NORTH SOMERSET SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

OVERVIEW REPORT

"HOLLY"

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May 2016

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PART 1 - INTRODUCTION

1. This Serious Case Review (SCR) concerns a three year old child who was admitted to hospital in December 2015 suffering from a range of health issues allegedly caused by parental neglect. The most serious of these was life threatening.

2. The child is known as Holly, she is the youngest of three children, both her siblings had been subject to neglect but not to the same degree as Holly.

3. All three children have been placed with foster carers and their future is being decided through care proceedings.

Conducting a Serious Case Review

4. When abuse or neglect of a child is known or suspected and either the child has died or the child has been seriously harmed and there is cause for concern as to the way in which services have worked together to safeguard the child, the Local Safeguarding Children Board (LSCB) has to consider whether a Serious Case Review should be carried out.

5. In this case the family had been known to the universal services, that is doctors, midwifery, health visiting and housing, they had been referred to Children's Social Care but there was no active involvement. North Somerset Safeguarding Children Board (NSSCB decided the criteria was met and notification of the decision was made to the Department for Education.

Review Period

6. A Review Panel was convened comprising of senior managers from the relevant organisations and chaired by the NSSCB chair. The panel set out some terms of reference and agreed the review period would be from the period of the mother's pregnancy with her eldest child (June 2009) up to the date Holly was referred to hospital in December 2015.

Method

7. The Review must be conducted in line with government guidance, Working Together to Safeguard Children, 2015. For this review, the SCR Panel decided to request Independent Management reviews (IMRs) from the agencies who had contact with the family. An Independent Reviewer was appointed whose job it was to review and analyse the practice, consider the learning and write this report.

8. Two practitioner events were held to provide an opportunity for those who worked with the family to contribute to the review, those who were unable to attend met separately with the Independent Reviewer.

9. The Review addresses the question of who did what and why; it looks at procedures and practice guidance which were in place at the time, the work with the family and any challenges and barriers to effective practice. It also recognises that people work in complex organisations where a range of factors can impact on the nature of the work; and, where relevant, the report includes some research and links with other SCRs which contribute to the learning from this case

Findings and Recommendations

10. The IMRs detailed the involvement of agencies with this family and critically reviewed their agency's practice. Most identified learning and have made some changes to the way they work in order to strengthen their safeguarding practice.

11. The learning from this case comes from the analysis of events. The report is presented in three parts, Introduction, Facts of the Case and Analysis and Findings.

The learning themes are:

- Identifying, Understanding and Working with Neglect
- Application of Thresholds
- The Voice of the Child

A Glossary of Terms is appended to explain the terminology.

PART 2 - FACTS OF THE CASE

12. This section provides some background information about the family and the involvement of the various agencies with the family, what the practitioners did and what they were thinking at the time. In Part 3 of this report these events are evaluated in more detail with a focus on learning.

FAMILY BACKGROUND

13. In order to protect the privacy of the family the child is known as Holly, her siblings as Evie and Maisie and her parents as Ms D and Mr D.

14. Significant family members are:

Holly	Subject of the Review, aged 3 in May 2016
Evie	Holly's sibling, aged 4 in May 2016
Maisie	Holly's sibling, aged 5 in May 2016
Mr D	Holly's father
Ms D	Holly's mother
Nina	Ms D's niece, who stayed with the family for about 3 months in 2014

Summary of Family History

15. Mr and Ms D were living with their three children in two bedroom accommodation on a social housing estate. The couple were both from a large extended family and had been together for some years; Ms D was in her early 20's when she had her first child.

16. Ms D reported that she came from a Traveller background (she was not specific about which particular culture) and wished her children to be brought up within those cultural norms. She told practitioners that she had been bullied as a child and didn't want her children to have the same experiences; therefore she told practitioners she didn't want them to mix with other children on the estate where they lived or go to school sooner than they had to. The family were also very resistant to any intervention from the helping agencies.

17. Both parents have a learning disability and difficulties with reading and writing although the degree of difficulty was not always apparent to those who knew them; they were able to leave notes for the Health Visitor and send texts. The couple were formally assessed after this review and Ms D was deemed as lacking the capacity to instruct a solicitor in care proceedings.

18. The estate where the couple live is an urban area of Multiple Deprivation, the area has the third highest level of child poverty in the South West falling in the top 1% nationally and 7th highest levels of health inequality nationally. Data shows that:
    - 44% of children in the Ward live in poverty
    - 46% of children live in work-less households
    - 56% of Looked After Children in North Somerset come from the Ward
    - 64% of children are eligible for Free School Meals, well above the national average of 26.2%

19. The community is described by practitioners as having high levels of alcohol and drug abuse, sexual and physical abuse, poor health, unemployment and anti-social behaviour. School staff indicated that many families living on the estate have low aspirations for education which is transmitted to their children.

20. This couple were described by practitioners as living in long term poverty; they appeared to struggle with financial management although the reasons for this were not known. They were in receipt of benefit and Mr D worked from time to time, he had some health problems which prevented him working consistently and this may have disrupted the family's benefit claims. They had accumulated rent arrears which prevented them having a housing transfer to a larger property. The home conditions were a constant source of concern and are described in more detail later in this report.

Involvement of Family Members in this Review

21. Holly's family were invited to meet with the reviewer to share their views about services. Members of the extended family shared their frustration that practitioners had not recognised the impact of the neglect sooner and acted more assertively.

22. Mr and Mrs D explained that their learning disability limits their memory of the events which preceded the removal of the children. With hindsight they were able to identify some things which helped them and some things they would have liked to have been done differently. They appreciated:
    - The practitioners who they believed spoke plainly about what was on their mind
    - Being given clear instructions about what they needed to do to clean and tidy the family home
    - The practical help with acquiring household items

23. Mr and Mrs D suggested that some practitioners:
    - Gave up too easily when trying to weigh Holly
    - Were unclear about exactly their role was and didn't explain things clearly

Holly's Experience

24. Parental neglect led to Holly spending almost a month in hospital. When she was admitted she was described as "pale with static weight", she was malnourished and severely anaemic which was affecting her heart function. She needed a blood transfusion, had muscle wasting and as a result was unable to walk, she had gum disease, tooth decay and required several extractions, she had head lice and thread worm.

25. On discharge from hospital Holly was placed with foster carers who met with the Reviewer to help provide insight into what life might have been like for Holly and her siblings. The foster carers reported that in addition to Holly's physical problems, the three children appeared to have had a limited experience of the outside world and are slowly gaining confidence and learning how to play. Evie and Maisie are attending school regularly and are becoming more confident in expressing themselves. Holly is making slow progress both physically and emotionally.

TIME LINE

2010	Evie born	
2011	Maisie born	
2011		First mention in records of concern about home conditions and children being dirty
	July	Health Visitor referred the family to the fire and rescue service for fire safety advice
2012	Holly born	Holly is born, normal birth, family indicate they don't want contact with support services
2013	November	1st referral to Children's Social Care (CSC) from the police who describe home conditions as "squalid" In response to referral, CSC visit and talk to the Health Visitor, decide no further role for them
		Children's growth is being monitored, Maisie is described as very overweight Health Visitor is trying to get the older children to attend nursery / school
2014	January	2nd Referral to CSC, from a member of the public, alleging the children are neglected, CSC talk to Health Visitor who reassures them, CSC take no further action

	March	Ms D's niece, Nina, is staying with the family, she is a child in care in a neighbouring authority The police visit to check on Nina and return her to her foster carers
	June	The Health Visitor through the GP, referred Maisie to the paediatric dietician, she attends once only with no specific follow up arranged
	September	Evie attends school for her only full day
	November	3rd referral to CSC from the neighbouring authority who visit Nina at the family home and are concerned about home conditions Social Worker carries out an assessment and decides case doesn't meet threshold for intervention from CSC
	November	The school arrange a Team around the Child (TAF) meeting to consider Evie's school attendance
2015		The Heath Visitor is becoming increasingly concerned about Holly who is described as pale and unresponsive Maisie is significantly overweight Maisie and Evie are given places at the local nursery / reception class, the school try to encourage attendance
	April	Evie starts at a new school Evie is "distraught" at school, her hair is matted, her behaviour causes the school concern The school discuss the family with CSC and are advised the case does not meet the threshold for intervention
	July	The family's cooker caught fire and the Fire and Rescue Service attended the family home Fire and Rescue Service and Housing both make a referral to CSC who visit and decide no further action by them is indicated
	August	Holly seen by Health Visitor, she appears tired Ms D tells the Health Visitor she had taken Holly to the GP and the GP is not concerned The GP sees Holly, unaware of the health Visitors concerns, the GP concludes Holly looks well Housing refer the family to the High Impact Families (HIF) project and make a joint visit, the family do not engage
	October	HIF are concerned about Holly, Ms D tells the HIF worker Holly has had a blood test which is normal, this is not true. HIF share

		concerns with the health Visitor.
	September - December	Mr and Ms D cancel three appointments with the Health Visitor
	December	Holly doesn't want to be weighed, Health Visitor telephones CSC for advice , the parent's haven't given consent for a referral and neither the Health Visitor or CSC consider the information indicates the threshold for a Child Protection referral is met
	December	The Health Visitor arranges a GP appointment which leads to Holly's hospital admission

26. Neglect is a complex issue and the effects on children are not easily identified. It is not unusual when reflecting on such cases to find that there were no particular crises in the family and no single events which raised concern, but that the concern was always present and the degree varied from week to week. In such cases evidence has to be pieced together over time.

