

Swindon Safeguarding Partnership

Serious Case Review Child Q

September 2017

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1. EXECUTIVE SUMMARY

- 1.1 This Serious Case Review (SCR) was commissioned by Swindon Local Safeguarding Children Board (LSCB) in February 2017 following the completion of a Local Case Review (LCR) regarding the same events. It concerns the admission to hospital in September 2015 of a 5 year-old girl (child Q) in a severely malnourished and dehydrated condition, who was described by the paediatrician who examined her as being in a potentially life-threatening condition.
- 1.2 The review focuses on the period between July 2014 and September 2015. In July 2014 child Q and her siblings were made subject to a Child Protection (CP) Plan in the category of neglect. At a review conference in January 2015 their newborn sibling was also made subject to a plan. In March 2015 they were all moved from CP Plans to Child in Need (CIN) Plans and in August 2015 the cases were closed and the family was referred to Families First (FF) Service, a service that works with families with children who no longer meet the CIN criteria.
- 1.3 The family had been known to children and family services - social care, health and education - as well as to the police and housing authorities for a number of years and there had been ongoing concerns about the welfare of all of the children leading to previous CIN planning for them. A range of health, social, emotional and educational needs had been identified leading to the instigation of child protection procedures in July 2014.
- 1.4 There were considerable complexities for professionals at the time in trying to understand what was going on for child Q. Significantly, it is not possible at the time of the SCR to state with certainty how much of her developmental delay and her ongoing health problems were a result of her premature birth and associated early health needs and how much were a result of parental neglect including inadequate nutrition.
- 1.5 However, this SCR identifies a range of missed opportunities during 2015 for professionals involved to better understand what was happening for child Q and to intervene to prevent her health deteriorating to the extent it did by September 2015.
- 1.6 Despite the best intentions of those involved with child Q, she was not adequately protected due to a combination of a number of significant factors, which have been identified by this review:
 - the size of the family and the complexity of the family's needs
 - child Q's extreme prematurity and consequent additional health needs and how these were perceived by her family and professionals
 - recruitment problems in Children's Social Care (CSC) at that time resulting in the use of unusually high numbers of agency staff and high turnover
 - inadequacies in some of the communication and information systems and practice between and within agencies (primarily health and social care)
 - a lack of robust safeguarding supervision and management oversight within some agencies.
- 1.7 All of the frontline professionals involved in this case who participated in the review and all of the Individual Management Review (IMR) authors have

contributed with honesty and professionalism to this review and they are commended for this. Some significant areas of individual practice were found to be problematic and have prompted some of the recommendations, but the majority of the learning and the consequent recommendations are focussed on organisational, systemic and procedural issues, which, had they been addressed previously, would have helped to ensure that practice was more collaborative, considered, responsive and therefore ultimately more protective.

2. INTRODUCTION & BACKGROUND

- 2.1** This SCR was commissioned by Swindon Local Safeguarding Children Board (LSCB) in February 2017 following the admission to hospital in September 2015 of a 5 year old girl in a severely malnourished and dehydrated condition. Child Q then weighed 10.8kg, the weight of an average 15 month old. The medical view was that she was in a potentially life-threatening condition and no underlying medical condition was subsequently found which would have caused this.
- 2.2** The family at that time consisted of mother, Child Q's step-father, her siblings and half-siblings. Also present in the family home was a maternal uncle.
- 2.3** The family had been known to a number of local services since at least 2010 and all of the children had been subject to CP Plans under the category of neglect during the period July 2014 to March 2015.
- 2.4** In 2015 the family were experiencing housing and financial difficulties. There were several children in the family including a number of pre-school children. Child Q and one of her younger siblings had significant additional needs including health needs due to being born prematurely. These had required attendance at a significant number of medical appointments in their early years. Further details of these medical issues will be given in sections 4.1 and 4.2.
- 2.5** All the children were removed from CP plans and put on CIN plans in March 2015. CSC closed the case in August 2015 as the family had agreed to a referral to the Families First service to provide ongoing support.
- 2.6** During the months leading up to her hospital admission, health professionals had very little access to Child Q and although she had a place at a school-attached nursery, her attendance there was very infrequent.
- 2.7** It is not possible to ascertain whether any professional saw child Q between late April and early August 2015. However it is clear that after one contact in August she was not seen again until school staff saw her at home in September 2015 (the day she was admitted to hospital).
- 2.8** Child Q was due to start school at the beginning of the September term in 2015 but was not taken until late September, following a warning from CSC that child protection procedures would be implemented if she did not attend.
- 2.9** On the 1st day child Q attended school and as a result of child Q's physical appearance, school staff contacted children's services and later that day mother took child Q to hospital.

