GSCB

“James” Serious Case Review

and

Action Plan

Report Author Joanna Nicolas

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Acronyms Used

CSC – Children Social Care
DASH – Domestic Abuse, Stalking, Harassment and Honour-based Violence
ED – Emergency Department
GSCB- Gloucestershire Safeguarding Children Board
MARF – Multi-agency Request for Service Form

1. Background to the Report

1.1 In August 2016 Gloucestershire Safeguarding Children Board (GSCB) commissioned a serious case review in respect of James because the circumstances of the case met the statutory criteria for when a Local Safeguarding Children Board must commission a serious case review.

1.2 Initial work on the serious case review was completed in November 2017. Upon reflection GSCB felt the serious case review had not captured all the elements of the case and therefore the necessary potential learning and so commissioned another independent author to do further analysis and work to the serious case review.

2. About the Author

2.1 I have worked in child protection/safeguarding for 25 years, the last ten of those as an independent safeguarding consultant, serious case review author and trainer. This work has included leading ten serious case reviews and a number of other reviews into practice for a range of organisations. I have led, or co-led, a number of reviews in Gloucestershire, the last one being in 2012.

2.2 I have delivered training for Gloucestershire Safeguarding Children Board for the last ten years and in addition to that I develop and deliver child protection training across a number of organisations, including other Local Safeguarding Children Boards.

2.3 For more information please see my website https://joannanicolas.co.uk

3. Methodology and Limitations

3.1 The first iteration of the serious case review was undertaken using systems methodology. This means there are two groups, as well as the two lead reviewers: the review team and the case group. The review team is made up of senior managers from each of the agencies involved, who had no involvement with the case, the case group is made up of the key frontline professionals who were working with the family during the period under reviews.

3.2 Unfortunately at the commencement of my involvement four members of the review team were no longer working in Gloucestershire. I have met with three members of the review team; from Gloucestershire Constabulary, Children Social Care (CSC) and the Clinical Commissioning Group. I communicated with a fourth by email; the review team member who represents Gloucestershire Hospitals NHS Foundation Trust. I also met with the professional who had the most involvement with the family during the period under review, the community family worker.

3.3 As well as having sight of the first iteration of the serious case review and associated documents I have also seen minutes of child protection conferences, core groups and child in need meetings in respect of Child One.

3.4 This report builds on the first iteration of the serious case review and therefore parts of that report are included in this.

3.5 It is essential that organisations and individuals learn from research and learn from findings and recommendations from previous serious case reviews. The most comprehensive analysis of serious case reviews has been commissioned by the Department for Education since 2003, first biennially, then triennially. The last analysis published[1] considered 293 serious case reviews between 2011-2014. They were considered in the context of the findings from the previous four publications. It is to that analysis that I will refer most frequently because it should be a key learning tool for all professionals working with children and their families. Henceforth I will refer to this analysis as the Department for Education's analysis of serious case reviews.

4. Introduction

4.1 Why this case was chosen to be reviewed

4.2 Gloucestershire Safeguarding Children Board, as it was then, determined to conduct a Serious Case Review (SCR) because the circumstances of this case met the statutory criteria:

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

4.3 Succinct summary of case

4.4 This review concerns services provided to James and his family. James was four months old when he died. He had spent all his life living with his mother and father. The mother had an older child who had been the subject of a child protection plan and then a child in need plan but this came to an end before the mother was pregnant with James.

4.5 James received services from midwifery and then health visiting services.

4.6 Following his death there was a post mortem that identified the cause of James's death as an injury to the brain through lack of oxygen, possibly resulting from submersion in water. There were also other injuries identified; healing fractures of the lower ribs in his back (between 6-8 weeks old) and possible injuries to his brain and bleeding from his retina which suggest that he suffered physical abuse, likely by shaking.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-_Pathways_to_harm_and_protection.pdf

4.7 Professionals working with James had not identified any significant areas of concern prior to his death.

4.8 Family composition

Family member	Age at the time of the child's death
James	4 months
Child One	2 years
Mother	20 years
Father	26 years

4.9 Timeframe

The time frame for the serious case review was agreed as being from January 2015, by which time Child One had been on a child in need plan for five months until 30th July 2016 when James arrived at hospital having suffered life threatening injuries.

5. Significant Events During the Period Under Review

Date	Event
5.1.15	The mother contacted GP with abdominal pain
5.1.15	The mother told CSC she had been with James's father for eight months.
7.1.15	The mother informed she was on the verge of being evicted due to breaching tenancy conditions by not keeping tenancy in a suitable condition
7.1.15	Children's Centre attempted home visit. No response
8.1.15	The mother attended the Emergency Department (ED) with symptoms including abdominal pain
12.1.15	Joint visit by Children's Centre and housing officer. Mother had bruising to her eye. Explanation given was Child One had hit her with a plastic hammer. Mother told worker that James's father stayed over sometimes
12.1.15	The mother told would not be evicted because the state of the home and garden had improved
14.1.15	The mother contacted GP with symptoms including abdominal pain
15.1.15	Child in Need meeting. Professionals told the mother's benefits had been stopped because of the belief James's father was living at her property. From CSC the allocated social worker attended and the community family worker
20.1.15	Bruise on the mother's face still evident and now described as "bruise to the side of her face" and "a large yellow bruise on her cheek". James's father gave one of

	his alias names and correct date of birth when asked by a professional
27.1.15	Children's Centre attempted planned home visit. No response
27.1.15	Child One fell down the stairs, observed by the community family worker, who was on the doorstep, not allowed in. James's father appeared at the top of the stairs asking what had happened
2.2.15	The mother attended ED with a laceration to the thumb - explanation given – cut it while washing up
4.2.15	CSC transferred case to Countywide Intervention Team, this meant the community family worker was no longer involved
18.2.15	The mother attended ED with abdominal pain
19.2.15	The mother contacted out of hours GP service. Abdominal pain getting worse
21.2.15	The mother attended ED alleging assault by unknown assailant. Jaw fractured in three places. She declined admission due to childcare issues. Returned the next day for surgery then self-discharged, which she later denied
27.2.15	The mother failed to attend health visitor appointment at the GP surgery
27.2.15	First mention in the chronology of James's father's real name
2.3.15	Health visitor attempted planned home visit. No answer
3.3.15	The mother told Children's Centre worker she had hurt her jaw by tripping over a paving slab when she was out with friends. She had fallen and hit her chin on the pavement. (This contradicts what she said at the hospital). Mother also said that Child One was being looked after by James's father the evening she was out with friends and he had also looked after Child One while the mother was having her jaw reset
4.3.15	Child in Need meeting. Concerns discussed about the mother's recent injury. New lead agency social worker said she would check the hospital report. No evidence this happened
10.3.15	Children's Centre worker planned appointment to take the mother and Child One to the Children's Centre. No answer at the home
12.3.15	Unannounced visit by the health visitor. James's father present. The mother told the health visitor she was assaulted but she did not know who by and said the police were involved. The mother also mentioned she had not seen X – a male – recently and voiced concerns he was stalking her. Now know X was an ex-partner, who

	was abusive. James's father was present initially and then went upstairs
19.3.15	The mother caught shoplifting. Stole a number of items, including groceries. Child One was with her and was "distressed and crying"
31.3.15	Child in Need meeting. Mother failed to attend. Notes from the meeting include "Professionals still unaware if police involved in the incident where the mother's jaw was fractured, the shoplifting incident, the mother had told the social worker her benefits had been stopped and she had no food and the group "still unaware of issues with James's father". Actions from the meeting included – social worker to complete core assessment, written agreement to be drawn up for the mother to engage with the Children's Centre and to keep appointments"
2.4.15	Joint home visit, Children's Centre and CSC. James's father answered the door and said the mother and Child One were not at home
7.4.15	The mother attended GP surgery. She is pregnant
8.4.15	The mother told her social worker she is pregnant
13.4.15	CSC, case transferred to Pod 6 team. Allocated to the original community family worker, as the lead professional as a Child in Need case
14.4.15	Community family worker undertook home visit. The mother noted to look in a poor state.
16.4.15	Police check completed on James's father. Confirms aliases and CSC records note "information includes assaults, drug dealing, being questioned in connection with a murder and punching a female in the jaw (not the mother)"
17.4.15	Children's Centre undertook home visit. The mother said she had taken Child One to a play session at another Children's Centre. This was checked and found to be untrue
17.4.15	Housing officer attempted planned home visit. No reply
21.4.15	Community family worker attempted home visit. James's father answered the door and said he was putting Child One down for a nap and it was not convenient. The community family worker questioned him about using an alias, which he denied. He also said he did not think a plan was necessary because everything was fine
28.4.15	Health visitor attempted home visit. No response
29.4.15	Child in Need meeting. It had been brought forward because of concerns of a lack of engagement by the mother, who was informed it may be escalated to child protection. Different programmes, including the

	Freedom Programme, were discussed with the mother, who said she had no interest in attending groups at the moment. The mother once again at risk of eviction
6.5.15	The mother caught shoplifting, items including groceries. Child One was with her
6.5.15	Children Centre worker attempted home visit. Refused entry by the mother, who said it was not convenient. James's father appeared at the door and said he did not like different faces appearing at the door all the time and did not like people being involved
11.5.15	Tenancy review took place. Property was now in good condition
13.5.15	Although a recommendation of the core assessment that had been completed, it was decided by CSC that there would not be a strategy discussion. Decision was made that there would be one if there was a deterioration in the home, further injuries, or inability to gain access
14.5.15	The mother attended CSC office asking for a food voucher. She said she was not getting her benefits
20.5.15	The mother told the health visitor that James's father stayed over sometimes. She denied being routinely short of money. Unclear whether he was contributing to bills at the mother's home. Noted that he was not claiming benefits, nor working. The mother denied low mood.
27.5.15	The mother attended ED with James's father with miscarriage. Left hospital against medical advice following a verbal altercation between the parents. James's father was refusing to look after Child One if the mother remained in hospital. The hospital notes said the mother was crying a lot and the midwife did not have the opportunity to speak to her alone. The mother returned to hospital later saying Child One was being looked after by the maternal grandmother
9.6.15	The mother failed to attend Child in Need meeting. Meeting informed the mother would not engage in any healthy relationships programmes, or outreach support and so the Children's Centre were closing the case
11.6.15	Health visitor attempted planned home visit. No response
25.6.15	Community family worker bumped into the mother and her grandparents. The mother was noted to look very pale and thin. Her grandfather told the community family worker that her flat was not decorated and there was no furniture
13.7.15	The newly allocated social worker completed the single assessment without seeing the family
28.7.15	Child in Need meeting. The mother did not attend.