27. This was the situation in this case. The time-line shows that the practitioners who were seeing the family were consistently worried about Holly and, during the review period, five contacts / referrals were made to Children's Social Care (CSC). One of the referrals led to an assessment but there was no ongoing involvement from Children's Social Care. At the time, none of the practitioners involved with this case indicated that it crossed the threshold for Child Protection intervention. This is explored in detail in the analysis.

UNIVERSAL SERVICES

28. Universal Services, sometimes referred to as mainstream services, are those which are provided, or are routinely available, to all children and their families. Universal services are designed to meet the sorts of needs that all children have; they include housing, early years provision and education in mainstream schools as well as health services provided by GPs, midwives, and Health Visitors.

Midwifery

29. Ms D's three children were born in the same local hospital; she was considered low risk for the pregnancies and was a regular attendee at ante-natal appointments. During her first pregnancy Ms D was briefly admitted to hospital and discharged herself against medical advice, otherwise she engaged well with maternity services and during this review, those midwives who knew Ms D described her attendance as "impeccable." This was reassuring to the practitioners.

30. Holly was born healthy after a normal pregnancy and birth. Ms D told the midwives that she had experienced bereavement during the pregnancy and they described her as having a "low mood;" however she declined offers of additional support. Before being discharged from hospital, Ms D had to be reminded on two occasions that Holly needed feeding at night. After the first occasion it was not clear to the midwife whether Ms D lacked understanding or chose to ignore the advice, the midwife does not recall Ms D as having a learning disability. There was nothing in Ms D's involvement with the maternity services which suggested any alternative actions should have been taken.

Health Visiting

31. The health visiting service is for all children up to and sometimes beyond the age of 5 years. Health Visitors see children at home or at the local clinic, they are trained in child protection and recognising signs of abuse and neglect in children. When necessary they work closely with other organisations to safeguard and protect children. Depending on the Health Visitor's assessment, some families may have minimal contact with their Health Visitor, for others who have greater need; the level of support can be higher. Health Visitors have no statutory powers and a family's engagement with the service is entirely voluntary.

32. The health visiting IMR describes the purpose of their work as:

- assessing and reviewing parenting capacity
- monitoring the children's developmental progress
- monitoring the children's growth and weight
- assessing the quality of the home environment
- supporting and enhancing parenting capacity

This is based on the National Healthy Child Programme, Department of Health, 2009

What did the Health Visitors find?

33. The IMR says that it was obvious to the Health Visitor that these parents needed substantial support and, during the period of this review, this amounted to 36 home visits, numerous failed access visits and considerable time and resources invested in liaising with others trying to arrange additional support. Most of the contact was with Ms D who seemed to take the lead on the care of the children, although Mr D was often present.

Health Visitor Assessment

34. The Health Visitor carried out a Health Needs Assessment with the family which they updated following the birth of each child. The key findings from the assessments were that this couple would benefit from support with their parenting especially with regard to the home environment, (home conditions) stimulation and play opportunities and dietary advice. The assessment noted that Mr D and Ms D did not want any support from the community, for example children's centres or nursery; the family reported that they had good family support and the children had socialising opportunities with their cousins.

35. The Health Visitor quickly became aware that the parent's engagement with the service was tenuous and believes they saw little value in professional involvement in their parenting.

36. Although the Health Visitor had concerns about the children's care, she was reluctant to act too assertively in case she was refused entry. The Health Visitor's approach was to ensure ongoing access to the children by gentle persuasion and the agency acknowledge that this sometimes involved the use of what they describe as an "entry ticket" such as a Christmas hamper, toys and swimming vouchers, to make the service seem useful to the family. Usually one Health Visitor saw the family but on occasions they visited in pairs in order to have extra time to try and engage the children. Despite their best efforts and imaginative approach, the health visiting team made little progress in being able to monitor Holly's weight, growth and development. In addition to the regular visiting, the table below summarises the attempts made to monitor Holly's weight.

Health Visitor's monitoring of Holly's weight

November 2012	Birth weight 3.38kgs (7.45lbs)
December 2012	3.29kgs - it is normal for baby's to lose some weight immediately after birth
November 2013	9.9kgs (21.8lbs) -75th centile Routine one year check
March 2014	10.41kgs, 75th centile
July 2014	Holly clings to her mother, doesn't want to be weighed
December 2014 January 2015	Parents cancel visit
May 2015	Visit – Holly reluctant to be weighed 2 further visits cancelled by parents
July 2015	Parents cancel 2 appointments
August 2015	Growth and Development Review Holly would not be weighed, Health Visitor asked the parents to take Holly to the GP

	The GP saw Holly but did observe anything of concern
September - December 2015	Parents cancel three visits
15th December	Holly doesn't want to be weighed, Health Visitor arranges GP appointment which leads to hospital admission
16th December 2015 Hospital admission	Holly weighs 10.4 kgs (22.9 lbs) 0.4 -2nd centile

37. The table shows that Holly was a normal birth weight and gained weight steadily up to 16 months old. By the time Holly was 20 months old, she became distressed when the Health Visitor tried to weigh her and her mother would not cooperate with weighing. A pattern of the parents avoiding seeing the Health Visitor emerged and, during 2015, five planned visits were cancelled and unannounced visits were unsuccessful in gaining entry. The Health Visitor persisted in her attempts to see Holly and when she was weighed in December 2015, aged 3 years, she was the same weight as she had been when she was 15 months old.

Parenting Style

38. The greatest challenge for Health Visitors was that, Ms D in particular, did not like to see the children becoming distressed. She tried to avoid this where possible and often this meant the children were seen "clinging" to their mother and they would cry if any attempts were made to separate them. When the Health Visitors suggested weighing Holly she would cry if any attempt was made to move her from her mother or lift her from her pram, where she was often covered with a blanket. This would inevitably lead to the other children crying.

39. The Health Visitor, in her notes, described Holly's reluctance to be separated from her mother as a "secure attachment" saying there was "no doubt that the children were loved and cared for emotionally." It was this parenting style which prevented the Health Visitor reviewing Holly's growth and weight, the situation was described by the Health Visitor as "difficult and awkward." The Health Visitor could have weighed Holly with her mother and then weighed Ms D separately but this did not occur to her at the time.

Other factors which inhibited the Health Visitor's ability to observe and Assess Holly

Traveller Culture

40. It is evident from the IMR and talking to practitioners that the Health Visitors were aware of Ms D's "traveller background" to which she made frequent reference. For the Health Visitors, this indicated a need to tread carefully, to respect the culture and try not to impose values which Ms D might not agree with, especially when Ms

D pointed out that "was not way Travellers did things." For the Health Visitors this created an additional challenge in bringing about any change.

41. It was also the children's reluctance to be separated from their mother that led to difficulties in getting Evie to school. She would cry for her mother and make herself sick, Ms D would immediately come and take her home and not want her to go back. Ms D pointed out that part of the Traveller culture was to keep children at home with their parents until they reached statutory school age.

Learning Disabilities

42. Although both parents have since been identified as having learning disabilities, this was not seen as a significant factor for the health visiting service. That is not to say practitioners were oblivious to the parent's presentation, they knew both had some degree of literacy problems but in their experience the couple managed to send texts, write notes and said they could manage to read information leaflets and documents given time. The Health Visitors moderated their approach to the family taking time to explain things clearly and sometimes helping with forms such as school registration documents.

Poverty, Home Conditions and Neglect

43. For the health visiting service it was notable that this family struggled with continual poverty. The family home was described as poorly furnished, nothing was new and furnishings were threadbare. The children were sharing a double bed, which on one occasion the Social Worker observed had a quilt but no sheets or pillow cases. The Health Visitor arranged for the family to be given bunk beds but they did not use them as they said they didn't fit in the bedroom, they were dismantled and the parts left upstairs.

44. The home was described at various times as "squalid" "dirty" and "cluttered" with a strong smell of "bins" and at another time, "a strong smell of vomit." At the request of the Health Visitor, the fire service had attended to give the family advice about clutter and the risk of fire. When there was a cooker fire in 2015, the service reported that basic safety features, such as doors and a loft hatch, were missing.

May 2015 – December 2015

45. In May 2015 the Health Visitor who had been working with the family changed roles and a different Health Visitor became involved. This Health Visitor's experienced the same difficulties engaging the family and observing and weighing Holly.

46. In the summer of 2015 the Health Visitor was worried that Holly was looking very pale and asked Ms D to take her to the GP. The GP saw Holly but Ms D allegedly reassured the GP that Holly was eating well and her appearance was a typical

family characteristic. From the records it is likely that Ms D told the GP she was there for Holly to be immunised. Although the Health Visitor did contact the surgery, she did not contact the GP directly.

47. In October 2015 the Health Visitor was still concerned about Holly who was looking very pale, and the Health Visitor reflected that she had never seen her walking; Holly, at this time almost 3 years old, was always wrapped up in her pram or clinging to her mother. The Health Visitor again asked Ms D to take Holly to the GP. The Health Visitor told the GP about her worries but, on that occasion, Ms D did not take Holly to the GP and the Health Visitor did not follow up the outcome with the GP.

Holly is admitted to Hospital

48. From mid-October to mid-December the Health Visitor made seven unsuccessful attempts to see Holly but each time the parents made excuses why they could not be available. The Health Visitor discussed this in supervision with her safeguarding advisor with reference to the "no access" guidelines and it was identified that concerns were escalating. Had the Health Visitor not been able to see the family in December, the plan was that a referral to Children's Social Care would be made.

49. On 15th December the Health Visitor made a visit and saw Holly. She was very concerned about her, in particular her pale appearance. Ms D told the Health Visitor that Holly had seen the GP for a blood test but at this point the Health Visitor checked with the GP and found this to be untrue. During this visit Ms D mentioned to the Health Visitor that she was worried about Holly's foot and the Health Visitor used this opportunity to arrange for the GP to see Holly the next day.

