked directly with mother and whilst they may have seen the children during their visits they did not talk to them and would not have considered this to be a required part of their work. Cafcass also had no direct contact with the children as the expectation is that their work to produce a schedule 2 report is based on telephone contact with parents. Sussex police also had no direct contact with the family prior to the incident on 14th July.

5.2.2 The schools had most direct contact with both children. There is evidence that the staff at the primary school in Grimsby had a conversation with S regarding the reasons for the child's absence from school. They were therefore able to identify discrepancies between the father's description of the events in December 2010 and the child's experience. They talked to S about the bruise to the child's face and the reasons given by the child and mother tallied and this reassured the school that the change in presentation was because of marital discord rather than anything else.

5.2.3 There is no evidence that the primary school in East Sussex attempted to ascertain the children's wishes and feelings and when interviewed, staff at the school felt that the children were too young to be consulted. This was a significant omission as these people were in the best position to build a rapport with the children and were the people in the best position to gain an understanding of any changes being experienced by the children.

5.2.4 The social worker completing the initial assessment did talk with the children and they told her about the toys and clothes that they had left in Grimsby. This was a first contact and it is probable that the children would have been inhibited from sharing anything other than superficial aspects of their home life; however, the worker was clear that the children were very chatty and open. It is equally possible that at that stage there was little for them to tell a professional except about the move from Grimsby as mother was clear that MP had limited contact with the children prior to their move to bed and breakfast.

5.2.5 The children were also seen by the GP and the school nurse but these contacts were for formal medical assessments and usually within significant time constraints. It would not normally be expected that children would be encouraged to discuss their wishes and feelings during such appointments. It is noteworthy that the school nurse described H as a chatty child and had clearly been able to talk with H about H's daily life including what H had for breakfast. Again however this contact was while H was living with maternal grandmother and the care provided may have been different from that experienced later.

5.2.6 Overall there is limited evidence of direct communication with the children but that this gap is most stark with regard to the East Sussex Primary School that probably had the best opportunity for building a relationship with the children and gaining an insight into their lives.

5.3 Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

5.3.1 All agencies report having policies and procedures in place for safeguarding and promoting the welfare of children. Most of the Sussex agencies refer to the Sussex Child Protection and Safeguarding Procedures, and many reports supplement that with local or professional guidance as well as describing training and supervision processes. The only agency where there is evidence of a lack of awareness of procedural responsibilities was the RSPCA in Grimsby who seemed unaware of their duty to share information with ESCSC which resulted in a delay of four weeks in the duty workers accessing information which was relevant to a safeguarding assessment.

5.4 Did your agency consider that the threshold was reached for any relevant legal intervention at an earlier stage?

5.4.1 Prior to the police becoming aware of the neighbour's concerns on 14th July 2012 there was no evidence that would have warranted any agency taking legal intervention because of child protection concerns.

5.4.2 School attendance by both children was on occasion intermittent; however, S's attendance was never sufficiently poor as to require legal action and H was not of statutory school age.

5.5 What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way, and if this was not the case, what was preventing this?

5.5.1 There were six points at which an assessment would have been appropriate:

- when S was seen in school in Grimsby with a bruise and there were concerns about hygiene;
- when the family moved to East Sussex;
- when the family had contact with a registered sex offender;
- when mother asked for support as a victim of domestic abuse;
- when the family made a homeless application; and
- when the neighbours reported child protection concerns.

5.5.2 When school staff in Grimsby noted the bruise on S they acted appropriately in contacting the social work team, and, following advice, clarified with the child and the mother the context in which the injury occurred. Becoming aware of the marital dispute, they followed this with a meeting with mother and monitoring of S's school attendance and hygiene which appeared to improve. Afterwards there was some further evidence of low level indicators of neglect which were discussed with mother. These were however insufficient to warrant a further referral to social workers until the family moved to East Sussex.

5.5.3 The second opportunity for intervention was when the family left their accommodation in a very poor state and abandoned their dog. Whilst the school in Grimsby recognised the issues, there was no action taken by agencies in Grimsby because the family had moved. The school in East Sussex was slow to respond and make a referral to ESCSC and the Statement of Referral did not convey any sense of urgency or need for immediate action. The decision by that team to suggest that the school attempt to work with mother via a CAF seems reasonable given that the school were not raising current issues of concern and did not seem to have tried to work directly with the family. It is of concern that the checks undertaken, including contact with RSPCA, were incomplete at the time the decision to recommend a CAF was made, and, that there was no attempt to contact the landlord in Grimsby to clarify directly the state of the property. In the event the information was obtained later from the RSPCA and was reviewed by the manager who confirmed the previous decision to take no further action.