	Professionals were concerned it was James's father who was telling her not to go
12.8.15	The mother told the housing officer, who noted the sofa had gone from the living room during a home visit that they had taken it to her mother's house while they were redecorating.
18.8.15	CSC made the decision to close the case because of lack of engagement and they concluded there was not enough evidence to suggest the level of harm met the threshold for a strategy discussion under s.47, Children Act 1989
23.9.15	The mother informed about being at risk of eviction again due to the state of the garden
5.10.15	The mother attended ED with abdominal pain. She was 14 weeks pregnant but had had no antenatal care. She did not wait but left the hospital
12.10.15	The mother attended ED with a lacerated thumb. She said she had cut it on a broken glass
20.10.15	CSC closed the case
25.11.15	The mother attended a walk-in clinic, Gloucester Health Access Clinic. She was 18 weeks pregnant. Said she had not seen a midwife yet because she was scared
3.12.15	Health visitor attempted planned home visit to undertake developmental review of Child One. James's father answered the door with Child One in his arms, partially clothed; she had nothing on her bottom half. He told her the mother was out. The health visitor heard the mother talking. The review was not done and the health visitor left
10.12.15	Midwife accepted the mother's explanation that her involvement with CSC related to foster care when she was in London. The midwife did not have access to the GP/HV system as the mother was registered with a different GP practice
11.12.15	During a tenancy review the housing officer noticed damage to the lounge and bedroom door. The mother indicated it had been like that when she first moved in
4.1.16	Gloucester Health Access Clinic received the mother's antenatal scan and suggested there should be a consultant review.
14.1.6	Health visitor attempted planned re-arranged home visit to undertake developmental review of Child One. No response
2.4.16	The mother attended the Birth Unit with James's father. She was in labour. The mother explained she was anxious because of her recent miscarriage. James's father was reported as telling her to "stop being a drama

	queen". He also said he was hungry and irritable and he did not like hospitals. The midwife was concerned about this conversation between the parents. She contacted the safeguarding midwife who said she would contact CSC. The mother wanted to go home and was discharged home to wait events
3.4.16	The mother returned to the Birth Unit. She was tearful and the tearfulness continued throughout her labour. The midwives were unable to confirm James's father was present but think he was but sat in a chair and did not engage with the mother or the midwives. James was born that day
4.4.16	Multi-agency referral form completed by another midwife, not the ones with the concern on 2.4.16. No details of those concerns were included in the multi-agency referral form. The information in the referral form was in relation to the concerns about the mother's previous fractured jaw, her history of violent relationships, the parents' chaotic lifestyle, financial and housing problems and the mother not attending appointments. CSC concluded these were historical concerns and there was no role for them
12.4.16	At routine home visit midwife noted small lump on the front of James's head. It was described as "not bruised or painful"
14.4.16	Health visitor carried out new birth visit. The mother said James's father did not live there but visited during the day. He was upstairs during the visit and did not appear. The home smelt of cannabis, the mother denied any use. She also said she had no history of drug use, including alcohol, or of domestic abuse, none of which was true. The lump on James's head was not red or inflamed. The health visitor informed the mother that Child One had still not had her Ages and Stages Questionnaire assessment
17.5.16	Health visitor attempted planned home visit. James's father said the mother and James were out
23.5.16	The mother told the health visitor on the telephone that she was away that week and back the week after
30.5.16	Anonymous call to the police saying there was an outstanding warrant out for James's father and he was living at the mother's address. Police searches completed. There was no outstanding warrant
31.5.16	Health visitor undertook home visit for 6-8 week review. Both parents present. Did not ask about domestic abuse because the father was present. Plan to see the family

	again in 12 months
24.7.16	Report to police by a member of the public that they could hear screaming and banging coming from the mother's home. Police officer attended and gained entry. Both parents present and the mother denied any incident had taken place. Both children seen
30.7.16	James admitted to hospital where he later died. The post mortem showed that four of his ribs had been broken six-eight weeks previously

6. Appraisal of Practice

6.1 The Department for Education has long tried to move serious case reviews away from a culture of blame. In 2014 they undertook a study[2] looking at barriers to learning from serious case reviews and how to overcome those barriers. The issue that came up in that study and remains today is the feeling that serious case reviews still look to apportion blame. It is always important to consider the context in which an individual is working and the wider-system they work within. Practice will be appraised through that lens.

6.2 If I have considered in the analysis of practice that the practice warrants a finding, then that practice will be commented on in the subsequent section – the Findings. This section is only for practice which, in my view, should be commented on and can be learnt from, if it has not been already, but does not merit a finding.

6.3 At one point a social worker undertook a single assessment of the family; this was also referred to as a core assessment. This assessment was completed without direct contact with the family, instead relying on information provided by other professionals, mainly the community family worker, different reasons were given by CSC as to why that was. One explanation was that it was because of a perception that the mother had an on-going relationship with the community family worker and was in the process of disengaging and it was thought that another professional becoming involved would be unhelpful. The other explanation given was that in the time the social worker had the mother would not make herself available. Whatever the reason, this decision was flawed. It was poor practice and undermined the effectiveness of the assessment.

6.4 CSC has provided assurances that it would be extremely unlikely to ever happen again, that a single assessment could be completed and signed off without the family, including the child being seen. It is no longer physically possible to sign off an assessment unless a box has been ticked to say the child

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/331658/RR340.pdf

has been seen. Social work managers have been given clear guidance that they must not sign off assessments without the information about the child and family being seen and CSC can confirm this is happening through their completion of single assessment data. They also check this through audit – approximately 60 children are audited each month and one of the questions is around assessment and was the child seen and spoken to alone etc.

6.5 At the point the single assessment was completed, in the summer of 2015, there was a change in the management of the locality team and the social worker undertaking the assessment also changed role. This meant there was no direct discussion between the social worker and the manager about the assessment recommendations. The new manager had limited management experience and her line manager was not available at the time. She therefore discussed the case with the previous locality team manager and, based on her advice, did not endorse the social worker's recommendation for a strategy discussion. She instead determined that there should be a further child in need meeting which would attempt to engage the mother, but that if that was unsuccessful the case should be closed. This decision was flawed because if all the information had been considered and the risks of domestic abuse understood, the social worker who undertook the assessment was right in her recommendation that there should have been a strategy discussion. Also, "lack of engagement" should not be a reason in itself to close a case. There should be analysis of risk factors, a comprehensive assessment of all agencies' information and current circumstances and a thorough assessment of potential risk of harm.

6.6 Two months after CSC actually closed the case the mother presented at the Emergency Department with possible gastro-enteritis and she advised staff that she was 14 weeks pregnant. An appointment was made for the mother to attend the Early Pregnancy Assessment Unit however she left the hospital before being told about the appointment. The hospital did make several attempts to contact her. When the mother failed to attend the appointment there was no follow-up because she was not deemed to be vulnerable and also it is not unusual for appointments to be missed if the pregnancy has not progressed. This issue has now been reviewed by the Hospital Trust and the Hospital Trust Vulnerable Women's Team is now routinely advised of all pregnant women who attend the Emergency Department. That team will then assess whether more should be done and ascertain if the midwifery service is involved. The midwifery services also now follow up to ensure the woman has been booked by a maternity service in or out of county.

6.7 A common thread running through this case was a lack of professional curiosity. The mother's words were accepted, even though sometimes she said different things to different people about the cause of the injury to her jaw, for example, and also how much time James's father spent at her home. In the words of the Department for Education triennial analysis of serious case reviews "Effective work with parents requires professional curiosity and challenge, without which analysis may lack rigour and depth. Failure to do so leaves children unsafe". That is exactly what happened in this case.

7. Findings in this Case

7.1 When doing a systems review the review team – the group of senior managers from each of the agencies involved – and the serious case review author/s agree on what the key findings/issues are from the case being reviewed. The task of the review team is then to look wider and test out whether the issues identified in this case are commonly found issues across the agencies and across the workforce as a whole.

7.2 As four of the original review team members no longer work in Gloucestershire the findings have been agreed by the remaining members, as well as the GSCB serious case review sub-group. It will then be for the Board to test out the findings more widely across Gloucestershire. The suggestion for how to do this is set out in the action plan.

7.3 It is also important to consider the national context. Themes from serious case reviews across the country tend to be very similar. The reason for that is because professionals are working with extremely complex issues. If the issues were simple it would be easy to find solutions to them and so they would not occur anymore. Not only are we working with human beings, who are unpredictable and with software systems that do not link up, As well as this professionals cannot remove risk in every case. Risks have to be managed. It is clear from all the serious case review data that the greatest risk factors for children who die, or suffer lasting detrimental affects as a result of maltreatment are domestic abuse, parental unmet mental health needs and/or parental substance misuse and that the risks increase exponentially when more than one of those factors is present. Professionals cannot remove every child from a home where one or more of those factors are present. What professionals have to do is assess risk and act accordingly. What is incumbent on every agency is to ensure their staff understand what the risks are for children and that is where the failings often lie.

Finding One

7.1.1 There Can be a Fundamental Lack of Understanding of the Risk Factors for Children, in Particular Domestic Abuse

7.1.2 There is a considerable amount of evidence about the risks to children of domestic abuse, parental substance misuse and parental unmet mental health needs and yet what serious case review analysis tells us if those risks are not always clearly understood and assessed.