50. On the same day the Health Visitor contacted Children Social Care to discuss the case but did meet the threshold for a Child Protection referral and Children's Social Care would not accept a Child in Need referral as the parents would not give consent.

51. The following day the GP saw Holly and referred her to hospital. She was medically examined and found to be have muscle wasting in her lower limbs and was not able to walk, she had nappy rash, overgrown fingernails and dental decay. She had severe anaemia leading to heart problems, she had a prominent abdomen and her weight was 10.4 kgs or 22.9 lbs. This is 0.4 -2nd centile. Her speech and language were delayed.

The Role of the GP

52. The family were registered with a general practice near their home. During the period of this review, (6 years) the children, between them, were seen by sixteen

different clinicians, a combination of doctors and nurses. The children's attendance at the surgery was for common childhood ailments, for example, ear infections, chest infection, coughs and colds. In 2015 there were four non-attendances at appointments for immunisations.

53. During 2015 Holly was seen by a GP at the practice four times, in January, July and twice in August, for common childhood illnesses

54. When they reviewed this case, the most striking issue for the GPs was the failure of the parents to bring the children for their immunisations. Although this, in itself, is not uncommon and would not be a sufficient reason to contact Children's Social Care, the IMR indicated that some action might have been taken although the IMR author was not clear what this be.

55. This family did not present with the characteristics often associated with child abuse and neglect, for example as far as we know, they did not misuse drugs or alcohol and there were no indictors of domestic abuse, but there were a few subtle signs which might have been considered as part of a holistic view. In 2014 Maisie was seen by GPs three times and it was in June 2014 that she was described as obese and referred to the dietician. She also presented with head lice although the record doesn't say how severe an infestation, the school records suggest her hair was matted. In November 2015 the records note that Mr and Ms D had declined the dietician appointment. The Health Visitor knew the family well but there is no evidence that there was any communication between the GP and the Health Visitor until late in 2015.

56. This family were registered with a particularly busy surgery located in an area of significant deprivation. The surgery has a high turnover of staff, many of whom are temporary. It is not unreasonable in this case that each presentation to the surgery was seen and managed in isolation.

57. However this case does remind practitioners of the need to "Think Family." In March 2014 the North Somerset Think Family Strategy Group issued Think Family Multi-Agency Guidance which encourages agencies to consider the family as a whole and ask the question "*how are the needs and behaviour of the individual service user impacting on other members of the family?*"[1]

58. One of the appointments in August was as a result of the Health Visitor asking Ms D to take Holly to the GP because the Health Visitor was concerned about her appearance. The records show that the Health Visitor did not contact the GP before or after the visit and the outcome was that the GP considered Holly's appearance to be the result of a minor infection. We now know that by December 2015, four months after the August appointment, Holly's poor weight gain and general health were a serious concern.

[1] North Somerset Joint Working, Think Family: Multi-Agency Guidance, March 2014

59. It was in December 2015 when one of the GPs from the practice caught a brief glimpse of Holly whilst visiting a relative of hers. This GP, who had not seen Holly before, noticed that she was "grubby and dishevelled." The GP did not consider this was enough evidence to make a referral to Children's Social Care and spoke the Health Visitor who made a visit. It was this visit and the persistence of the Health Visitor which led to Holly being seen by a GP again two days later and subsequently admitted to hospital.

Were there missed opportunities?

60. With hindsight it seems surprising that the GPs did not observe anything unusual in a child who, four months after being seen in surgery, was severely underweight, pale in colour and so seriously ill.

61. It appears from the reports that Ms D told the GP she had brought Holly for her immunisations and didn't mention the Health Visitor's concerns. The GP concluded Holly had a slight fever and had no reason to undress or weight Holly, the GP notes indicate that Holly "looked well." Had the Health Visitor communicated directly with the GP before the appointment it is probable the GP would have carried out a more thorough examination which might have expedited Holly's access to medical intervention

EARLY HELP

What is Early Help?

62. Working Together 2015 states:

> *"Where a child and family would benefit from coordinated support from more than one agency (e.g. education, health, housing, police) there should be an inter-agency assessment. These Early Help assessments, such as the Common Assessment Framework, (CAF) should identify what help the child and family require to prevent needs escalating to a point where intervention would be needed via a statutory assessment under the Children Act 1989".*

63. Based on Working Together, North Somerset's Early Help Strategy sets out the principles, process and guidance on how to achieve the stated aims of:
    - Early Help being focused on those at the greatest risk of poor outcomes
    - Multi-agency delivery of those interventions is efficiently planned and executed
    - The limited resources available are focused on those interventions which can make the greatest difference [2]

64. In this case the health visiting team were aware that, although they felt this case didn't meet the Child Protection threshold, Early Help was indicated and that there were several agencies involved with the family who could contribute to an assessment and plan. According to the local guidance, this placed the case at level 2b, "*children with multiple needs - two or more agencies involved"*

For level 2b the guidance indicates it would be good practice to:

- Hold Team Around the Family meetings
- Complete multi-agency Early Help Assessments
- Complete multi-agency care plans to identify the needs of the child

65. The Early Help model of service provision is dependent on the agreement of the parents; the guidance states that an Early Help Assessment (CAF) can only be undertaken with the informed and explicit written consent from the child/young person and/or their parents/carers.

66. In this case Mr D and Ms D would not agree to any kind of, what they saw as, formal intervention. This meant the Health Visitor felt powerless to progress this formally and facilitate any kind of multi-agency Early Help assessment. In the circumstances the Health Visitor took a pragmatic view and, in the autumn of 2014, at the point the local school became involved, together they organised a Team around the Family meeting.

[2] North Somerset Safeguarding Children Board Early Help Strategy 2014 - 2017

67. Ms D and Mr D were invited to the meeting and the notes indicate they both attended.

Team around the Family

68. The purpose of a Team around the Family (TAF) meeting is to "*bring together practitioners from across different services to co-ordinate and deliver an integrated package of solution-focused support and meet the needs identified during the Early Help assessment (CAF) process."* [3]

69. It appears from the chronology of events that the meeting took place on the same day that Children's Social Care visited the family to carry out an assessment following a referral about Holly from the neighbouring local authority.

70. The TAF meeting was focussed on the single issue of getting Evie attending school (Holly was still only 2 years old) and the plan detailed how Mr and Ms D could be supported to enable this, for example texting to remind them and walking to school with them.

71. In effect the Health Visitor became the "Early Help Coordinator" but without the benefit of a multi-agency assessment or the meaningful participation of the parents. The health visiting IMR points out that unlike other services, Health Visitors cannot close cases and the service has no "end point" at least before the youngest child is aged 5. The Health Visitors felt a heavy responsibility for this family. The TAF plan was never reviewed or updated.

72. Since the period covered by this Review, all North Somerset schools have had training in facilitating Early Help. A "triage team" has been established to provide advice, liaise with Children's Social Care and, where appropriate, identify an Early Help Co-ordinator; there is now an outcomes tracking tool that all agencies can complete with families which helps evidence progress in each area of a child's well-being.

The Role of the School

73. In the autumn term of 2014 Evie started at the local school. The school allocated a Family Support Worker to work alongside Mr D and Ms D to try and build a relationship of trust, to encourage them to bring Evie to school and help her settle. This was not successful, by December 2014, Evie had only completed one full day at school. (in September 2014)

74. Based on their contact, the school had no particular concerns about Evie which would have led them to consider making a referral to Children's Social Care. They

[3] North Somerset Safeguarding Children Board Early Help Strategy 2014 - 2017

observed that Evie had poor social skills and was very needy of adult attention and worked with the Health Visitor to arrange the TAF described earlier.

75. As a result of Evie's non-attendance she lost her place at the school, she was still not of statutory school age. The Health Visitor helped the family register Evie at another school in the locality.

76. In April 2015 Evie started at the new school. At this time Holly was aged 16 months.

77. The new school were aware of the parent's history and, what the school described as their anxiety about the children starting nursery and reception. In order to try and work with the family, a slow transition was planned and efforts made to gain the trust of the parents. The school allocated a Parent Support Advisor (PSA) to the family who worked with them during the eight months between Evie's starting school and Holly's admission to hospital.

78. During March 2015 the Parent Support Advisor (PSA) and a colleague made three visits to the family home. Detailed recording includes a description of:
    - the children constantly crying,
    - conditions in the home being "very poor"
    - the furnishings were "poor and grubby"
    - an absence of toys with "absolutely nothing in the room for children to play with"
    - the children had slept on the floor on single mattresses which were dirty with no bottom sheets
    - the children were poorly dressed, in contrast to Mr D who was "very smart" in a new white shirt and suit

79. The Parent Support Advisor (PSA) telephoned Children's Social Care for advice, discussing the family without disclosing who the family were. (this is common practice in North Somerset when parents haven't given consent for a referral, a case can be discussed with Children's Social Care and a course of action agreed) In this case the PSA was advised that the case did not meet the threshold for a referral and was advised to refer the family for a parenting course. This was suggested to the parents but they did not attend.

80. In April, following a home visit the PSA noted few toys in the room, Evie and Maisie both barefooted and whose feet were "black," Holly was observed to be "very small and pale for her age (2 years 3 months) and didn't show any response to (the PSA) being there, she spent the whole one hour visit in her mother's arms."

81. Evie was assessed using the Thrive Online method, this includes assessment of a child's emotional and social skills against age related expectations and is commonly used by schools to establish a baseline for children. This showed that Evie would benefit from input from a speech and language therapist. Mr D and Ms D refused permission for this.