3. METHODOLOGY FOR THE REVIEW

- 3.1** This SCR has been undertaken with the intention of extracting useful learning from a variety of perspectives of those involved with the family. Underlying themes/patterns and specific practice issues have been identified which lead to some clear proposals for actions that may help to avoid similar occurrences happening in the future. The Terms of Reference for this review are attached (Appendix A).
- 3.2** The author was asked to focus on the period from June 2014 until the admission to hospital of child Q in September 2015.
- 3.3** The review also takes into account the wider circumstances of the family history and considers some safeguarding issues relating to the other children.
- 3.4** The SCR author previously undertook a Local Case Review (LCR) and has used the information gained from that process to inform the SCR. The LCR process involved an examination of documents, one-to-one discussions with a number of individuals and a group meeting with some of the front-line professionals involved with the family during the period concerned.
- 3.5** The LCR identified that agencies did not work well together under the CP and CIN processes and that therefore the case met the criteria for a SCR.
- 3.6** There were three professionals who had significant contact – either ongoing or single - with child Q who did not contribute to the LCR or the SCR. The CSC case worker for the period December 2014 to September 2015 was an agency worker employed within the team as an Assistant Team Manager (ATM) who subsequently ceased work for Swindon Borough Council (SBC). The ATM was contacted by the author in order to seek their views but did not contribute. A paediatric Senior House Officer (SHO) who assessed child Q when she attended the Great Western Hospital Emergency Department (ED) in December 2014 and a Paediatric Registrar who reviewed her development in February 2015 are no longer working there and so were unavailable.
- 3.7** For the SCR, Individual Management Reviews were requested from the following agencies:
- Swindon Borough Council Children, Families and Community Health Services – Children’s Social Care
 - Swindon Borough Council – Education Department
 - Swindon Borough Council Children, Families and Community Health Services – Health Visiting
 - Swindon Borough Council Children, Families and Community Health Services – Speech and Language Therapy
 - Great Western Hospital NHS Foundation Trust – Paediatrics, Community Paediatrics and Dietetics
 - Swindon Clinical Commissioning Group – GP services
- 3.8** The author and LSCB Strategic Manager met with child Q’s mother and step-father to hear and record their views.

Child Q's birth father has not been consulted. CSC advised the author that he had no involvement with the child during the time in question (although the CSC IMR author notes discrepancies regarding records of his involvement) and attempts by the department to contact him had failed.

Consequently child Q's birth father's views are not available to inform this review.

NB The term 'parents' is used in this report to refer to child Q's birth mother and step-father.

4. THE FACTS

2010-2013

- 4.1** Child Q was born in November 2010 at 27 weeks gestation and had significant medical issues as a result. Her birth weight was 1.09kg. Discharged home at 6 months on oxygen and naso-gastric feeding, she required oxygen until 18 months.
- 4.2** She was followed up by paediatrics, cardiology, Speech and Language Therapy (SLT) and dietetics. She was discharged from hospital finally in September 2012, to be followed up by the team for Children with Disabilities at Saltway Centre. She was at that time considered to have a mild delay, recorded by the hospital as functioning at about 18 month level.

2014

- 4.3** In July child Q and her siblings, already receiving support from CSC under CIN procedures, were made subject to a CP plan under the category of neglect. Issues identified included poor school attendance, poor state of the home, unexplained bruising on some of the children, and housing and financial problems.
- 4.4** Possible lactose intolerance was raised by child Q's mother with her GP in November.
- 4.5** At a home visit in December the Health Visitor Team Leader (HVTL) recorded her weight as 11.54kg and recorded bruising to her cheeks. A referral was made to dietetics due to her concern about the weight but no action recorded regarding the bruising.
- 4.6** Child Q attended the Emergency Department (ED) at Great Western Hospital (GWH) in December with mother reporting seven days of diarrhoea and vomiting (D&V). She was weak and unable to stand. (There was no reference to D&V in the HVTL's recording of her home visit two days earlier.) She had hypoglycaemia (low blood sugar). The paediatric Senior House Officer (SHO) made an urgent referral to dietetics, but child Q was assessed and discharged without any apparent consideration of the fact that she was on a CP plan. There was no contact made with CSC nor any involvement of a senior paediatric colleague. It is unclear whether ED staff made the SHO aware of the CP alert.