7.1.3 A theory put forward in the Department for Education's analysis of serious case reviews is one of cultural normalisation and professional desensitisation, which they talk about in the context of "needy families." *"The sheer volume of needy families in an area was a frequent feature in reviews. This can mean that there is little to distinguish at-risk families from other families in the area. A*

danger that can arise in such situations is that of cultural normalisation and professional desensitisation. This may be a very appropriate coping mechanism by professionals overwhelmed by the volume and complexity of their task, but can result in vulnerable children being left without adequate assessment of their needs". If one combines that with the prevalence of domestic abuse, the sheer volume of domestic abuse cases, and the normality of domestic abuse being a factor in a high percentage of families receiving additional support. As referenced elsewhere in the report the Best Beginnings website gives a succinct summary of domestic abuse research, which includes the following:

- 1 in 4 women experience domestic violence over their lifetimes
- 6-10% of women suffer domestic violence in a given year
- 1 woman in 9 is severely beaten by her male partner in a given year

7.1.4 As the NSPCC summarises[3] domestic abuse is a feature in over half of all serious case reviews and a third of children exposed to domestic abuse will also be suffering another form of abuse.

7.1.5 What happened in this case?

7.1.6 What was missing was an understanding of the risk indicators of physical harm to a child under one or an unborn baby, the risk of physical harm to the mother, both in pregnancy and with a child under one, the impact of the emotional harm to a child of living in a home where there is domestic abuse, the mother's age, substance misuse and concerns at times about the mother's mental and physical health. There is also some evidence of a lack of professional curiosity.

7.1.7 These risk indicators should be clearly recognised by all agencies and reiterated to their staff over and over again and be firmly embedded in practice. From the Department for Education's analysis of serious case reviews:

- 41% of the children were aged under one year at the time of their death, or incident of serious harm; and nearly half of these babies (43%) were under 3 months old
- 74% of the non-fatal incidents of physical harm were in relation to a child under one. Such assaults often took place in the context of domestic abuse and chronic neglectful care of children
- In 54% of the cases the mother was aged 19 or under at the time of the birth and two of the issues which arose most frequently were lack of support from the baby's father and/or an unstable relationship with the father

7.1.8 In addition to the research around domestic abuse highlighted elsewhere in this report, other relevant research is summed up succinctly on the Best

[3] https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/domestic-abuse/domestic-abuse-facts-statistics/

Beginnings website[4]:

- In 90% of domestic violence incidents, children were in the same or the next room
- In over 50% of known domestic violence cases, children were also directly abused
- Over a third of domestic violence starts or gets worse when a woman is pregnant
- 15% of women report violence during their pregnancy
- 40%–60% of women experiencing domestic violence are abused while pregnant

7.1.9 It was known the mother had lived with domestic abuse as a child. It was also known the mother had a history of smoking cannabis and drinking alcohol, she also had a conviction for possessing Class A drugs, and was found with Class A drugs on another occasion.

7.1.10 It was known that the mother had been in at least two abusive relationships by the time she entered a relationship with James's father, and she was only 19 at that time.

7.1.11 The Department for Education's analysis of serious case reviews found that *"other frequently co-existing risks include adverse childhood experiences, a history of criminality (especially violence), acrimonious separation, and a pattern of consecutive partners*". Most of these applied to the mother.

7.1.12 In January, 2015, the mother told professionals she had been in a relationship with her new partner, who was to be James' father, for eight months. This means that either she had been in a relationship with him at the same time as her previous partner, or as soon as that relationship ended. Either way there appears to have been no break between one abusive partner and the next. The mother told professionals that her new partner treated her well and was nice to her, which is what she had told professionals about her previous partner, who had a long history of allegations of rape and assault made by previous partners, for the majority of their relationship.

7.1.13 Although a requirement of the child in need plan was for the new partner to be police-checked the check did not happen until April, 2015. It is not clear what caused this delay. Given the information confirmed he should be considered to be a risk to children it is a real concern that he was living with a young child and a vulnerable young woman for four months before that check was completed. The police check confirmed professionals' suspicions that he was using an alias. His real name was confirmed, as well as another alias he used. The check showed he was well-known to one police force and known to three other forces. Most police information related to concerns of dealing drugs

[4] https://www.bestbeginnings.org.uk/domestic-abuse

and smoking cannabis. He had convictions for resisting police[5], common assault of a female victim – not domestic abuse - and burglary. Further offences, which did not result in convictions, related to possessing cannabis, robbery, common assault, murder (he was a suspect in a stabbing), possessing a prohibited weapon (taser) and criminal damage. The criminal damage was following a verbal argument with his mother. He allegedly told his mother he would damage her car if she called the police. The mother then found damage to her car wing mirror. The young siblings aged one and seven were present and upset. He also had a previous conviction for punching a female in the jaw. Nothing was actually done with this information when it was received by CSC, which is extremely poor practice.

7.1.14 In the words of the Department for Education's analysis of serious case reviews *"The presence of a criminal record should be seen as a risk factor for serious or fatal maltreatment, particularly when combined with other parent/carer risks such as domestic abuse, substance misuse or mental health problems".* Interestingly, in this case the mother was not police-checked, even though some professionals knew she had a criminal record. She too should have been police-checked.

7.1.15 During the period under review the mother presented with bruising to her eye and cheek that she said was caused by Child One, who was 14 months old at the time, hitting her with a plastic hammer. The bruising was evident for some time after the alleged event. One would have to question first of all if a 14 month old would have the physical strength to hit hard enough to leave bruising and how could a child's plastic hammer have a large enough surface area to bruise the eye and the cheek? The mother has always maintained this is what happened. During the serious case review process some professionals did say they questioned the mother's explanation and did not believe her but none disbelieved her to the extent that they requested a strategy discussion, or used the GSCB escalation of professional differences guidance when CSC took no action.

7.1.16 Four weeks later the mother was seen in the Emergency Department with a fractured jaw which she said was caused by an unknown assailant. Her explanation was accepted by hospital staff and no further questions were asked, about domestic abuse, or anything else. There are a set of safeguarding questions that have to be asked if hospital staff are concerned about a patient. These questions were not asked and it is not known why not. Also the mother said she could not stay and have the surgery then because of childcare. This too should have raised an alarm, if hospital staff had shown professional curiosity as to how the injury had occurred. Questions should have been asked about where she was when it happened, what had happened, how come she did not see her assailant etc., etc. When she returned the next day for planned surgery on

[5] https://www.sentencingcouncil.org.uk/offences/magistrates-court/item/obstructresist-a-police-constable-in-execution-of-duty-revised-2017/

the jaw the hospital staff again accepted her explanation of the injury and did not consider domestic abuse. There was nothing in the notes on transfer from the Emergency Department to the surgical team that indicated a need to follow up on the cause of the injury.

7.1.17 Mandatory safeguarding training for hospital staff includes the need for professional curiosity and routine questions asked about domestic abuse as part of the routine screening questions for safeguarding for both adults and children attending the Emergency Department. It is concerning that in this case those questions were not asked by the Emergency Department, nor by the surgical team. It is the responsibility of the Emergency Department to ask the safeguarding screening questions specifically but one would want all medical staff to show professional curiosity in how an injury occurred.

7.1.18 The community family worker did contact the GP following this injury. There is no record that any of the professionals involved checked directly with the hospital, police or ambulance about the cause of the injury and to ask if the explanations given were consistent with the reported history and clinical findings. It would be the responsibility of the lead professional, who should be a social worker not a community family worker, to ask those questions. It is unclear why there was no triangulation of information but it may be because a community family worker, quite rightly, would not consider that to be their role.

7.1.19 Over the next few weeks the mother gave two different explanations for how this injury had happened, to different professionals. She told one she had sustained the injury by tripping over a paving slab and then later on told another she had been assaulted but she had not seen her assailant and the police had been involved. None of this was followed up or challenged. The mother also mentioned her ex-partner and concerns he may be stalking her but this information was not acted on either. The mother always denied that James's father caused the injury. It was discussed with her at a child in need meeting and professionals remained disbelieving of the explanations for the injury given by the mother and were suspicious that James's father had caused it. This issue was not discussed further at later child in need meetings. There is no evidence anyone discussed it with James's father. It should be noted that post James's death the mother said James's father punched her in the jaw and that is how it broke in three places.

7.1.20 Professionals at the time expressed concerns that the mother was leaving Child One with her partner – the mother had said she had left Child One with him when she was out with friends, when she allegedly fell, breaking her jaw. This was not followed up although it was known James's father had a long history of involvement with four different police forces, for drugs and violence, including punching a woman in the jaw. None of this information was put together.

7.1.21 In terms of Child One the mother was very good at telling professionals about her routine and all the delicious meals she prepared for her. This was not always believed but it was hard to prove otherwise when the child showed no

physical signs of neglect or emotional trauma.

7.1.22 The day before James's birth the mother presented at the hospital, with James's father, possibly in labour. One midwife was concerned about the partner's responses to the mother. She read the midwifery notes and found a green 'concerns form' which she thought related to the current pregnancy but had been completed for the previous pregnancy when the mother miscarried and had been misfiled, as each pregnancy should have its own sub-file. She noted that the mother had previously had a black eye and a fractured jaw and contacted CSC Emergency Duty Team and was told if she continued to have concerns to make a referral to CSC using a multi-agency request-for-service form (MARF). The midwife recorded this advice on the existing green concerns form. The mother came back to the hospital the next day and gave birth to James. The midwives involved then did not notice anything out of the ordinary but felt that in light of the previous midwife's concern that a referral to CSC should be made and so completed the MARF. This would have been good practice if the MARF had included what had led the first midwife to be concerned in the first place, namely the conversation she witnessed between the parents; the mother had explained she was anxious because of her recent miscarriage and James's father told her to "stop being a drama queen". He also said he was hungry and irritable and he did not like hospitals. However this information was not included in the MARF

7.1.23 The MARF was received by CSC but as the information it included was considered to be "largely historical", although the fractured jaw was only 14 months previously, and the conversation between the parents that was witnessed by a midwife was not included, it was felt that there was no need to take any action. This was wrong. Even with the professionals' limited understanding of domestic abuse they should have assessed that a newborn baby going into a home where professionals believed there was domestic abuse would have met the threshold for a strategy discussion, under s.47, Children Act, 1989.