82. The school continued to share information with the Health Visitor, school nursing team and housing and in September 2015 a referral was made to High Impact Families (HIF) who, as part of the remit, offer intensive support for families who struggle to get to get children to school.

83. The school continued to work with the family; several issues were noted over the next few months including the parents inconsistent efforts to take the children to school, Maisie not being toilet trained (aged 4) being "grubby with matted hair but smelling better." In September 2015 Evie was described as very distressed at school at being separated from her parents, she wet herself and made herself sick, she was described as "dishevelled with hair full of nits, she was very overweight, wearing clothes for a 9-10 year old when she was 4 years old. She was still not attending school regularly. The school staff persistently tried to support the family and provided school uniform and furniture and applied for funding for a cooker after the house fire.

84. Overall the school described the family as "borderline for social care." The IMR notes that the school considered there was a "small amount of evidence of neglect regarding home condition, not sufficient to make a referral to Children's Social Care." With regard to further input within the Early Help framework, the school concluded "that ongoing work with the family was sufficient and the Early Help would not add anything to the process as all relevant agencies were involved."

High Impact Families

85. In November 2011 the Government announced a programme to tackle the needs of "troubled families." In North Somerset this is known as the High Impact Families Programme. The programme is designed to "break the cycle of inter-generational deprivation by focusing on getting parents into work, children attending at school, reducing crime and anti-social behaviour, thereby reducing the cost to the state".

86. A Case Coordinator is dedicated to the family who "looks at what's really happening for the family as a whole and gives practical hands-on support with an assertive and challenging approach backed by an agreed plan and common purpose among the relevant services."

87. The guidance states:

> "*Families do not need to agree to a referral being made as, although the programme will ideally engage with families identified as meeting the criteria on a voluntary basis, efforts will be made to ensure engagement using a range of methods, including the implementation of partner agencies' potential sanctions*." [4]

[4] High Impact Families, North Somerset People and Communities Board

88. In September 2015 a housing worker made a referral and the High Impact Families (HIF) Service visited the family. During the visit the HIF worker had concerns about Holly similar to those expressed by housing, primarily the home conditions and the appearance of Holly. When asked about this, Ms D lied to the worker and said Holly had been seen by the GP, had a blood test and the results were normal. The HIF worker, who believed Ms D, chose not to refer to Children' Social Care but discussed her concerns with the Health Visitor. The worker was re-assured by the Health Visitor's plan to visit the family, although the Health Visitor said she often had trouble gaining access to the family home. This was about 6 weeks before Holly was admitted to hospital.

89. In this case the family did not want the input from HIF and the case was closed to them.

School Nursing Team

90. The school health nurse had very limited contact with the family. Evie transferred to the school nurse from the health visiting service when she started school in September 2015. On handover, the Health Visitor "flagged" Evie which meant she was given priority for the routine health needs assessment which all children have on starting school. Maisie was due for a school entry health review and the children were seen together, with their parents, once. Both children were assessed as being overweight and as having missed vaccinations, these matters have since been followed up. The school nursing service had no involvement with Holly during the period of this review.

INVOLVEMENT OF CHILDREN'S SOCIAL CARE

Making a Referral and Use of Thresholds

91. In North Somerset referrals about children and families are managed by Children's Social Care within a single team of social workers, managers and administrative staff known as the Referral and Assessment Team. The team receives information from a variety of sources and in a variety of forms, for example telephone calls, emails and in writing. Professionals are required to put their referrals on a referral form, with the exception of the police, who send their information in on their own documentation.

92. The first task of the team is to decide if the information they have received as a "contact" is a "referral." A referral should lead to an assessment of the needs of the children concerned, a contact may be responded to a variety of ways including giving the caller advice, noting information or where appropriate, taking no action. All decisions about what action to take are approved by social work managers.

93. Every authority in England and Wales has a "threshold document" usually developed jointly by the key agencies who work with children and families (for example health, education, the police) its purpose is to clarify at what point children are eligible for services.

94. Working Together[5] states:

> *"It is important that there are clear criteria for taking action and providing help across this full continuum. Having clear thresholds for action which are understood by all professionals, and applied consistently, should ensure that services are commissioned effectively and that the right help is given to the child at the right time"*

95. To ensure this happens, in common with all authorities, North Somerset multi-agency guidance is available in the form of a threshold document, "Threshold Guidance, North Somerset's Safeguarding Children Board Threshold Criteria for Children in Need and Child Protection Referrals to Children's Social Care." (July 2015)

96. In this case there were five occasions when Children's Social Care were contacted about Holly, twice in 2015, the most recent (during the timescale of this review) was a few days before Holly was admitted to hospital.

97. One of the contacts in 2014 led to an assessment, in the others the information provided and discussed led to the conclusion that the case did not meet the threshold for intervention by Children's Services. Although this caused the referrers frustration, when the details were explored in the multi-agency practitioner events, there was agreement that, at the time of the contacts, there was insufficient evidence to make a Child Protection referral.

98. To make a referral about a "Child in Need", the referral and assessment team require consent from the child's parents, the parents in this case did not consent and therefore the case did not meet the criteria for a "Child in Need" referral.

Reaching the Threshold

99. The Children Act 1989 provides the legal framework for authorities providing services for children. Section 17 of the Act defines a Child in Need as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled. Section 47 of the act places a duty on local authorities to investigate and make inquiries into the circumstances of children considered to be at risk of 'significant harm' and, where these inquiries indicate the need, to decide what actionit may need to take to safeguard and promote the child's welfare.

[5] Working Together 2015

100. If the child does not meet the threshold to receive services under section 17 or section 47 of the Children Act, the family may be offered help under the Early Help provisions. This is "aimed at children and young people at risk of harm but who have not yet reached the "significant harm" threshold and for whom a preventative service would reduce the likelihood of that risk or harm escalating"[6]

101. Early Help can be coordinated and provided by for example, education, health or children's centres; Early Help plans should have focused outcomes for children and families and should be actively planned with them."

Use of the Threshold Document

102. Threshold Documents in use through the UK are broadly similar in their content, in line with the guidance, they describe a continuum of need with specific examples of what might be know or observed about a child and their parents. The documents vary in presentation with some being up to 55 pages long (for example Plymouth) and others being presented as a one page fold out document. (for example Devon) The document titles vary, most are described for example as interagency threshold protocols for "support and intervention" or for "improving outcomes" or for "accessing services." Some describe levels of need in terms of levels of service provision, others describe children's needs in child focussed, age related categories.

103. In North Somerset the threshold document (38 pages) provides a continuum of need, examples of how need might present itself and points out that this not an "exhausted list of fixed criteria." The examples are matched with levels of intervention, level 1, universal services for children who are doing well with no additional needs, level 2 Early Help, level 3 for children who might be defined as Children in Need and level 4 for children with acute needs, who are in need of protection and require specialist assessment. A one page summary of the document has been circulated to all agencies.

How did thresholds work in this case?

104. In this case, the title of the threshold document indicates it is a threshold for "Referrals to Children's Social Care." Before making a referral, agencies, for example health visiting or housing staff, are expected to be clear if they are referring a child "in need" or making a Child Protection referral.

105. If a case meets the threshold for a Child Protection investigation, the procedures are clear and the response is relatively straightforward.

[6] Local Government Association Guidance, What you need to know about Early Help, July 2013

106. In cases of neglect, knowing when the situation reaches the Child Protection threshold is not easy. Unlike physical abuse where injuries can be observed, or sexual abuse when a disclosure might be made, child neglect is not event focussed. Evidence relies on a picture being built up over time, sharing and evaluating what is observed by those who know the family and retaining focus on the child and their experience.

107. In this case practitioners found it difficult to demonstrate that the case met the threshold for a child protection referral.

Contacts and Referrals

First Contact / Referral

108. In 2013, Holly had just had her first birthday, when the first contact to Children's Social Care was made by the police. They had called at the family home in response to a report of noise and described home conditions as "squalid". Children's Social Care defined the information as a "contact" and made a visit to the family home described by them as "mini assessment."

109. The social worker observed the home conditions, commented on the smell, the clutter and that the two older children were wrapped in adult coats watching TV. The Social Worker saw the children's sleeping arrangements and briefly commented on each child's presentation. Evie was described as smiling and full of character, Maisie was described as quieter and as having a "tummy bug" and as being "very overweight." Holly was said to be sat on Ms D's lap and smiling.

110. Following the visit the Social Worker contacted the Health Visitor who shared her concerns about hygiene in the home "and Holly." The Health Visitor's comments included the "warm interaction" between Mr and Ms D and the children. Based on the findings from their visit and the conversation with the Health Visitor, Children's Social Care concluded the home conditions were "not unsafe" and as the Health Visitor was providing support regarding Maisie's weight, nutrition and home conditions there was no further action required from Children's Social Care.

Second Contact/ Referral

111. At the beginning of 2014, two months after the previous contact, Children's Social Care received a call from someone who knew the family, gave their name and contact details but asked to remain anonymous. The caller expressed concern about the home conditions and the eldest child's development.

112. Children's Social Care designated this as a "contact" and made three visits to the family home, twice there was no answer and on the third occasion a family member was there but would not let the Social Worker in. The Social Workers

intention was to determine if the concern reached the threshold for a referral and subsequent intervention.

113. Because they couldn't get to see the children, Children's Social Care initially responded by asking the police to make a visit and establish the children were safe and well but later, having spoken to the Health Visitor, they were re-assured that the Health Visitor had "no concerns" and no further action was taken.