5.5.4 The third point when assessment was required was when it was known that there had been contact with a registered sex offender. The response by ESCSC was appropriate and the mother and children were seen and an assessment was undertaken in an informed and professional way albeit its over-narrow focus meant that wider information about the family's functioning was not gathered.

5.5.5 Mother's request for assistance because of domestic abuse was the fourth time when assessment was possible and this was undertaken in accordance with the guidance despite, possibly, not meeting the required thresholds for MARAC intervention. As has been previously reported, this assessment was flawed in that it did not explore fully with mother her current relationships or identify their controlling nature.

5.5.6 The next opportunity for assessment was when the family made a homeless application and were placed in bed and breakfast. The key agency involved at this time was the Housing department who did alert ESCSC to the family's move which enabled them to share the earlier concerns about the state of the house that the

family left in Grimsby and it was agreed that Housing staff would monitor and contact ESCSC again if there were further concerns. The decision made by ESCSC to take no further action is understandable given the recent initial assessment that had raised no significant concerns. The school nurse was also aware of the move and had contact with ESCSC who advised that support could be best offered to the family via a CAF. The school were also aware of the move, via the school nurse.

5.5.7 The final opportunity for assessment was when the neighbour raised concerns about H and the police visited and then initiated promptly a full child protection investigation. This work was completed in an informed and professional way.

5.6 Were concerns about this child shared between the relevant agencies in a timely manner, with appropriate communication and analysis? Should communications be reviewed between agencies, in order to identify if there were issues of concern that were not shared?

5.6.1 There were some problems in communication within Grimsby, most notably being that the health visiting service was unaware of H living in the area despite the family registering with a GP and S having been seen by the school nurse.

5.6.2 There were also delays in the transfer of S's school records from Grimsby to East Sussex albeit that much information was shared by telephone soon after the children started at the new school. The school in East Sussex failed to formally request the school records until November and the school in Grimsby, in accordance with the regulations, was awaiting the formal request via the 'school to school' system. [10] The lack of case recording by NE Lincs CSC and Humberside Police also meant that these agencies were unable to share with any other professional information about the state of the house and the abandoned dog until September 2011 despite the concerns being raised by the school in July 2011.

5.6.3 Generally communications between agencies in East Sussex was timely and effective although poor communication between professionals within the school meant that information such as the children's move to bed and breakfast was not known by the form teacher.

5.6.4 A further limitation in communication between agencies was that the information about the state of the flat when the family left Grimsby was known to ESCSC and the school but was not reported at the MARAC meeting which meant that the ES Housing Department did not have access to this information.

5.7 Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments? If appropriate actions did not take place, what was obstructing this?

[10] School to School (s2s) is a website produced by the Department for Education (DfE). Schools can use the website to transfer data securely between one another, using data files. The Education (Pupil Information) (England) Regulations 2005 describe the information that must be transferred and the method by which transfer must take place: (5) Subject to paragraph (6), where the pupil is under consideration for admission to another school (including an independent school) or to a further education institution or higher education institution, the governing body shall transfer the pupil's curricular record to the responsible person, free of charge, within fifteen school days of receipt of the responsible person's written request for that record.

5.7.1 The major way in which actions did not accord with assessments was in the decision by the school and school nurse separately not to initiate a CAF assessment. The effect of this was that there was no direct effort made by these agencies to engage mother and support her in parenting. It also meant that low level concerns were not shared which prevented any one professional having a holistic picture.

5.7.2 The reluctance by both the school and the school nurse to initiate a CAF did prompt discussion amongst the review group about the effectiveness of the CAF process. The review group was aware that from the summer of 2012 East Sussex had introduced a new approach known as THRIVE which included a review and development of the early help services. The THRIVE model was considered to be better at involving other agencies in developing early help plans that are outcome focussed and incorporates the previous CAF and Team Around the Family (TAF) arrangements.