7.1.24 It should be said that as previously stated the Local Authority is the lead agency in child protection and child in need cases but it is the responsibility of all professionals in all agencies to escalate their concern, if they have any. The escalation process in Gloucestershire has been renamed and has had a number of iterations since 2015 but the basic premise has always remained the same. In the words of the current guidance "Where professionals consider the practice of other professionals is placing a child/children at risk of harm, they must be assertive, act swiftly and ensure that they challenge the relevant professionals in line with this policy".

7.1.25 The escalation process was not used by any individual in any agency during the period under review. In conversations with frontline staff the view was expressed that it was hard to challenge CSC and if one attempted to one could be put down and made to feel inferior for questioning the greater knowledge and expertise of CSC, even though in some cases social workers and social work managers may have much less experience than other professionals.

This was something that Ofsted identified in their 2017 inspection, specifically *"An unprecedented number of staff anonymously raised concerns with the inspectors about the culture of bullying and blame that is prevalent in children's social care. Senior managers have not been able to support an environment in which healthy challenge is consistently evident and social work practice is allowed to flourish".* It should be noted that there have been many changes and improvements since the initial inspection but GCC have done significant work in this area, as part of the post Ofsted improvement plan to address concerns about the culture, including a large staff engagement exercise in Autumn 2018. Subsequent Ofsted monitoring visits and staff surveys have confirmed that morale has improved. (This is addressed in the Action Plan)

7.1.26 In July 2016, a week before James's death, the police were called late on a Sunday night to an incident at the parents' flat. The police received a telephone referral from a member of the public who did not wish to provide details, but the phone number was recorded automatically on police systems. The person said screaming and banging had been heard coming from the address, that there had been previous 'domestics' at the address and that there was a female screaming and it sounded like she had been pushed down the stairs. The control room incorrectly coded this as 'concern for welfare' incident rather than as domestic abuse. A police officer visited the family and both the mother and her partner were very un-cooperative, initially refusing to talk to the police officer, with the mother denying that anything untoward had happened. The police officer was joined by another police officer and eventually both were shown the children who were noted to be " safe and well" by which he meant they did not have any visible signs of injuries or emotional trauma. There were no signs of a disturbance at the property.

7.1.27 Afterwards the police officer was concerned for the welfare of the children because of the parents' attitude and he intended to complete a Domestic Abuse, Stalking and Harassment (DASH) checklist which would have then been reviewed by the Multi-agency Safeguarding Hub. Unfortunately, the police officer forgot to complete the DASH checklist and this combined with the fact the incident had not been coded as a domestic abuse incident and the children were described as "safe and well" meant it was not passed to the Central Referral Unit who would then have reviewed it. That review should have led to a referral to CSC. This meant that the details of this domestic abuse incident and the concerns about the children were not shared with other agencies that were therefore unaware of the potential risks. This was poor practice by the police control room and the attending officer. Since this happened more thorough systems have been put in place to make every effort to ensure this could not happen again.

7.1.28 During the mother's relationship with James's father there were a number of other concerns which were not considered sufficiently, in the context of what professionals believed was an abusive relationship; in January, 2015 the mother told the social worker her benefits had been stopped because her new partner – James' father – was living with her and she had no money for

food. During that home visit the social worker commented how cold the home was. The mother said the meter was not working and she had no heating and hot water in the home. The minutes from the child in need meeting held on 15.1.15 state that the mother was going to speak to the utility company about the meter. Children Social Care records state that a visit was made on 20.1.15 and there was still no heating or hot water. According to the community family worker the issue was that there was a problem with the meter, rather than the bill had not been paid and it was she who spoke to the company and sorted it out.

7.1.29 One would have expected the professionals to not only think about how the mother was going to cope with no money but also it was the middle of winter, there was a 14 month old in the home and there was no heating or hot water and seemingly no money to buy food. What was the impact on Child One of this situation? How was she going to be fed and kept clean and warm and also this situation would put more pressure on the adults and how was that likely to manifest itself?

7.1.30 This point brings to mind another Gloucestershire serious case review "Abigail". This review was published in 2014. In that case for five months professionals talked about the little girl's extreme nappy rash and what to do about it, it was a chronic neglect case. What no one was thinking was "what is the impact on this little girl every minute of every day and night?" Also, there is no medical reason, other than a zinc deficiency, which "Abigail" did not have, for such severe nappy rash and the moment she was cared for properly, the nappy rash disappeared.

7.1.31 Also conditions within James's home were considered to be "variable" and on occasions all the professionals considered the basic care provided to Child One to be inadequate. Professionals were usually only allowed in the living room, although on one or two occasions workers saw Child One's bedroom and a cot with no bedding, or dirty bedding.

7.1.32 James's father did not work and professionals were told he did not qualify for benefits. How was he funding his life? Although the community family worker tried hard to gain information none was forthcoming and nothing further was done.

7.1.33 Between 8.1.15 and 28.5.15 the mother attended the Emergency Department on six separate occasions; once for a laceration to her thumb, once with a fractured jaw and four times for abdominal pain and other symptoms. Not once were the safeguarding screening questions asked, at any of the six attendances. This is very poor practice, this was a young woman who over the years had attended ED on an usually high number of occasions but that did not raise a concern for the staff in ED, which it should have done. (This is addressed in the Action Plan).

7.1.34 Also, the mother was caught shoplifting on two occasions, stealing groceries on both occasions but again, no thought was given as to why she was

stealing food, just a mention in a child in need meeting that work should be done with the mother to help with budgeting and she would not be providing a good role model to her child if she was stealing. The mother was given vouchers for a food bank.

7.1.35 During the entire involvement with professionals the mother frequently did not keep appointments, attend meetings, attend sessions she had said she would attend, or answer the door when professionals visited for pre-arranged appointments. She often said she forgot appointments. She started one programme for victims of domestic abuse but then said it was not for her and stopped going. She said she would attend another but never did and nothing was done about it.

7.1.36 Also during the period under review a social worker made a home visit and noted "sparse living conditions", no food in the fridge, no bedding on Child One's cot. The mother told her she was having problems with her benefits. She also said she was pregnant. During another visit the mother was looking in a very poor state. There was no furniture in the living room and the mother said they had taken the sofa to her mother's house because they were decorating. If one considers that logically – the effort of moving a sofa, which would require a car, which neither adult had, rather than just putting it in the middle of the room with something over it to protect it. It is possible furniture was being sold to fund other things but no one asked that question.

7.1.37 The mother went on to miscarry this baby. She attended hospital, with James's father, and was advised to stay in overnight. As stated earlier in the report there was an altercation between the mother and father because the father refused to look after Child One; this meant the mother had to leave the hospital. The hospital staff who witnessed this altercation did not raise concerns with any other professionals. Advice should have been sought from a more senior person in the hospital.

7.1.38 On one occasion a housing officer visited and noted the doors were damaged. The mother said they were like that when she moved in. One would have expected the housing officer to go back and check the records and if it were not true to have a conversation with CSC. It is not uncommon to find doors damaged in homes where there is physical violence. Again, there was no evidence of professional curiosity.

7.1.39 In terms of the mother's physical and mental health, professionals noted that after her jaw was broken she was losing weight and looked in poor physical health. At her first appointment with the midwife when the mother became pregnant with the baby that she then went on to miscarry the midwife referred her to a consultant for a number of reasons, including concerns about her mental health.

7.1.40 In terms of Child One and domestic abuse, the professionals all seemed to think the relationship between the mother and James's father was abusive but felt they could not prove it. There was much emphasis on the fact that Child One

was meeting her developmental milestones and appeared chatty, happy and content and generally clean and well cared for by her mother, which whom she was described as having a good bond. When she started attending nursery, when James was about ten weeks old, she presented as a happy child who was developing well. The nursery staff had no concerns about the child or the wider family. Professionals were expecting to see outward signs of trauma, or signs of physical harm to Child One if she was suffering harm and in the absence of either felt there was no evidence of Child One witnessing or hearing domestic abuse. Again this shows a lack of understanding of the impact of domestic abuse on children. Not all children will react in the same way or show outward signs at such a young age. Child One was only two and a half when James died. There is a significant body of research about the impact of domestic abuse on children, both in the womb and when the child is born but this was not taken into account, nor seen as significant evidence.

7.1.41 Throughout the period under review the mother was at constant threat of eviction, due to the state of the home. Problems with housing and homelessness are a common theme of serious case reviews, and in particular, eviction, which the Department for Education's analysis of serious case reviews notes as being a significant risk factor.

7.1.42 The word that kept being repeated by the professionals involved in the serious case review for this case was a lack of "tangible" evidence. It is extremely concerning that with all the evidence that there was neither the frontline workers, nor their managers where relevant, saw that as enough to meet the threshold for enquiries under s.47 of the Children Act 1989.

7.1.43 How likely is it this is a widespread issue in Gloucestershire and not unique to this case?

7.1.44 I co-led the serious case review in Gloucestershire in respect of "Lucy"[6]. The serious case review was published in June, 2016. "Lucy" was 16 when she was murdered by her abusive partner in April, 2014. She was pregnant at the time of her death and the baby did not survive the attack either. "Lucy" had been deemed to be a child in need, as was the mother in this case, in both cases until they became pregnant and then there was a child protection plan in place in respect of the unborn baby.

7.1.45 Much of that serious case review resonates with this case, for example: "This review indicates a general lack of understanding of how to recognise key features of domestic abuse in children under the age of 18, leaving child victims without the necessary support and protection" Although the mother in this case was an adult when she became pregnant with James, she was a child when she gave birth to Child One.