Third Contact/ Referral

114. Towards the end of 2014 Ms D's niece, for the purpose of this Review known as Nina, had been living with the family for several months; she was 16 years old and in the care of a neighbouring authority. Nina's previous placement had ended because of a family bereavement and she was allegedly unhappy at the alternative arrangements made for her. Nina decided she would stay with Mr and Ms D and, as this was the least risky option for her, in the difficult circumstances, her home authority supported Nina's decision. The impact of Nina's living with Mr and Ms D was that the family home was overcrowded, with Mr and Ms D, Nina and three children living in a two bed-roomed property, also Nina's older boyfriend was visiting and this caused some friction in the family.

115. Nina's social worker visited Holly's family home and made a referral to North Somerset expressing concerns about neglect. Children's Social Care designated the information as a safeguarding referral and visited the family to carry out an assessment known as a "single assessment."

The Assessment, Quality and Outcome

116. This was the only assessment recorded as such, carried out by Children's Social Care during the period of this Review. It included two visits to the family home over 5 days. The assessment document indicates that the Health Visitor and Family Support Worker from the local school contributed information.

117. The assessment follows the guidance from the Framework for Assessment which includes the children's development needs, parenting capacity and family and environmental factors with a summary which is entitled "what this means for the child."

118. The assessment in this case was based on concerns about poor home conditions and this was the focus of the work. The information gathered was primarily based on the family's self reporting, some of the information, which we now know was inaccurate and misleading, was taken at face value. The children were not seen alone, the social worker felt this was unnecessary because of their age and the focus on home conditions.

119. The outcome of Children's Social Care Assessment was that there was no further role for them. This was based on "the significant improvement in home conditions" (over the 5 days) the view that the parents were meeting the basic care needs of the children, and the fact that the children's "support needs" were being managed by a TAF plan. The social worker offered advice to the family about the home conditions and the risk of fire and wrote a letter supporting their request to housing for a larger property. The social worker appeared to be unaware of the family's debt and how this impacted on their eligibility for a housing transfer.

120. The parents were sent a copy of the assessment which states they must:
    - Continue to engage with professionals who will offer support to the children
    - Access Evie's school place
    - Continue to maintain an adequate standard of the home conditions

121. By the time the assessment was signed off Evie had lost her school place because of non-attendance, the parents had not engaged with the dietician and the Health Visitor's engagement with the family was becoming more and more difficult.

Fourth Contact/ Referral

122. In July 2015 the Fire and Rescue Service attended the family home because of a house fire. There was some minor damage but it was the home conditions which led them to refer the family to Children's Social Care. They described the fire risks, including missing doors and loft hatch and faulty electrics. The family had been left without a cooker (the source of the fire) the fire service described rubbish, overflowing bins, dirty nappies, mattresses on the floor and concluded the home was "uninhabitable."

123. The fire service liaised with housing who made a visit and wrote a letter to Children's Social Care detailing their concerns; they included a description of the home and the children's sleeping arrangements, the family had been given bunk beds for the children but had dismantled them due to lack of space and the pieces were spread over the two bedrooms.

124. The children's demeanour was described in the letter and reference made to their separation anxiety and reluctance to be apart from their mother, particularly Holly, it also commented that her "eyes looked sore." The housing worker was clear in her letter that she had told the parents she was going to raise her concerns with Children's Social Care, had reassured them this was for help and support, and Ms D had "accepted the referral."

125. In response to the letter a social worker made an unannounced visit to the family. The record of the visit describes the home conditions in detail and said the parents

had been given advice about clearing out some clutter. The three children were sharing a double bed which had a duvet and pillows but no covers. The pillows were old and stained. The parents reported they would be buying new bedding the next day. Holly was observed sitting on her mother's lap, she appeared sleepy but her eyes did not look unusually sore.

126. The social worker contacted the school for information about the children and noted that the family "engage really well and have good communication with the school" The school were said not to be "overly concerned about the home conditions."

127. In their IMR the school described their considerable efforts to engage with the family but said the parents were anxious and gave several examples when the parents had said they would do something but then didn't. The school also pointed out that the parents had withdrawn from the High impact Families programme when the school allege "they realised there was no financial support attached to the programme." This appears to be in contrast to the comments in the social workers assessment.

128. The Social Worker also contacted a Parent Support Advisor (PSA) from the school who had worked with Mr and Ms D. In March 2015, four months earlier, this worker had contacted Children's Social Care for advice and was told the case did not meet the threshold for intervention. Although she said she remained concerned about the state of the children's home and the social worker allegedly told the PSA she had assessed it as "good enough."

129. The conclusion was that there was no role for Children's Social Care, housing were reminded to refer again if the situation deteriorated.

Fifth Contact / Consultation

130. In December 2015, two days before Holly was admitted to hospital, the Health Visitor contacted Children's Social Care for a consultation asking about making a referral for service. There is some discrepancy in the IMRs about what information was exchanged but both agencies agree they concluded there was insufficient evidence to make a Child Protection referral.

131. The Health Visitor raised the question about whether a referral could be made at the Child in Need level described in the threshold document; however the Threshold Document clearly states that a referral for a Child in Need assessment will not be accepted unless a parent has given "consent." In this case the parents did not want any formal intervention and when asked, would not do so, this was the explanation given to the Health Visitor why a referral could not be made.

PART 3 - FINDINGS AND LEARNING

Introduction

132. This section summarises and analyses the key practice events of this case with a view to identifying what can be learnt and what the North Somerset Safeguarding Children Board (NSSCB) need to consider in order to strengthen their safeguarding systems.

133. The practice is described in three overarching themes which have emerged from the narrative, Identifying, Understanding and Working with Neglect, Application of Thresholds and The Voice of the Child. Clearly these themes are linked.

IDENTIFYING, UNDERSTANDING AND WORKING WITH NEGLECT

134. Messages from Research evidences that that neglected children show the poorest outcomes in comparison with other forms of child abuse.[7]

135. Marion Brandon in her work on findings from Serious Case Reviews[8] says:

> "*The possibility that in a very small minority of cases neglect will be fatal, or cause grave harm, should be part of a practitioner's mind-set. This is not to be alarmist, nor to suggest predicting or presuming that where neglect is found the child is at risk of death. Rather, practitioners, managers, policy makers and decision makers should be discouraged from minimizing or downgrading the harm that can come from neglect and discouraged from allowing neglect cases to drift".*

136. Neglect is a complex safeguarding issue which differs from other forms of abuse in that it is not observable in a single incident. In order to gain an understanding of neglect, it must be part of a practitioner's mind-set as a concept and then a picture must be built up over time in order to understand the causes of neglect and the effects on a child.

Gathering Evidence

137. In this case the practitioners who knew this family, primarily health visiting, were . aware that "there was neglect within the family" but this "never reached a level of significance or intensity to warrant a child protection referral." They invested substantial energy in trying to build a picture, primarily with a view to demonstrating that this case met the threshold for intervention by Children's Social Care

[7] 1 C Davies and H Ward, Safeguarding children across services: messages from research, Department for Education, 2011

8 Brandon et al, Neglect and Serious Case Reviews, 2013

138. The Health Visitors, in reflecting on the case, observed that as they were gathering evidence they were waiting for the neglect to escalate in order to demonstrate the case met the threshold for intervention from Child's Social Care; they were also conscious that Evie was almost at the age for statutory school attendance when non-attendance would have led additional input by the education welfare service and more formal intervention.

139. In assessing neglect the factors to be considered in building a picture include:
    - Child's physical appearance
    - Child's behaviour
    - Parental behaviour – implications of service resistant families
    - Environmental factors – language, subjective response, poverty

140. The Health Visitors had substantial contact with this family and, particularly in the months leading up Holly's hospital admission, were becoming increasingly concerned about her appearance. It is a key part of the Health Visitor's role to monitor the health and development of a child but in this case Holly was not weighed between March 2014 and December 2015. In December 2015 her weight was the same as it had been 21 months earlier. Whether she had gained weight and then lost it again or failed to gain any weight at all, we cannot know.

141. It was the Health Visitor's persistence which eventually led to Holly being seen by a doctor and admitted to hospital but the delay in recognising the seriousness of Holly's condition raises the question of why Holly's faltering growth was not picked up sooner and whether there were any other reasonable alternative actions.

142. From the chronology it is evident that Holly's parent's behaviour made it difficult to observe Holly clearly. In the light of Holly's distress when she was approached and her mother's response, it is understandable that the Health Visitor did not force the issue of weighing the child.

143. With regard to gathering evidence however, two issues were missed. Firstly, Holly's clinging to her mother was interpreted by the Health Visitor as a "secure attachment" which implies this was a positive feature of parenting, when it is possible that Holly was so anxious that she wouldn't leave her mother, this is more likely an indication that her emotional needs weren't being met. Secondly, there appears to have been insufficient thought given to what this parental behaviour indicated about the parent's understanding of Holly's needs and their parenting capacity.

144. It was difficult for the Health Visitor to gather evidence of neglect when from day-to-day she was focussing on building trust with the parents and trying make things better for the children. Non-compliance and disguised compliance by parents is a common feature in the cases reviewed by Ofsted in their report into professional responses to neglect. [9]

[9] In the Child's Time: Professional Responses to Neglect, Ofsted, March 2014

145. The Ofsted report highlights the importance of consistent challenge when parents are non-compliant and outcomes for children are not improving. In this case it appears that the Health Visitor's substantial efforts and emphasis on maintaining a relationship with the parents delayed the more assertive action which later, potentially saved this child's life.

Learning Points:

- Drift and delay have serious consequences for children, resulting in them continuing to be exposed to neglect.
- If there is evidence of faltering weight gain in a young child without a medical diagnosis, the possibility of child neglect should always be considered.
- Parental behaviour including, noncompliance, has consequences for children. Practitioners need to retain their focus on the child and not be distracted by the needs and demands of the parents.