5.7.3 The other area of discussion within the review group was about the purpose and function of the MARAC assessment. It was considered that the case was not fully representative of the usual threshold for MARAC involvement but that the actions following the discussion were of limited value. In particular, the action to place information on all agencies' databases seemed to be implemented with varying success. In particular, there was no process whereby the information could be put on the school or education service records and yet these were the agencies likely to have ongoing contact with the children. There is no education representation on the MARAC panel and the ESCSC representative has no direct links with schools or education services. There were also problems in sharing MARAC information within health agencies particularly with school nurses.

5.8 Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?

5.8.1 Prior to the incident in August there was no significant involvement with the family outside of normal office hours. The Emergency Duty Service worked closely with the police to safeguard the children once the extent of H's injuries was known. There was timely and positive joint working to arrange for the children to be moved to a place of safety and then make an application to the court for an interim care order to ensure their longer term safety.

5.9 Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability to the child and family, and were they explored and recorded?

This family did not have any significant racial or linguistic needs and none of the adults or children had a disability. There was little evidence in the IMRs that agencies recorded religion and there was little information provided about the social and cultural background of the family. In general, most professionals in contact with the family recorded minimal information about the family's cultural and social identity which may reflect an absence of issues but could also indicate a lack of awareness of the importance of these factors in determining how families function.

5.10 Were senior managers or other organisations and professionals involved at points in the case where they should have been? If this did not take place, what were the reasons for this?

5.10.1 Generally the IMRs indicated that senior management involvement was as expected. Unsurprisingly, senior management input was largely limited to involvement in the final investigation of child protection concerns. In most agencies there was little reason for involving senior managers prior to that time.

5.10.2 The East Sussex Education IMR identified as an issue the absence of supervision for the designated teacher within the East Sussex School, and considered that the absence of reflective supervision may have affected the decision-making regarding initiating a CAF and making a further referral to ESCSC.

5.10.3 There was no specific reference in the IDVA IMR about the quality of supervision provided to the IDVA; however, it is acknowledged that the IDVA's line manager should have probed the reason for mother previously being referred to CSC and should have checked whether the IDVA had contacted agencies in Grimsby. Furthermore it reported that following the MARAC meeting, all cases related to this IDVA were monitored with more scrutiny and that every MARAC or safeguarding referral was discussed, cleared or rejected by the line manager,

5.11 Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards? If this was not the case, what was preventing this from happening?

5.11.1 All agencies identified that practice was in accordance with the East Sussex LSCB's policies and procedures for safeguarding. Most of the IMRs also identified local agency and professional policies that directed practice.

5.11.2 The ESHT (Health Visiting and School Nursing Service) report also identified that the significant resource pressures within the school nursing service meant that implementing The Healthy Child programme (5-19 years) was not feasible within the restricted service.

5.12 Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

5.12.1 Most agencies reported that there were no significant organisational difficulties. The School nurses however reported feeling that senior managers had insufficient understanding of the pressures on the school nursing service and that their responses were 'reactive not proactive' with regard to decision-making about managing a reduced service. They considered that this had resulted in poor morale within the service and had affected decision-making in this case. It was reported to the review panel that the school nursing service within ESHT had been under considerable pressure and was placed on a 'risk register' due to recruitment issues and staff vacancies. This led to a decision that a service would only be offered to families/children where there were identified safeguarding concerns. The school nurses described a lack of senior clinical oversight of their roles which led to

confusion as to what the restricted service encompassed which resulted in low morale within teams.

5.12.2 The East Sussex Children's Social Care IMR reported that 'there were no significant levels of vacant social work posts or staff sickness' and that 'caseloads were high' but the senior practitioner 'had known them to be higher'. In another section of the report however, a senior manager is reported to have said that 'there was a high volume of initial contacts' and the process for authorising assessments was unmanageable. The social worker also described a team culture that considered undertaking a second visit on routine initial assessments to be a 'luxury'. This would seem to indicate that there were pressures on the service that did affect practice at the time.

5.13 Was there sufficient management accountability for decision making? If accountability was lacking, what would have assisted this in taking place.

5.13.1 Most IMRs reported that there was sufficient management accountability for decision-making and no agency identified major shortfalls in management oversight of professionals' work.

5.13.2 The East Sussex Children's Social Care IMR, whilst acknowledging that there was sufficient management accountability, also indicated that the quality of decision-making by managers had been compromised by the volume of decision-making regarding assessments and referrals.

5.13.3 As previously stated, the IDVA IMR raised questions about whether there was sufficient oversight of the work of the IDVA by the line manager.