7.1.46 The "Lucy" serious case review goes on to say *"When a teenager is*

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[6] https://www.gscb.org.uk/media/1606/scr_0114_lucy_final_010616-66831.pdf

involved in an intimate abusive relationship there is a pattern that professionals do not always seek to test out whether the young person does truly have rights of self-determination, such rights of self-determination can be impaired by elements of the abusive relationship, such as coercive control. This increases the likelihood that the teenager will be left at risk. Teenagers are inherently vulnerable, as is being increasingly recognised through child exploitation serious case reviews nationally. For a pregnant teenager if the focus is primarily upon the unborn baby this distracts from the fullest assessment of risk to the child, as an individual in her own right and overlooks their vulnerability. The consequence of this is that it is more likely that there will be an incomplete assessment of the risks posed to the child and the mother". Good practice would ensure that the needs of, and risks to, both a vulnerable young mother and her baby (born or unborn) are identified.

7.1.47 It should be noted that since "Lucy's" death there is now guidance and there are a number of tools for working with teenage victims of domestic abuse, which are all set out on the GSCB website.

7.1.48 In their inspection in 2017 Ofsted found *"Plans are often overly optimistic about the capacity of parents to change or their ability to protect their children, particularly for those children who experience domestic abuse, parental substance misuse or the cumulative impact of neglect".*[7]

7.1.49 Also in Ofsted's inspection report *"The impact of domestic abuse, adult substance misuse or parental mental health is not always understood or given sufficient focus in terms of the cumulative and emotional impact on children. There is an over-reliance on parental self-reporting, with insufficient challenge or consultation with partners to verify parents' accounts of events and incidents. In stronger assessments, children's views are clear and include a thorough assessment of risk with clear actions, but too many are descriptive and lack sufficient or effective analysis".* That is what happened in this case.

7.1.50 In Gloucestershire there is a specialist domestic abuse support service, Gloucestershire Domestic Abuse Support Service, and part of their remit is to provide support to professionals. It would be useful to know how widely this part of their service is known about and how often it is used, and by which agencies. (This is addressed in the Action Plan)

7.1.51 Gloucestershire Constabulary had a poor Her Majesty's Inspectorate of Constabularies (HMIC) inspection on their approach to tackling domestic abuse in 2014. Following this much work has been done to improve practice and at the most recent update visit HMIC was very impressed with the progress Gloucestershire Constabulary has made. As an example; domestic abuse training is given to all new police officers as part of the training they receive. The training is delivered by a Detective Sergeant from the Domestic Abuse Safeguarding Team. There has been a significant amount of training for

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[7] https://files.api.ofsted.gov.uk/v1/file/50004377

existing staff in terms of domestic abuse awareness, coercive control and vulnerability training for all staff, which had significant input around domestic abuse and child protection. They also ran question and answer sessions on domestic abuse, which focused on use of the Vulnerability Identity Screening Tool (VIST), safeguarding, evidence gathering and arresting perpetrators. It is likely that there will be further domestic abuse input in 2019 but the contents are yet to be confirmed.

7.1.52 Since James died there has only been one child death in Gloucestershire where the perpetrator was a perpetrator of domestic abuse. My only concern is the police created an internal "How to proceed" in domestic abuse cases and nowhere in the 34 page document does it set out what the research tells us about the risks of physical assaults starting or increasing during pregnancy, or when a child is born, or that the age at which one is most likely to die a violent death is under one. Frontline officers are told to use their professional judgment when coding a case but at the same time it is well-known that frontline officers have to know so much about so many different things. They cannot be expected to be experts in domestic abuse.

7.1.53 Following sight of the first draft of this report the police review team member has recommended changing that guidance. The recommendation is as follows:

"Gloucestershire Constabulary to ensure that the presence of an unborn child or a child under one year within a household where domestic abuse occurs is considered as a specific risk factor. Currently Constabulary Guidance refers to children in a generic term". The police's proposed actions are to update the force's "How To" guide, to make changes to the Vulnerability Identification Screening Tool form to specifically ask if there is a child under 12 months and guidance given on the form that this is an increased risk factor and that updates are made to the ongoing training within the Constabulary for call takers, first responders and investigators emphasising the increased risk to a child under 12 months".
(This is addressed in the Action Plan).

7.1.54 This should be a significant improvement, if all call takers, first responders and investigators are aware of the increased risk, not only to a child under 12 months but also if the woman is pregnant, in domestic abuse cases and incidents are initially coded as high risk and then professionals with greater specialist knowledge can assess each individual case. However it will only have a positive impact on children if CSC and partners working in the Multi-agency Safeguarding Hub are equally aware of the additional risk. Currently Gloucestershire's Levels of Intervention Guidance, the threshold document for all professionals working with children, makes no mention of the additional risk factor if there is a child under one, or the woman is pregnant, and there is domestic abuse. (This is addressed in the Action Plan).

7.1.55 As stated previously, Gloucestershire Constabulary has invested considerable training in the response to domestic abuse, including the need to consider children who may be within the family. They do not train the term 'Safe

and Well' but now teach staff to capture "the voice of the child". This should go far beyond simply checking that there are no outward signs of injury or distress and should involve talking to the child, where appropriate.

7.1.56 The lack of professional curiosity has been a feature of a number of local serious case reviews. All GSCB training covers learning from serious case reviews, including the need for professional curiosity; however this training reaches a limited audience and is rarely attended by police officers or child protection social workers and many health professionals only have to attend single-agency training. The same is true of the GSCB domestic abuse training. Some agencies make it mandatory for their staff, particularly their safeguarding leads, to attend certain GSCB courses. None of the courses are mandatory for CSC or the police.

7.1.57 If agencies, particularly the lead agency in child protection, are not sending their staff on GSCB training that is a concern. (This is addressed in the Action Plan). It is important to say that GSCB training can only be one part of the equation. It is the responsibility of each agency to ensure their staff understand risk factors for children and how to work effectively and this culture of constant learning and improving should be built into every organisation.

7.1.58 Is there any evidence this is a national issue?

7.1.59 As has been stated elsewhere in the report all of the issues highlighted in Finding One are common findings in serious case reviews across the country. There are different hypotheses as to why this is. In respect of domestic abuse, in my view it is because of the prevalence of domestic abuse and if we acknowledge that domestic abuse is child abuse in every case then that would mean that every child in those circumstances would have to be the subject of a child protection plan and if the domestic abuse did not stop, then CSC would have to apply to the court to remove that child and that is simply not feasible. It is, however, worth noting that 23 years ago the Metropolitan Police, and some other forces, would not attend a domestic incident, even if it was a 999 call, because they said they did not have the capacity. That would be unimaginable now for any police force.

7.1.60 There are also many aspects of domestic abuse that present huge challenges for professionals; if both parties are denying it, if both parties are saying the perpetrator does not live with the mother, or spend much time there, if there is no physical evidence of trauma in the child, if there is no evidence of physical abuse of the child, or the alleged victim. All of these factors make working with families where one suspects domestic abuse extremely challenging.

7.1.61 In terms of the lack of professional curiosity again this is a common finding from serious case reviews across the country. Serious case review analysis shows professionals can be too accepting of what parents/carers tell them, that professionals can be too optimistic, can be overwhelmed by the

chaos of the family, that children can become invisible, that agencies have not worked well together. Again there are different hypotheses as to why this is. In my view, having worked in this field for over 20 years, the pressure of workloads across all agencies means that professionals sometimes just skim the surface and no one understands what is really going on in that family until it is too late and the serious case review is being done. Frontline professionals in all agencies not only need to be equipped with the skills to understand risks, to assess and analyse risks and strengths in families, they also need to be given the time to work in a meaningful way with that family and with other agencies, and also to be supervised effectively. (This is addressed in the Action Plan).

7.1.62 The Department for Education's analysis of serious case reviews sets out concerns about using generalised language. In reference to the police the analysis found: *"Police officers and others responding to issues of domestic abuse need to recognise the on-going vulnerability of any child living in a context of domestic abuse, regardless of whether there are specific incidents of violence directly impacting on the child".* The research goes on to mention a specific serious case review *"Whilst the Police IMR confirmed that it was an expectation via the relevant domestic abuse policy that "children living in the location are physically seen and their welfare checked", this was not always apparent. On some occasions there was no reference to the whereabouts of the children, and when they were seen, there were generalised comments such as the children being "none the wiser", "safe and well" or "fine".*

7.2 Finding Two

7.2.1 The Systems, Guidance, Tools and Supervision in Place in Gloucestershire Currently do not Sufficiently Assist and Support Professionals Working with Cases of Domestic Abuse

7.2.2 Although it is important to recognise that both men and women can be perpetrators and victims of domestic abuse and both men and women can be primary carers of children, what occurs most commonly is the man is the perpetrator of abuse, the woman is the victim and the woman is the primary carer of the children. As that is what happened in this case, for the purpose of this report I am describing domestic abuse in that context.

7.2.3 As set out in the previous finding there are many factors that make working with domestic abuse so challenging for professionals and those challenges should not be underestimated. In addition to those described above; victims may not recognise they are victims of abuse, or minimise the abuse because they are made to feel it is their fault, they may not feel able to be honest with professionals about the extent of the abuse for fear their child may be removed from their care, or fear of retaliation by the perpetrator, or just a general fear about what may happen if anyone knew what was going on, there can also be a terrible sense of shame.

7.2.4 What happened in this case?

7.2.5 Prior to the mother becoming pregnant by James's father she always told professionals that he was not Child One's father and therefore they should not speak to him. He often appeared during home visits but usually at the top of the stairs, saying he was decorating. The professionals felt they could do no more because he was not the father. For a long time the mother denied he lived there, although professionals suspected he did.

7.2.6 The first visit by a professional after the mother sustained the broken jaw, James's father was in the room initially, as the mother told the professional she did not know how it had happened but that her ex-partner had made contact with her and she thought he was stalking her. James's father then left the room. One has to wonder if that was what she was told she had to say and he was there to make sure she did and to sow the seed about the ex-partner, although this was not investigated further by CSC, which it should have been.

7.2.7 From the time of the miscarriage the partner became very antagonistic towards professionals and he told them he blamed them for the mother's miscarriage. None of the professionals worked directly with James's father, even when the mother was pregnant and he was the father, who did not welcome involvement with services and was encouraging the mother to refuse to co-operate with the 'child in need' plan.