Accommodation of Culture / Traveller Culture

146. Ms D made it clear in her conversations with the Health Visitors that she came from a Traveller culture and this would influence the way she raised her children. For the Health Visitor this meant she felt she had to tread carefully in order to be culturally sensitive. This is a feature commonly described in Serious Case Reviews where cultural differences are used to explain potentially dangerous parenting practices. In this case, attempts to be sensitive to Ms D's Traveller background ran the risk of distracting practitioners from considering the impact of the parent's behaviour on the children.

Learning Points:

- Respecting culture is important but not at the expense of the children's well being and safety.
- Specialist advice and training is available for practitioners to help clarify cultural issues and where perceived cultural issues might be hindering the prioritisation of children's needs.

Early Help

147. The Health Visitor's intervention was also hindered by the lack of assessment of the family's needs and strengths which would have been provided through an effective use of the Early Help process. Because Holly's parents would not agree to an

assessment (CAF), the Health Visitor and school held a TAF meeting, devised a plan and continued to try and help the family without the benefit of an assessment. This limited the practitioner understanding of the family functioning, the nature and underlying causes of the neglect, for example the degree of the parent's learning disability, and the potential to measure progress.

148. In effect, the Health Visitor became the lead professional in trying to implement an improvement plan with this family whilst continuing to gather the evidence to support her concerns.

149. Others in the multi-agency network were faced with the same dilemma as the Heath Visitor, being worried about Holly but lacking the evidence to meet the threshold for referral and they shared their concerns with the Health Visitor. The HIF worker, whose concerns were based on one visit to the family, spoke to the Health Visitor and was re-assured that she was planning a visit; the GP just before Holly was admitted to hospital, had a brief glimpse of Holly and contacted the Health Visitor to discuss the case; on several occasions Children's Social Care were reassured that the Health Visitor was monitoring the situation; this was a heavy responsibility for a single worker within that agency.

Learning Points:

- Practitioners must assure themselves that when they share information it is planned and purposeful and they are not abrogating their professional responsibility or simply relieving their own anxiety.

- If Early Help is to be effective, practitioners will need to demonstrate skill in engaging families who are reluctant to participate or who do not understand the purpose.

The Importance of Supervision

150. The Health Visitor did seek advice from the health visiting safeguarding advisor which led to a decision to act assertively in December 2015. It is surprising that the supervision did not lead to a greater focus on Holly's health needs and a more robust approach to professional drift. Insisting that Holly was weighed sooner might have led to an earlier identification of her faltering weight gain. It is possible that

Learning Point:

- Supervision and management support is vital for all practitioners to manage, monitor and think systemically about a case where neglect is, or might be an issue.

Learning Disability

151. The degree of the parents learning disability was never clear to those who worked with them, information has come to light since this review which suggests it is a significant factor in the parent's lack of understanding of their children's needs and in their parenting capacity.

152. Cleaver and Nicholson[10] in their research report:
"While there is no association between learning difficulties and wilful neglect there is considerable evidence to suggest children suffer neglect by omission as a result of a lack of parental education combined with the unavailability of supportive services".

153. This case serves as a useful reminder that learning disability often affects opportunities to learn how to parent and knowledge of children's basic needs as well as the ability to understand and accept advice.

Learning Point:

- If a parent has a learning disability it is potentially more difficult for them to understand concerns about their parenting and to take and act on advice. This should be considered when deciding whether to make a referral to Children's Social Care and in deciding on an appropriate response to a referral.

Neglect and the Single Assessment

154. Towards the end of 2014 an assessment was carried out by Children's Social Care. The assessment followed a referral about the children's home conditions and was based on two visits to the family home during which time Mr D and Ms D were said to be cooperative. Information was sought from the school and the family's health visitor. The outcome of the assessment was that there was no role for Children's Social Care.

155. Holly was two years old when this assessment took place. It was a superficial piece of work which meant that an opportunity for a robust look at whether Holly and her sibling's needs were being met was lost.

156. In this case the focus of the assessment was the home conditions, the clutter, lack of hygiene and overcrowding. Insufficient thought was given to parenting capacity and the underlying reasons for the poor home conditions, the parent's history of

[10] Cleaver & Nicholson et al, Children's Needs: Parenting Capacity, 2011

compliance and prospects for change and, most importantly, how the parent's knowledge and behaviour impacted on the children.

157. The assessment lacked detail about, for example, the parent's learning difficulties and their substantial debts and ability to manage their finances. Holly was described as being in good physical health when in fact she hadn't been weighed for 9 months, and the assessment contained incorrect information about Maisie's obesity being managed by a dietician when the parents had not actually engaged with this service.

158. There was some misleading information in the assessment, for example that the situation was being managed by a TAF plan when the TAF meeting had only just happened and the plan, focussing entirely on school attendance for Evie, was ineffective.

159. The key learning is that in order for an assessment to be effective the practitioner needs to be equipped to recognise neglect and assess its impact on the child. Poverty and poor home conditions, whilst not synonymous with neglect, are more commonly associated with neglect than other forms of child abuse; also the stress associated with long term poverty can add to the likelihood of poor parenting.[11]

160. Neglect is also commonly recognised where there are poor or unsafe physical living conditions,[12] the impact of a child's living conditions on their physical and emotional well-being is an important part of any assessment.

161. In summary the assessment would have been improved by:
    - Considering the possibility of neglect as part of the referral information
    - Considering the history of the case, previous contacts and analysis of the building picture
    - Acknowledging the links between poor home conditions and child neglect and assessing the children with this in mind
    - Basic information about the children's health, in particular the weight gain of the youngest child who is most vulnerable
    - Exploration of the parents learning difficulties and the impact of this on their parenting capacity

162. The Referral and Assessment Team had had a particularly busy period over the Christmas period in 2014, during which they described as feeling as if they were "drowning" in work. There were a number of relatively inexperienced staff in post and, although the assessment was signed off by a manager, there is no evidence of challenge over its quality. The manager in post at the time has since left the

[11] Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? Research report, Brandon et al, 2014

[12] Slack, KS Holl, JL McDaniel, M Yoo J (2004) Understanding the risks of neglect: an exploration of poverty and parenting characteristics, Child Maltreatment, 9, pp.395-408. Cited in Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? Research report, Brandon et al, 2014

authority but this case it does raise the question of links between capacity and quality of practice. This is an issue the NSSCB might wish to review.

Childhood Obesity and Neglect

163. It is interesting to note that in this case one child in the family was obese and another severely underweight. Whilst childhood obesity alone is not a child protection concern, nor is failure to control weight but consistent failure to change lifestyle and engage with outside support can indicate neglect, particularly in younger children. This is of particular concern if an obese child is at imminent risk of health problems such as diabetes or mobility restrictions.[13]

164. In this case the Health Visitor went out of her way to try and get the family to engage with the paediatric dietician but although they attended one appointment, they did not understand and follow advice or attend for any follow up. Mr and Ms D, in their contribution to this Review, were clear that their understanding was that they would receive a letter from the dietician to which they would have responded.

165. The learning from this case is that insufficient thought was given to what Maisie's weight indicated about her parent's ability to meet all the children's basic needs and also how this might have influenced the discussion about threshold for referral to Children's Social Care.

Learning Point:

- Childhood obesity can be an indicator of neglect if there are other factors which suggest parents are unaware of the health risks or are unwilling or unable to prioritise the child's needs.

Use of a Tool Kit

166. Gathering evidence of neglect is difficult as indicators can be many and varied. When evidence was presented to Children's Social Care there was an inconsistent response, partly influenced by the use of subjective language. For example the home conditions were variously described as grubby, squalid, cluttered, unhygienic and uninhabitable; engagement with professionals was described on a continuum from good to non-engagement.

[13] Guidance for Safeguarding Overweight Children (0-18 years) in Cornwall, South West Child Protection Procedures

167. Another factor which influenced this case was the locality in which the family lived. The area is known to have high levels of deprivation and many families who struggle with poverty and parenting. In these circumstances it is an additional challenge for practitioners, particularly those providing universal services, to identify those children who have exceptional needs. In this case there were times during the review period when Holly and her siblings did not stand out among the other children in the neighbourhood.

During this Review the staff who participated in the practitioner events were unanimous that a recognisable framework to collate and analyse indictors of neglect would be useful. Some local authorities have introduced "tool kits" to address this need.[14] North Somerset have already started work on this.

Learning Point:

- "Tool kits" which include definitions and possible causes of neglect, a framework for identification of neglect, guidance on decision-making and thresholds and what to include in referrals to Children's Social Care can be a valuable asset in working with neglect.

APPLICATION OF THRESHOLDS

168. It was the Health Visitor's action which ultimately led to Holly being admitted to hospital yet it is notable that, two days before her admission, based on the information they had at the time, neither the Health Visitor nor Children's Social Care considered the case to meet the threshold for referral.

169. There were clearly challenges in systematically gathering the evidence of neglect and in this case, the application of the threshold for referral also appears to have been a barrier to effective intervention. In discussions at the practitioner events participants generally agreed they found the thresholds to be "confusing" exacerbated by what practitioners described as "inconsistent responses" from the Social Workers they spoke to.

How Thresholds are applied?

170. Finite Resources have to be rationed and for this to work effectively practitioners need to know which children need help.[15] This knowledge requires professional judgement, based not just on a tangible measure of the severity of the neglect, but for example, if parents are cooperating and willing to accept help. If they are,

[14] See for example South Gloucestershire and Islington.
[15] Brandon et al, Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? Research report Childhood Wellbeing Research Centre November 2014

intervention may be provided within a child in need framework, if parents do not see, understand or accept the problems, even if the neglect is less severe, intervention might need to be within a Child Protection framework; it is vital that formal processes allow for professional judgement on these issues

Contacts, Referrals, Assessments and Mini-Assessments

171. In North Somerset the Threshold Guidance describes how professionals must make referrals to Children's Social Care using a referral form. A referral is followed by screening to determine if it meets the Child in Need threshold for an assessment. If not, the Referral and Assessment team will advise the referrer or the family about other options which may be available to them.