6 General comments on the review process

6.1 This was a review that involved three LSCBs and agencies across three geographical areas. This inevitably presented some challenges and did lead to some delays but the process was well-managed and generally there was good co-operation by all agencies.

6.2 IMRs from East Sussex agencies were usually good and most that needed significant amendment were from agencies that have less involvement in the serious case review process.

6.3 The exception to this was the borough council IMR which despite significant advice from the Serious Case Review Panel remained unsatisfactory and work with this agency is ongoing regarding its safeguarding responsibilities.

6.4 The panel was keen to enable involvement in the review by family members and there was some further delay in completion of the report in order to facilitate their input to the process.

7 LESSONS LEARNED FROM THE REVIEW

7.1 The importance of effective early intervention processes that are owned and understood by all agencies.

7.2 The relevance of reflective supervision, management challenge and scrutiny of assessment work to ensure that all aspects are covered. In particular the need to prioritise the 'critical review' aspect of supervision as there are certain types of erroneous thinking and decision making that will simply not be picked up by the individuals concerned themselves.

7.3 The need to ensure that MARAC systems and MARAC processes within agencies enable full information sharing in writing between front-line professionals about victims and perpetrators.

7.4 The impact on professionals, particularly those at the front line such as school staff, of working within areas of significant poverty and deprivation which may desensitise and lead to a normalisation of low level concerns. Given that this is an issue raised in a previous serious case review, there is a need to establish how significant a problem this is within East Sussex.

7.5 The importance of the public in protecting children and the need to ensure that the wider community, including people who provide services privately such as bed and breakfast proprietors, are fully aware of their responsibilities to report child abuse concerns.

7.6 The effect on safeguarding systems of resource shortfalls and the need to ensure that the LSCB is fully informed by managers and front-line staff of the impact of service constraints on child protection.

7.7 The need for all agencies to ensure that relevant information about current male partners is collected during assessment processes and to ensure that their assessment processes are adapted accordingly.

8 CONCLUSIONS

8.1 The injuries to H were hard to anticipate as previous contact with the family had not provided any information that would indicate that the child was at risk of significant harm from physical abuse.

8.2 Agency contact with mother could have identified that she was a vulnerable parent and that she would benefit from support; however, the major issues of concern were around neglect rather than physical abuse. The involvement in H's life of mother's boyfriend was not known to most agencies and yet he caused the injuries.

8.3 As the assault on H could not be predicted, it is hard to identify ways in which it could have been prevented; however, the case review has acted as a 'window on the system'[11] and has enabled areas for service improvement to be identified.

9 RECOMMENDATIONS

LSCB

9.1 That East Sussex LSCB ask East Sussex Children's Services to review and report on the effectiveness of THRIVE in enabling front-line professionals such as school nurses and teaching staff to provide early help to vulnerable families.

9.2 That East Sussex LSCB via the Section 11 process require all agencies to report on the effectiveness of their supervision and management processes in ensuring that the work of front-line professionals is scrutinised and challenged.

9.3 That East Sussex LSCB require Sussex Police to initiate a review of the MARAC process to ensure that all meetings are suitably recorded and that all agencies have systems in place to enable records from MARAC meetings to be placed on individual case records. This review should include consideration of how the MARAC process interfaces with the child protection system.

9.4 That East Sussex LSCB reconsider whether there is a need for research about the impact on the professional judgements of managers and front-line staff working within areas of significant poverty and deprivation where it may be hard to distinguish between poor parenting as a result of neglect and parents experiencing difficulties because of material poverty and environmental issues.

9.5 That East Sussex LSCB consider how best to ensure increased public awareness of the role of family and community in safeguarding children.

9. 6 That East Sussex LSCB develop mechanisms for ensuring that the views of managers and front-line staff about the effect of resource shortfalls are regularly reported to the LSCB.

9.7 That East Sussex LSCB, in consultation with relevant district and borough councils, consider how to enable private providers of accommodation used by housing departments to receive appropriate training regarding their responsibilities to safeguard children.

9.8 That all partner agencies should satisfy the East Sussex LSCB that assessment processes ensure the effective consideration of fathers and partners, and other men within the household.

9.9 That the Chair of the East Sussex LSCB discusses with the Chair of the Grimsby LSCB the Serious Case Review Panel's concerns regarding 'agency's recording of advice' and their 'thresholds for identifying safeguarding concerns'.

Fiona Johnson

[11] C A Vincent, Analysis of clinical incidents: a window on the system not a search for root causes