7.2.8 A lot of the language used in the assessments and meeting minutes was unrealistic and vague. Every single set of minutes I read referred to "ensuring", often in the context of safety. The mother will "ensure Child One is kept safe from harm", "The mother will ensure Child One does not witness any arguments". If only it were so simple. If one uses language like that the subconscious message is that all these changes are pretty simple. Also, one can never "ensure" safety. One cannot ensure safety of one's own children. The minutes said the same things over and over again but nothing really changed. The mother never completed a course for victims of domestic abuse.

7.2.9 James's father was never observed playing with, feeding, or caring for Child One in any way. There was no understanding of the part he played in her life, although it was known that sometimes he was alone with her, according to the mother. There was no sense in any of the minutes of who this little girl was what her life was like and no sense of having walked in her shoes for a day. The community family worker told me she was a robust, healthy-looking child, not remotely underweight and she was a chatterbox, with a good understanding of what was said. She did not present as a worrying child.

7.2.10 In this case written agreements were discussed on two occasions, although it is unclear whether they were ever actually put in place and they went wider than domestic abuse. In March, 2015 it was minuted at a child in need meeting that the mother was not going to groups and not engaging with the social worker so a written agreement needed to be put in place. Outside of the timescale under review it was minuted at a child protection conference that a written agreement was needed for the maternal grandmother not to be

abusive towards her children, including James's mother. Again, if only it were that simple.

7.2.11 In this case there was no evidence at all that supervision of any of the frontline staff made professionals question their judgement in this case, or that those in a supervisory role had any better understanding of domestic abuse than the frontline professionals. Effective supervision could have shown the frontline professionals that actually there was a huge amount of evidence, but no one was bringing it all together. Supervision should add another layer of checks and balances for the child. In this case that layer was missing.

7.2.12 How likely is it this is a widespread issue in Gloucestershire and not unique to this case?

7.2.13 It was a finding in a recent serious case review in Gloucestershire "Philip", published in 2016 that *"A lack of recognition of the role of fathers/father figures can leave children unprotected and at risk of harm".* It went on to say *"Fathers and father figures can play a very important role in family life and research suggests that they can have a great influence on the children's lives both positively and* negatively[8]. The implications of this are that the benefits for children are often overlooked, and the risks posed by fathers and men more broadly are not well understood leaving children at risk"[9]. As mentioned elsewhere in the report some professionals thought they could not speak to James's father in the time before the mother was pregnant with James because he was not the father of Child One (This is addressed in the Action Plan).

7.2.14 It was a finding in the "Lucy" serious case review that professionals did not know to work with her partner, who was a perpetrator of abuse. In that case when "Lucy" became pregnant her partner was told he had to take responsibility now because he was going to be a father. He should attend the ante-natal classes and the pre-birth child protection conference, all of which he did and he was praised for doing so, but the serious case review found that he would rarely let her out of his sight and it was all part of his control. (This is addressed in the Action Plan).

7.2.15 For many years GSCB has run courses on domestic abuse, which covers how to work with perpetrators of domestic abuse when you are working in children services. The courses are highly regarded but not mandatory for all agencies. Also, as mentioned previously GSCB training can only be one part of the puzzle and as one of the domestic abuse trainers said *"working with domestic abuse perpetrators is highly skilled and focused work – to be implemented by specialist agencies/individuals in order to manage risk and*

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[8] http://www.communitycare.co.uk/engaging-fathers/

[9] http://www.fatherhoodinstitute.org/

ensure that all is done to increase the safety and welfare of the victim and children". I would hazard a guess that there are very few professionals in Gloucestershire, outside of the specialist service, who have that level of expertise. Therefore, understandably, many professionals feel uneasy and anxious about working with perpetrators. They feel unequipped with the skills to have the dialogue; they feel afraid they will increase the risk to the victim and the children by doing so; they feel afraid for their own safety if their interventions should provoke an aggressive reaction from the perpetrator. (This is addressed in the Action Plan).

7.2.16 Although there is a lot of content on the GSCB website about domestic abuse there is nothing specifically about working with fathers and/or father figures. The same is true of the GDASS website. (This is addressed in the Action Plan).

7.2.17 So what we have currently is a situation where domestic abuse is extremely prevalent but the workforce is not equipped with the skills to deal with perpetrators. (This is addressed in the Action Plan).

7.2.18 Following the "Philip" serious case review GSCB developed a one-day course on working with fathers. Whilst this is excellent the reach will be relatively small and therefore it must be incumbent on each agency to make sure their staff are clear about how/when/why it is so important to involve fathers and how one can do that safely in cases of domestic abuse, as set out above. (This is addressed in the Action Plan).

7.2.19 It is possible that written agreements are still being used in Gloucestershire. This is in spite of an internal review that was done in 2011 in respect of a neglect and domestic abuse case finding that written agreements have no value in keeping children safe but only give false assurances to professionals that they do. The mother in that case said that of course she signed it because if she had not CSC would have taken her children away. A recommendation was made to GSCB and accepted by GSCB that written agreements would no longer be used in the county.

7.2.20 Sometimes an argument is put forward that the written agreement is useful for providing evidence to the court should it not be adhered to. The response to that is that is what the child in need, or child protection plan should do.

7.2.21 Supervision was noted by Ofsted in their inspection report in 2017 as being inadequate. In their most recent monitoring visit in January, 2019 this is what they said: *"While social workers report that supervision is regular and reflective, it does not focus sufficiently on weaknesses in practice and does not drive casework with clear timescales for improvement. There continues to be delay in progressing plans and in improving young people's lives, due in part to the changes of social worker experienced by children. Management oversight is*

not sufficiently rigorous to mitigate these changes"[10]. (This is addressed in the Action Plan).

7.2.22 The use of generalised, vague and unrealistic language is not unique to this case, neither is the ignoring of fathers nor the lack of knowledge about what the child's life is like day-to-day. Evidence comes from other serious case reviews in Gloucestershire and has been set out elsewhere in the report.

7.2.23 Is there any evidence this is a national issue?

7.2.24 It is a common finding from serious case reviews nationally that professionals ignore fathers and do not make enough effort to work with fathers; the focus is almost always on the mother.

7.2.25 It is found in a number of serious case reviews nationally, particularly in domestic abuse cases, that written agreements have been put in place but have provided no protection for the child but made professionals feel that child is safer. In one I led the mother told me she signed it because she knew they would take her children away if she did not, just as the mother in Gloucestershire did. She went on to say how could she possibly have stopped him coming to her home? He controlled everything she did. In that case the father killed the baby and the mother went on to take her own life. The Department for Education's review of serious case reviews noted *"the limitations of 'working agreements' i.e. written agreements, in child protection practice. Working agreements can lack rigour and clarity, leaving parents and professionals uncertain of expectations and plans, and raising concerns about truly informed consent".* It should be noted that written agreements are different from pre-proceedings plans which are used legitimately as part of the Public Law Outline, the Ministry of Justice legal frame for children's care and supervision orders. (This is addressed in the Action Plan).

7.2.26 The Department for Education's analysis of serious case reviews found that inadequate supervision is a common feature in serious case reviews and supervision has not always been effective and played the part it should, as part of the checks and balances that should protect children. If the frontline professional does not have the knowledge or experience to understand risks and protective factors it is for the supervisor to recognise that and take the appropriate action.

7.3 Finding Three

7.3.1 There can be Insufficient Significance Given to Family History

7.3.2 What happened in this case?

[10] https://files.api.ofsted.gov.uk/v1/file/50054390

7.3.3 From when professionals became involved with the mother, when she herself was a child, she was recognised as vulnerable and deemed to be a child in need, for all the reasons set out above. Specifically in terms of domestic abuse there are several studies worldwide that support the findings that rates of abuse are higher among women whose husbands were abused as children or who saw their mothers being abused[11].

7.3.4 As a result of all of these factors Child One was made the subject of a child protection plan prior to birth. When Child One was three months old professionals became aware that the mother was now in a relationship with a new partner who had had a number of allegations of assault and rape made against him by former partners. The minutes of various child protection conferences and core groups made reference to this and there was reference to a risk assessment being done but there is no evidence this was ever completed, or details of his criminal history ever being made explicit. There were a number of concerns that this was an abusive relationship but nothing was actually done about it.

7.3.5 Professionals working with the mother at the time knew that her partner was on license, he was then recalled to prison for breaching his license. At that time the mother disclosed he had been "quite controlling". As far as professionals were aware that was the end of that relationship. In July of that year, 2014, it was unanimously agreed by professionals that Child One was no longer suffering significant harm, or at risk of suffering significant harm and therefore should now be supported through a child in need plan.

7.3.6 At the time Child One became the subject of a child in need plan, as opposed to a child protection plan, the mother had attended three, or four, sessions of a twelve-week programme for victims of domestic abuse – the Freedom Programme. The mother then said the programme was not for her. She was offered another programme through her local Children's Centre, which she said she would attend. She never did. During this time the mother was also on the verge of being evicted due to the poor state of the property. Eventually though Gloucester City Homes decided not to apply to evict the mother in January, 2015 due to improvements.

7.3.7 Although part of the plan, the mother was not attending sessions regularly with Child One at the local Children's Centre, saying she preferred sessions she attended through her local church. (I have seen no evidence that any professional confirmed her attendance at the church group).

7.3.8 On 25th November 2015 the mother attended a Health Access Centre as a 'walk-in' patient, she was 18 weeks pregnant. She was seen by a locum GP who advised her to register with a GP and immediately took her to see the midwife who completed a pre-booking pregnancy appointment. This was very good

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[11] https://www.unicef.org/media/files/BehindClosedDoors.pdf

practice. These professionals did not access the mother's previous medical records as the GP notes could only be accessed once she had registered with the new GP; practice at that time was that midwives did not access previous records as the records were not available on the premises. Systems have now changed and for mothers who are resident within Gloucestershire previous midwifery records are now accessed however there is no mechanism to access previous records for women living outside Gloucestershire.