172. If a professional is unclear about whether to make a referral, after consulting their own Designated Child Protection Lead, they can consult with a member of the Referral and Assessment Team. Who initiates these consultations and what advice is given is recorded but not the name of the child or family because, at this stage, consent to share information has not been obtained from the family. This means that although trends can be evaluated and a Social Worker might recognise a familiar story, there can be no formal collation of concerns about a particular child.

173. Families are complex entities and it is unsurprising that referrers cannot always be specific about what it is they are worried about. This is a particular feature of neglect, where standards of care can vary from day to day and the long term effects cannot always be seen. The expectation that referrers will know whether the case is a Child Protection or a Child in Need referral places significant responsibility on referring agencies.

174. The referrer's view will be limited by, for example, the contact they have had with the child, not having seen the children's sleeping environment, their own knowledge of child development and also maybe by emotional involvement with the child and family. In this case it also depended on an understanding of the concept of neglect; in cases of neglect, even following as assessment from a skilled worker from Children's Social Care, it can be difficult to determine if a case meets the threshold as a Child in Need case or should be investigated within the Child Protection framework.

175. There were five contacts with Children's Social Care during the period of this Review which led to a range of responses variously described as contacts, referrals, home visits, a mini-assessment and a single assessment. There were also two consultations which concluded the threshold for intervention was not met.

176. The response of the Referral and Assessment team to the contacts appears to be inconsistent because layers of enquiry have been added to those set out in the documented guidance. The practice of assessing contacts prior to proceeding to a referral has evolved in an attempt to prioritise work. Although this may be a

pragmatic response, in this case, although it led to Holly being seen by Children's Social Care four times, the practice did not appear to have improved the quality of intervention.

177. It appears from the evidence that each referral was taken at face value and "investigated" as a single event when good practice would indicate that the case history should be reviewed in order to determine if a picture is building. This is a common feature in Serious Case Reviews concerning children who are neglected, sometimes described as "start again syndrome." The practice gives inadequate attention to the concept that neglect can be an insidious building of incidents which, if looked at individually, may seem innocuous.

Learning Point:

- When multiple contacts or referrals are received about the same children consideration should given to the history in order to determine if there is a pattern emerging and to avoid the risk of "start again syndrome."

What can we learn from this case about thresholds?

178. Reviewing the Multi-Agency Threshold Document in the light of this case highlights the difficulties of applying a strictly procedural approach to the more nuanced presentation of a neglected child.

179. Platt and Turney[16] in their research suggest there is a need to concentrate on the quality of the decision making and for organisations to have a thorough understanding of how decision makers actually operate in practice. In particular to consider what strategies staff use in order to reach a view and what factors might influence their thinking. The research shows this is a more complex task than applying a threshold. The task involves consideration of:

- Information about the family
- Collaborative working, relationships and influence of other professionals
- Structural factors, political, economic and organisational
- Individual professional factors, experience, knowledge, values and power relationships

180. Brigid Daniel in her research on neglect and what works [17]says:

[16] Making Threshold Decisions in Child Protection: A Conceptual Analysis, British Journal of Social Work, 2013
[17] Brigid Daniel, Why have we made neglect so complicated? Taking a fresh look at noticing and helping the neglected child, Child Abuse Review, Vol 24, 2015

" There are many children about whom a range of people may be concerned and who are known to communities and professionals but who are not actually receiving adequate direct help. We often hear concerns about "slipping though the net" but in fact it happens rather than slipping through the net they are in effect "stuck in the net."

181. Being "stuck in the net" for long periods of time before receiving help can contribute to further developmental delay and long term problems for children. If these children eventually become looked after away from their birth parents they can be harder to help.[18] This appears to be what happened to Holly.

Learning Point:

- In order to avoid the Threshold for Referral Criteria becoming a barrier to the recognition of children who need help, professional judgement must be used. Discussion between practitioners, particularly those from different professional backgrounds, can help clarify concerns and ensure child focus is not lost.

Consent and Information Sharing

182. In North Somerset, the referral process requires that at the point of referral, the professional referrer must make a judgement about whether they are making a Child Protection referral or a Child in Need referral.

183. With referrals which clearly meet the threshold for child protection, although desirable, consent from the child's parents is not required; the welfare of the child is paramount and there is no need for consent. For cases which do not meet the Child Protection threshold, the Referral and Assessment team will not accept a Child in Need referral unless the child's parents have given consent.

184. This is because the Referral and Assessment Team promote the important principle of being open and honest with families and past history has shown that, without consent, referrals have been of poor quality and social work resources wasted on visiting families who do not want and have no need of social work intervention.

185. However, in cases of neglect it can be hard for practitioners to identify a point at which the case reaches the threshold which defines it as child protection, partly because concerns can vary from day to day. If this point cannot be clearly identified, insisting on parental consent in every case before a Child in Need referral can be accepted raises the risk that children like Holly will not receive the service they need.

[18] Farmer and Lutman, Case management and outcomes for neglected children returned to their parents, a five year follow up study, Department of Children Schools and Families. London, 2010

186. In this case when the Health Visitor contacted Children's Social Care to discuss making a referral a few days before Holly was admitted to hospital. Based on their discussion, both agencies agreed the threshold for Child Protection intervention did not appear to be met and as the parents had not given consent, a Child in Need referral could not be made. The issue of consent became a barrier to making a referral about a child who we now know was seriously ill.

187. In addition to consent, this case created debate among practitioners at the learning events about information sharing and when and how it was appropriate. There was disagreement among the practitioners about what exactly parents were consenting to and, if they did not give consent to a referral, was this the same as not giving consent for information sharing?

What can we learn from this case?

188. Whilst consent from parents can be informed and based on their understanding of an issue, for example with regard to medical interventions, it can also be based on invalid assumptions, for example that social workers frequently remove children from their parents without reason, or it can be used by parents who deny or hide abusive behaviour.

189. In this case, work to improve the quality of referrals and encourage a more open and honest communication placed the emphasis on the need for consent as a means to encourage professionals to take responsibility for good quality referrals. An unintended consequence is that in Child in Need cases, "consent" has become an additional threshold to be met prior to referral.

190. In this case, discussion about day-to-day practice suggested that some staff approach consent as a seemingly straightforward matter which can be addressed with a single question, "do you give consent?" This could imply to the family that they are required to agree to some form of legalistic or formal intervention, whereas Child in Need interventions are more about working with and alongside the family; the question also implies that greater weight is given to parental consent than professional concerns but, most importantly, this approach concentrates on adult rights and potentially distracts professionals from focusing on the needs and well- being of the child.

191. If parental consent to a Child in Need referral is not given, further discussion about the parent's understanding would be helpful, in this case the parent's learning disability is likely to have impacted on their view. Discussing the children's needs would ensure focus on the impact of neglect is not lost and lead to the question raised in the Threshold document, whether the lack of consent changes the level of concern.

192. Further discussion about ways to approach obtaining consent would enable less experienced practitioners to benefit from the experience of the Referral and Assessment Team. If a non-professional referrer contacts the team, as happened in this case, the team might make a visit to assess the validity of the referral; in cases of neglect where professional judgement is that there is significant cause for concern further assessment would help establish if the threshold for intervention was met. A rigid application of the procedures should not over-ride professional judgement.

193. It is interesting to note that the matter of consent was managed well by the housing worker, in her letter of referral she made it clear that she had told the family she was concerned about the children and would be asking Children's Social Care to make an assessment of need. The family agreed to this. Also the High Impact Families (HIF) service is clear that they do not require consent for a referral to be made and that "efforts will be made to ensure engagement using a range of methods."

Learning Point:

- If a practitioner considers a referral to Children's Social Care is indicated but the parents won't give consent, reflecting on what the lack of consent tells the prospective referrer can help clarify the issues. The Threshold document states that consideration should be given to the impact this may have on the level of concern for the child.

194. If parents do not give consent to a referral this does not inhibit information sharing. Practitioners have a duty to share information, Working Together[19] points out that it is important that practitioners can share information appropriately as part of their day-to-day practice and do so confidently.

It states:

> *"It is important to remember there can be significant consequences to not sharing information as there can be to sharing information. You must use your professional judgement to decide whether to share or not, and what information is appropriate to share.*

195. Home Office Guidance which looked at multi-agency information sharing models, points out that "some (professionals) felt that the risk of sharing information is perceived to be higher than it actually is."

196. To help practitioners understand how to interpret the law, Government Guidance[20] includes the "golden rules" for information sharing, it includes the need to:

[19] Working Together 2015

[20] Information Sharing: Advice for practitioners providing safeguarding services to children, young people , parents and carers, HM Government March 2015 (updated from 2008)

"Base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions." In other words, do not lose the focus on the child.

"Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately."

197. This is reassuring to practitioners as it indicates it is appropriate to share when it is: "*Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely."*

198. For Holly, prioritising the consent to refer appears to have prevented the sharing of information which could have led to an agreement that a referral to Children's Social Care was clearly needed.

Learning Points:

- Working honestly and openly with families is an important principle that can be achieved in a variety of ways. If parents do not give consent to a Child in Need referral, it is important to understand why this is and what the implications are for the child. This is particularly important if the parents have a learning disability and there are indications of neglect.

- Practitioners can be confident that the law supports sharing information when it is done appropriately.

THE VOICE OF THE CHILD

> *"When seen from the perspective of the child, neglect is quite simply the experience of needs not being met and for some children this simple fact can lead directly or indirectly to their death"*
>
> Sidebotham et al 2011, Brandon et al 2012[21]

199. Failure to consider the child's experience or understand the child's world is a common finding in child protection research and a key feature of learning from Serious Case Reviews.

200. Working Together states:

> *"Effective safeguarding systems are child centred. Failings in safeguarding systems are too often the result of losing sight of the needs and views of the children within them, or placing the interests of adults ahead of the needs of children."* [22]

201. Although it can sound straightforward, it is not always easy to hear the child's voice when parents are themselves needy, when chaotic home conditions can distract practitioners, when resources are limited and there is practice guidance and procedures to consider. It is very easy for the child's voice to become lost within the complexities of day to day pressures.

202. Alyson Leslie in another Serious Case Review, CH, 2015, [23] gives some useful guidance, she says:

> "*The most important theme to emerge from the extensive documentation of (the CH case) is the importance of* ***understanding and responding to the child's perspective.*** *This is perhaps a more helpful way of thinking about "listening to the voice of the child"* which suggests a conversational approach to a child. She goes on to say that "*professionals must be attuned to understand the impact on a child*" of their experience of the place where they live and the people with whom they spend most of their time.

203. This is particularly useful when considering a non-verbal or pre-verbal child when their "voice" is communicated in a variety of ways, by their health and development, their appearance, their demeanour, their behaviour, the way they move and the way they play and communicate with others.

204. In this case the findings indicate that, despite the efforts of some of the practitioners, there was insufficient attunement to Holly's perspective. Looking back at references to Holly, descriptions of her include that she was frequently described as pale, was always seen either in her pushchair or in her mother's' arms was anxious and cried when she was approached, had little to play with, she slept

[21] Sidebotham P et al, Fatal Child maltreatment in England 2005-9, Child Abuse and Neglect, 2011
Brandon et al, New learning from Serious Case Reviews, DfE, 2012
[22] Working Together, 2015, page 8
[23] Haringey LSCB, 2015

on a grubby mattress in a home which was often dirty and cluttered and wasn't seen walking or crawling. The implications of these observations for Holly were not given sufficient attention.

205. Hearing the voice of the child is not just an issue for practitioners, it must be a feature of management and supervision, making and responding to referrals, thresholds, assessments and intervention. Systems need to be child focussed and aimed at streamlining the child's journey as advocated by Munro in her Review of Child Protection, 2011.[24]

206. Asking the question what is life like for this child in this family would have shed light on Holly's experience.

Learning Points:

- The parent's needs and wishes can distract from the child's needs.
- When focussing on practice guidance, criteria for referral and procedural demands, the child's voice can be lost.
- Supervision provides a valuable opportunity to reflect on what the child is communicating.

[24] The Munro Review of Child Protection: Final Report *A child-centred system,* Department for Education, 2011

LEARNING POINTS

- Drift and delay have serious consequences for children, resulting in them continuing to be exposed to neglect.

- If there is evidence of faltering weight gain in a young child, without a medical diagnosis the possibility of child neglect should always be considered.

- Parental behaviour including, non-compliance, has consequences for children. Practitioners need to retain their focus on the child and not be distracted by the needs and demands of the parents.

- Respecting culture is important but not at the expense of the children's well being and safety.

- Specialist advice and training is available for practitioners to help clarify cultural issues and where perceived cultural issues might be hindering the prioritisation of children's needs.

- Practitioners must assure themselves that when they share information it is planned and purposeful and they are not abrogating their professional responsibility or simply relieving their own anxiety.

- If Early Help is to be effective, practitioners will need to demonstrate skill in engaging families who are reluctant to participate or who do not understand the purpose.

- Supervision and management support is vital for all practitioners to manage, monitor and think systemically about a case where neglect is, or might be an issue.

- If a parent has a learning disability it is potentially more difficult for them to understand concerns about their parenting and to take and act on advice. This should be considered when deciding whether to make a referral to Children's Social Care and in deciding on an appropriate response to a referral.

- Childhood obesity can be an indicator of neglect if there are other factors which suggest parents are unaware of the health risks or are unwilling or unable to prioritise the child's needs.

- Tool kits" which include definitions and possible causes of neglect, a framework for identification of neglect, guidance on decision-making and thresholds and what to include in referrals to Children's Social Care can be a valuable asset in working with neglect.

- When multiple contacts or referrals are received about the same children consideration should given to the history in order to determine if there is a pattern emerging and to avoid the risk of "start again syndrome."

- In order to avoid the Threshold for Referral Criteria becoming a barrier to the recognition of children who need help, professional judgement must be used. Discussion between practitioners, particularly those from different professional backgrounds, can help clarify concerns and ensure child focus is not lost.

- If a practitioner considers a referral to Children's Social Care is indicated but the parents won't give consent, reflecting on what the lack of consent tells the prospective referrer can help clarify the issues. The Threshold document states that consideration should be given to the impact this may have on the level of concern for the child.

- Working honestly and openly with families is an important principle that can be achieved in a variety of ways. If parents do not give consent to a Child in Need referral, it is important to understand why this is and what the implications are for the child. This is particularly important if the parents have a learning disability and there are indications of neglect.

- Practitioners can be confident that the law supports sharing information when it is done appropriately.

- The parent's needs and wishes can distract from the child's needs.

- When focussing on practice guidance, criteria for referral and procedural demands, the child's voice can be lost.

- Supervision provides a valuable opportunity to reflect on what the child is communicating.

RECOMMENDATIONS FOR THE NSSCB

The NSSCB should ensure that:

- Adequate and up to date training is provided for front-line practitioners and managers which enables access to contemporary research and best practice in identifying, understanding and working with neglect.

- The Multi-Agency Threshold for Referrals for Children and Need and Child Protection Referrals Children's Social Care and the way in which it is applied, adequately meets the needs of neglected children. This includes ensuring that there is sufficient room for professional judgement and to hear the voice of the child.

- The concept of consent and the guidance on information sharing is understood by all agencies and that the way it is interpreted does not lead to drift or become a barrier to making referrals.

- All agencies have access to good quality safeguarding advice and supervision; that all staff are aware of their duty to escalate concerns when they consider that a child is not appropriately protected and/or is suffering from neglect, including a procedure for challenging the decisions of Children's Social Care where cases are not accepted for assessment or a Child Protection investigation.

- The NSSCB should consider developing a tool kit to enable more effective assessment and shared understanding of neglect and its effect on children.

GLOSSARY OF TERMS

Local Safeguarding Children Board (LSCB): These were established by the Children Act 2004 to enable organisations to come together to agree on how they will cooperate with one another to safeguard and promote the welfare of children. The purpose of this partnership working is to hold each other to account and to ensure safeguarding children remains high on the agenda across their region.

Review Panel: this is the small group of senior managers delegated by the LSCB to set the terms of reference for the SCR and oversee the work of the independent reviewer including providing information local practices and context.

Common Assessment Framework (CAF): Sometimes called the **CAF Pathway**, this is a process for gathering and recording information about a child for whom a practitioner has concerns identifying the needs of the child and how the needs can be met. It is a shared assessment and planning framework for use across all children's services and all local areas in the UK. Sometimes referred to as **Early Help**, it helps to identify in the early stages the child's additional needs and promote coordinated service provision to meet them

Single Assessment: This replaced initial and core assessments with the intention of streamlining the assessment process, having fewer "tick boxes" and encouraging professional judgement. The assessment must be completed within 45 working days and may be done more quickly. The manager will discuss the appropriate timescale with the social worker at the start of the assessment.

Centile Chart: The curved lines on a baby's growth charts are called centile lines, and they represent the range of growth that's considered normal. They also show what percentage of babies, on average, will grow at a particular rate. The baby's weight is written on the centile chart and this enables parents and professionals to see if the baby's growth is within normal limits.

Multi-Agency Safeguarding Hub (MASH): The MASH is the central resource for a county receiving all safeguarding and child protection enquiries. It is staffed with professionals from a range of agencies including police, probation, health, education and social care. These professionals share information to ensure early identification of potential significant harm, and trigger interventions to prevent further harm.

Health Needs Assessment: Assessment of family health need is a central feature of health visiting practice in which a range of skills, knowledge and judgements are used. These assessments are pivotal in uncovering need, safeguarding children and in determining levels of health intervention to be offered to children and their families by the health visiting service in the UK.

Thrive-Online: is a web-based tool that will help you to assess and support children's emotional and social development. Using an integrative model drawn from child development, neuroscience and attachment research, the programme will identify the emotional learning the children need.

Start Again Syndrome: The 'start again syndrome' has proved a helpful way of conceptualising practice and decision making especially in cases of neglect. In these circumstances knowledge of the past is put aside with a focus on the present and on short term thinking.

List of Agencies involved in the SCR

SCR Panel	Agencies involved with the family
Independent Chair, North Somerset Safeguarding Children Board (chair of panel)	Avon Fire and Rescue Service
Director, People and Communities	Children's Social Care, North Somerset Council
Assistant Director, Children's Support and safeguarding, North Somerset Council	Alliance Homes, Housing
Avon and Somerset Police, Safeguarding Review Author	North Somerset Council Housing
Designated Doctor, CCG	WAHT, Paediatric Dietician
Service Leader Strategic Safeguarding and Quality Assurance	NHS England, GP
	High Impact Families (HIF) team
	Avon and Somerset Police
	North Somerset Community Partnership, (NSCP) Health Visiting
	Weston Area Health Trust (WAHT) Midwifery
	Seashore Centre, Paediatric ward