7.3.9 The GP notes were requested when the mother registered with the new GP practice and the electronic records were transferred immediately. There is no trigger to alert a new GP to previous concerns about a child so the new GP practice was not aware that James's sibling had been previously supported via a child protection plan and then a 'child in need' plan. The information was not immediately obvious on either the child's record or the mother's and therefore when the child and mother moved to another GP this information was not known to the GP managing the mother's pregnancy.

7.3.10 Throughout the period under review no weight was given to the family history, even the recent history. When James was born although the hospital midwife made a referral it was not seen as meeting the threshold by CSC because it was seen as "historical information", not taking into account what research tells us that risks of domestic abuse increasing when a child is born and the risks to babies under one and the even greater risk of death to babies under three months old, where there is domestic abuse.

7.3.11 History kept repeating itself, as it often does. The mother, who had grown up with domestic abuse went from one abusive partner to the next to the next. The mother, despite saying she would over months and months, failed to complete a single domestic abuse course, or attend sessions at the Children's Centre.

7.3.12 How likely is it this is a widespread issue in Gloucestershire and not unique to this case?

7.3.13 It can take months for paper notes to be summarised for the new GP practice. There is no guidance for GPs as to how long this should take. Furthermore, and possibly most importantly, there is no standardised trigger to alert a new GP to previous concerns about a child. Also in Gloucestershire GPs use different software systems and also different read codes, to alert GPs to specific issues.

7.3.14 In their inspection in 2017 Ofsted found *"The quality of assessments and plans is too variable. Although some are good, too many repeatedly fail to consider children's histories to ensure that all risks to children are identified".*

7.3.15 Ofsted also found *"Chronologies are not used well enough in care planning for children. Either an absence of chronologies or their ineffective use means that historical information about known risk to children does not routinely inform*

current planning".

7.3.16 Chronologies are not routinely used despite it being a recommendation from an internal review in 2011, the same review as mentioned earlier in the report. It was accepted by GSCB at that time that a multi-agency chronology should always be in place when a child is the subject of a child protection plan.

7.3.17 In 2016 GSCB issued a Single and Multi-agency Chronology Practice Guidance" document https://www.gscb.org.uk/media/12336/gloucestershires_chronology_guidance_v10_final-67717.pdf which states that *"a multi-agency chronology should be started as soon as there is multi-agency involvement".* To the best of my knowledge this has never happened and it is not completely clear why this is. I understand that some of the issues were to do with who is responsible for doing it initially and then updating it, how far should it go back, who owns the data, which agencies can hold sensitive data belonging to other agencies and the time factor of completing it. (This is addressed in the Action Plan).

7.3.18 Is there any evidence this is a national issue?

7.3.19 The issue of GP notes is a national issue. I understand that the NHS England safeguarding team is considering setting up a group to look at national guidance for record sharing/read coding/flagging etc. (This is addressed in the Action Plan).

7.3.20 As set out in the Department for Education's analysis of serious case reviews it is a very common finding from serious case reviews nationally that professionals have failed to consider the family history. It is also apparent that when a chronology is done for a serious case review that not all of the frontline professionals have had all the information in that chronology.

7.4 Finding Four

7.4.1 It is a Challenge for Gloucestershire County Council to meet its Statutory Requirements in Terms of Child in Need, as Set out in the Children Act, 1989 and Working Together to Safeguard Children

7.4.2 The status 'child in need' is defined in law and means children under 18 who require local authority services to achieve or maintain their health and development; the local authority has a duty towards these children. Other agencies have a duty to co-operate in this work. A key worker must be allocated from the local authority and it is expected that this be a social worker. Their responsibilities are the same as in child protection. They have to make sure the meetings happen regularly, the right people are at the meeting, the meetings are minuted and the minutes are circulated. They have to liaise with the child and the family, draw up the child in need plan with everyone involved and review the plan to make any changes that are needed.

7.4.3 Child protection work will always take precedence over child in need work, if a choice has to be made, because children in need of protection will always be the most vulnerable children and are recognised as such and therefore have to be prioritised, but in a safe system it should not be either or. In addition to this the Department for Education serious case review analysis shows tha*t "most children were not involved with the child protection 'system' through a child protection plan or a court order, although many were receiving services as 'children in need'; and (c) many of these children and families had been known to children's services in the past, and as such should be considered by agencies as having recognised vulnerability or risk. These findings are in keeping with previous national analyses and the wider research. It is clear that significant opportunities for protecting children lie in preventive interventions within the community and by universal services. Such opportunities arise through recognising and managing risk and vulnerability".*

7.4.4 What happened in this case?

7.4.5 During the period under review the case was initially held on duty because CSC were unable to allocate a social worker due to workloads. There were then numerous changes of workers, managers and teams and the case was led by a community family worker for a period of time, which meant CSC was not meeting the requirements of legislation. The Children Act, 1989 makes it clear that a social worker should always be the lead professional in child protection and child in need cases, and therefore this should not have happened. That being said, there is no evidence to suggest that if the lead professional had been a social worker all through the period under review they would have been a more effective lead professional and had a better understanding of the risks. The only social worker who recommended there should be a strategy discussion was the social worker who undertook the single assessment in the summer of 2015 but this assessment was done without seeing the family and her recommendation was overridden by the manager.

7.4.6 Although it could be said that if there had been a better understanding of domestic abuse this issue would not have arisen because it would have been worked as a child protection case there is no guarantee it would have resulted in a different outcome because the fundamental issue with this case was a lack of understanding of domestic abuse by all the agencies involved.

7.4.7 As mentioned earlier a social worker was allocated to write the single assessment and ended up writing it without seeing the family. An assessment that is completed without seeing the family can have little value.

7.4.8 The case ended up being closed on the basis that the mother was not meeting with professionals or doing any of the things she had ostensibly agreed to in the child in need plan. None of the professionals felt the case met the threshold for child protection, although conversely they all felt that the mother was a victim of domestic abuse, so there was a contradiction there. A family not engaging is not a reason to close a case. If the professionals were sure there was domestic abuse but believed they did not have the evidence to escalate to child

protection, that is when the advice of supervisors should be sought and the specialist advise of Gloucestershire Domestic Abuse Support Service, to see what action can be taken.

7.4.9 Professionals talked about the mother not engaging. What we often mean by "engaging" is attending. There is a huge difference between "attending" and "engaging" but the words are often interchanged, as if they mean the same thing. This goes back to the issue of language.

7.4.10 Tying in with Finding Two professionals felt they could not insist on involving James's father, not just because he was not the father of Child One but also because it was a child in need case, not child protection. He was encouraged to attend the child in need meetings but refused to do so. On one occasion a worker was upstairs in the house and there was a male upstairs but they felt they could not ask who it was because it was not child protection.

7.4.11 An additional point that came from the frontline professionals in this case was that they were unclear that any professional can request a strategy discussion. CSC arranges it and chairs it but if any other professional does not agree, if CSC says it does not meet the threshold for a strategy discussion, they can use the escalation of professional differences guidance.

7.4.12 How likely is it this is a widespread issue in Gloucestershire and not unique to this case?

7.4.13 CSC have said it would be extremely unlikely that it could happen again that a community family worker/family support worker was the lead professional on a child in need case because the teams have been restructured and family support workers no longer sit in the social work teams. (This is addressed in the Action Plan). As mentioned elsewhere the role of the "community family worker" no longer exists.

7.4.14 During the inspection Ofsted found *"in many cases, children in need plans lack rigour and are then stepped down to universal services far too early".*

7.4.15 We know from CSC performance data and other monitoring that there are concerns about children's cases being closed prematurely and without proper exit planning. Evidence for this comes from the high levels of re-referrals - at 29%, one of the highest in the country – and various dip samples. The most recent of which, in June 2018, confirmed that trends identified in an earlier dip sample in 2014 were still happening. For example at the time of this case 25% of children referred to CSC had had similar concerns raised in the previous 12 months. The 2018 audit confirms the findings within this report that cases were "stepped down" or closed too early.

7.4.16 In the Gloucestershire serious case review "Philip", which was published in 2016 one of the findings was *"The importance of clear and effective child in need processes".* The action from the finding was a single agency action for CSC:

"Review guidance and policy in relation to Children in Need cases so that there are robust arrangements in place to:

- *ensure a full assessment is undertaken in all cases where there are unexplained injuries*
- *ensure that assessments fully take into account all household members and evaluate the impact of any new household members*
- *ensure that Child in Need plans are reviewed and developed following the first Child in Need meeting, and in light of any new events or information*

7.4.17 It should be noted that some work was done by CSC following the "Philip" serious case review. I am told by CSC that a Child in Need Strategy was developed but it is unclear where that is and who is responsible for it as the head of service who was responsible left over a year ago. It may be this has happened because all of the senior management team have changed in this time, as has the GSCB chair and the business manager and other priorities have taken precedence, which is ironic because that reflects what happens with children in need with CSC workers on the frontline. (This is addressed in the Action Plan).

7.4.18 As a result of the Gloucestershire serious case review "Abigail" there should now be a six-weekly meeting when a child is on a child in need plan. It is not clear whether this is happening in every case. (This is addressed in the Action Plan).

7.4.19 The confusion over strategy discussions is not unique to this case. The Gloucestershire "Philip" serious case review found that on a number of occasions CSC did not hold a strategy discussion when the threshold had been met, they were making decisions unilaterally.

7.4.20 Ofsted mentioned strategy discussions in their inspection in 2017 but not in respect of there being confusion as to when/how they happen.

7.4.21 Is there any evidence this is a national issue?

7.4.22 Yes, as with the other findings these issues around child in need work are not unique to Gloucestershire but are seen across the country.

7.4.23 In terms of involving partners, the Department for Education's analysis of serious case reviews found that professionals are often unsure about involving new partners and how and when they should do that, whilst being mindful of confidentiality.

8. Summary

8.1 What this case highlights is the challenge of understanding and working with domestic abuse. It also shows there is much work to be done in Gloucestershire to bring staff in all agencies to a point where they are confident and knowledgeable about domestic abuse.

8.2 Ofsted has acknowledged CSC's improvement journey but it is a challenging

time for CSC in Gloucestershire, as it is for CSC departments across the country. They are the lead agency in child protection and child in need but it is essential that all agencies play their part and agencies work together, helping and supporting each other, in the best interests of the children of Gloucestershire.

9. Response Plan

Action One

The main issue in this case was a lack of understanding of domestic abuse. Many of the subsequent actions also reference domestic abuse but there needs to be an over-arching action and that is that the Safeguarding partnership commissions an expert individual or agency in the field of domestic abuse to analyse this SCR, and other Gloucestershire serious case reviews, multi-agency and single agency training and make recommendations through a report to the Safeguarding partnership advising on how each and every agency can work more effectively in all aspects of domestic abuse and embed the necessary learning in their agencies.

Response**: Completed**

- Current work being undertaken by the Social Work Academy, including the review of multi-agency training meets much of this action to date. Lessons from this and other SCRs feature in the delivery and review of training across the partnership.

Action Two

In reference to paragraph 7.1.25 work is required within each agency to assess the effectiveness of the escalation of professional differences guidance, specifically in relation to CSC. In particular what evidence is there that agencies feel able to challenge CSC and what response do they get. Agencies should consider how they record and report back to the safeguarding partnership on the use of the escalation policy.

Response: **Partially Completed**

- Following a review of the escalation process in October 2018 and a further amendment and review in March 2019. S175 asks schools about levels of understanding of escalation and its proposed to include this into S11 Auditing in the next cycle in 2020

Timescale:

- Single agency process in place, setting out how agency is managing the escalation processes by December 2019

- The S11 audit is due to be revised through the MAQuA subgroup in 2020 and the revised audit will cover assurance of compliance in the escalation processes

- Partnership to continue to monitor escalation and report on exception.

Action Three

In reference to paragraph 7.1.33 Gloucestershire Hospitals NHS Foundation Trust needs to ascertain if the safeguarding checklist is now being used appropriately and provide evidence to the Safeguarding Partnership.

Response: **Not Completed**

Timescale: September 2019

- Feedback to the September GSCE Delivery Board

Action Four

In reference to paragraph 7.1.50 GCC Commissioning Team to ascertain how widely understood the services of Gloucestershire Domestic Abuse Support Service are, in respect of offering advice to professionals and how frequently that aspect of the service is used and by which agencies, including how they intend to ensure the service effectiveness is to be maintained through future commissioning cycles and possible changes of provider.

Response: **Partially Completed**

- The commissioned GDASS service is now embedded in the MASH ensuring that the service is well understood through the front door process. In addition GDASS have representation in ED at Gloucester Royal Hospital and have been out to speak to social work teams through 2019.

- The GDASS service has been utilised to review the partnership training curriculum and assist in the design of bespoke specialist training workshops. It is intended to build on this through engagement at the Social Work Academy

- **Outstanding**: A partnership review on DA processes was undertaken by the Police following HMIC inspection with a follow on action to identify gaps in understanding of Domestic Abuse Services and make recommendations to the Board for plugging the gaps.

- **Outstanding**: These key aspects identified above would need to form part of any future recommissioning of the service. Commissioning to assure the Partnership that this is the case.

Timescale: September 2019

- Feedback to the September GSCE Delivery Board

Action Five

In reference to paragraph 7.1.53 and subsequent paragraphs, Gloucestershire Constabulary to confirm to the Safeguarding partnership when changes have been made to their domestic abuse "How To" guide, the Vulnerability Identification Screening Tool and embedded in training, that if there is a child under one in the home or the mother is pregnant and there is domestic abuse, that is a high-risk indicator, for the child and for the mother.

Response: **Outstanding**.

Timescale: September 2019

- Feedback to the September GSCE Delivery Board

Action Six

In reference to paragraph 7.1.54 The safeguarding partnership to review and amend the Levels of Intervention threshold document to reflect the additional risk if the mother is pregnant, or there is a child under one, and there is domestic abuse. Once this is done the amendment and the reasoning for it must be widely disseminated through the Safeguarding partnership with particular emphasis on CSC, as the lead agency in child protection, and the Multi-Agency Safeguarding Hub (MASH).

Response: **Outstanding**

- Including Action 5 above: a task and finish group to be set up chaired by GHNHSFT Midwifery Service to review and make amendments and present to the Board in September

Timescale: September 2019

- Feedback to the September GSCE Delivery Board

Action Seven

In reference to paragraph 7.1.56 the Safeguarding Business Unit to provide the Safeguarding partnership with details as to which agencies sends staff on the GSCB training. If, as appears to be the case, both the lead agency in child protection, CSC, and the biggest referrer to CSC, the police, are attending multi-agency training in limited numbers then action needs to be taken as the partners are therefore not benefitting from topics covered, or the multi-agency discussions which take place. In addition to this a report on training should form a part of the Safeguarding partnership annual report.

Response: **Completed**

- Training section in 2019 annual report with report of training submitted to the Partnership including attendance

- Arrangements are in place for the Workforce development Subgroup to submit an annual report om training to include attendance figures across all courses

- Multi-agency training to become part of the curriculum through the Social Work Academy in Gloucestershire

Action Eight

As stated in paragraph 7.1.60 and in many other parts of the report, there were many examples of a lack of professional curiosity. The safeguarding partnership through the Workforce Development subgroup should review and amend all training to ensure training on professional curiosity is delivered in all partnership training. In addition to this, all multi-agency thematic workshops should include professional curiosity.

Individual agencies must also report back to the Safeguarding partnership on what steps have and are being taken to improve the quality of frontline practice and supervision around professional curiosity.

Response: **Partially Completed**

- Multi-agency training is reviewed annually to incorporate learning from SCRs. professional curiosity is already a feature in existing training delivered across the partnership
- **Outstanding**: The partnership should define what it considers to be “Professional Curiosity” across a multi-agency spectrum once defined multi-agency and single agency training should reflect that definition

Timescale: March 2020

- Definition set out and agreed by the MAQuA subgroup at the 28th August 2019 meeting and report to the Delivery Board 2nd December

- Workforce Development subgroup partnership training review completed to include the agreed definition March 2020

Action Nine

As stated in paragraph 7.2.14 and elsewhere in the report, many professionals were unsure whether they could involve James’s father, prior to the mother becoming pregnant with James. The Safeguarding partnership should draw up guidance for all professionals setting out whether they can involve the male, if he is not the father of the child. This should then be shared widely across all agencies.

Response: **Outstanding**

- MAQuA subgroup to set out the legal position and an agreed guidance sheet disseminating across all partners at their meeting on 28th August 2019 and report to the Delivery Board 2nd December

- Workforce Development subgroup to include the agreed guidance across multi-agency training and the Social Work Academy curriculum

Timescale: December 2019

- Guidance to be drawn up and agreed in December

- Dissemination and inclusion in training from December 2019

Action Ten

In reference to paragraph 7.2.23 CSC to advise the Safeguarding partnership what steps have and are being taken to improve the quality of supervision.

Response: **Completed**

- Steps are set out in the CSC improvement plan monitored through the Improvement Board

Action Eleven

In reference to paragraph 7.2.27 CSC to audit how many cases currently have a written agreement in place between the parents and CSC, to ascertain the extent of the issue.

Safeguarding partnership to issue a clear mandate to CSC that written agreements between parents/carers and CSC are not to be used under any circumstances.

Response: **Completed**

- An audit of cases is not achievable as there is no way of generating the data on written agreements from the liquid logic system; as such a Mandate has already been sent out and will be revisited periodically.

- The Social Work Academy Advance Practitioners will reinforce the Mandate with teams where applicable.

Action Twelve

In reference to paragraph 7.3.17 the Safeguarding partnership to revisit the action from the 2011 internal review, referenced in this report, and agree on when and how chronologies will be used in Gloucestershire. In addition to this

the Safeguarding partnership to be advised by CSC on what actions they are taking in respect of multi-agency chronologies for children subject to child protection plans.

Response: **Partially Completed**

- A Task and Finish group has been convened to look at this through the MAQuA subgroup.

- The MAQuA subgroup to consider its findings at its meeting on 28th August 2019 and report to the Delivery Board 2nd December

Timescale: December 2019

- Report to GSCE Delivery Board.

Action Thirteen

In reference to paragraph 7.3.19 The Clinical Commissioning Group to make contact with NHS England to advise them of the finding in this serious case review, in terms of record sharing, coding and flagging of GP records and ideally to work with NHS England on a new and safer system.

Timescale: September 2019

Action Fourteen

In reference to paragraph 7.4.13 CSC to provide evidence to Safeguarding partnership that there are no cases where a family support worker is the lead professional in child in need cases, neither the named allocated lead professional, nor to all intents and purposes the lead professional, which would include chairing Child in Need meetings, even though a social worker is the named lead professional. CSC also to provide evidence to Safeguarding partnership that with the restructure and family support workers now sitting within the early help teams, rather than the social work teams, this could never happen again. (It should be noted that there are no longer community family workers in the Local Authority. There are only family support workers, which is why this action does not refer to community family workers).

Response: **Completed**

- CSC assured the Board on 13th June that this action is completed. Evidence is available through improvement journey work undertaken.

Action Fifteen

In reference to paragraph 7.4.16 CSC to produce a CIN Strategy for the county, this strategy to be presented to the Safeguarding partnership for agreement and

commitment to sign up to and work within. This strategy to be published through the Safeguarding partnership to ensure full understanding.

Response**: Outstanding**

- CSC are remodelling services and as part of this process they will be creating operating models for Children In Need
- CSC to present the developed Operating Models to the Board December 2nd 2019

Timescale: December 2019

Action Sixteen

In reference to paragraph 7.4.18 CSC to provide evidence to the Safeguarding partnership as to what percentage of child in need meetings are happening within the required six-week timeframe.

Response: **Completed**

- Data on this is made available to the Safeguarding partnership via the MAQuA subgroup and through to the Executive to monitor and comment on via the Data Scorecard produced quarterly.

When Actions Fourteen to Sixteen have been completed, combined with the work the Local Authority is already doing in response to Ofsted and their current improvement journey, the Partnership should have a good understanding as to how safe and effective the current Children in Need system is in Gloucestershire.