2015

- 4.7** A Review Child Protection Conference (RCPC) took place in January. Child Q's new-born sibling was also made subject to a CP plan. It was recorded as a 'holding' conference for the other children and lack of progress on CP plan

recorded. Following this conference, concerns were escalated to the CSC managers by other professionals involved and by the conference chair.

- 4.8** Child Q attended dietetics clinic twice in January and February. Mother was advised to continue the milk-free diet reportedly advised by her GP and a food supplement prescribed, but prescription was never collected from GP surgery. Child Q did not attend review appointment in April. This non-attendance was notified to other professionals including GP, HVTL and ATM.
- 4.9** Ongoing concerns were recorded by SLT, HVTL and nursery staff regarding child Q's hunger, non-attendance at nursery and overall condition, during the period January to March.
- 4.10** Child Q had a paediatric review at the Saltway Centre in February. She was recorded as having lost 0.3kg since October 2014 and being on the 0.4th centile for weight and the 2nd centile for height.
- 4.11** At a RCPC in March child Q and all her siblings were removed from CP Plans and put on CIN Plans.
- 4.12** Child Q was withdrawn from nursery by her mother in April after claiming staff had given her a dairy product.
- 4.13** In June Children Services received an anonymous referral with serious concerns about child Q. The referral was not followed up and was not shared with any other professionals or agencies.
- 4.14** Between early June and late August the Health Visitor (HV) made at least seven failed attempts to meet with mother and visit the home.
- 4.15** In late August the decision was made to close the case and refer to the Family First service for ongoing support.
- 4.16** Child Q was due to start school in Sept but did not attend.
- 4.17** In early September staff from the school attempted to make a home visit, but were denied access. They heard children screaming and the ATM was informed. No action was taken.
- 4.18** School staff gained access in mid-September and were then extremely concerned about child Q. The ATM was informed and reassured them that a home visit would be made. There is no record that a visit took place.
- 4.19** The next day, the ATM spoke to child Q's mother to warn her that she must take child Q to school on the following Monday or CP procedures would be instigated.
- 4.20** On the same day that child Q was first taken to school she was, later that day, admitted to hospital. She was found to be severely malnourished and dehydrated and was kept in hospital and monitored for four days after which she was discharged home. Three days later she was taken into care.
- 4.21** Action was taken by Children's Social Care to safeguard Child Q and the other children in the family. A criminal investigation was initiated and resulted in mother and step-father being charged with offences against Child Q and other children in the family. They were convicted in October 2018 and both received custodial sentences.

5. THE FAMILY

- 5.1** Child Q's mother and step-father met with the author and the LSCB Strategic Manager and contributed their views to this review.
- 5.2** They said that they first asked CSC for help with parenting in 2012. Additionally, at that time child Q was at home on oxygen and tube feeding and they had help from the HV and a nurse who visited regularly and supported them.
- 5.3** Mother told the author that a hospital paediatrician had told her that child Q would always be particularly susceptible to infections and she had many episodes of diarrhoea and vomiting, so it was hard to get her to put on weight. She expressed to the author her constant anxiety about child Q at that time.
- 5.4** They felt that one of the reasons that the situation became so serious for child Q was the frequent changes of social worker that they had experienced.
- 5.5** They expressed very positive views about the Assistant Team Manager (ATM) (who held the case during December 2014 – September 2015) who they felt was the most helpful social worker they had been involved with. Mother described the ATM as being like a friend or a grandparent to the children.
- 5.6** Mother said that child Q did not like the replacement dairy products that had been suggested by the dietician and wanted to eat the same as the other children. She said that she admitted that they might not have really known how much she was eating and 'should have done that better.'
- 5.7** Child Q's step-father described being away from home a lot working long hours and so was not available to help very much.
- 5.8** Mother expressed the view that professionals 'passed things on to others all the time' and that advice from professionals was sometimes contradictory.
- 5.9** The parents said that the only meetings they were invited to attend were Child Protection meetings. They felt that agreed actions were not carried out and nothing was done about it. They described not feeling really included in the meetings and mother 'felt they were being controlled'.
- 5.10** Mother stated that the social worker (ATM) was not concerned about child Qs weight and 'took them off Child Protection.' However although they were offered support by the ATM from Families First nothing was ever done and it was never talked about while they were on a plan.
- 5.11** Mother stated that she did not use the GP because child Q was under the dietician and Paediatrician. She believed that child Qs stomach upsets were due to eating dairy products and stopped when she did not eat them.

6. THE FRONTLINE PRACTITIONERS

- 6.1** During the process of the LCR, the author met with some of the frontline practitioners who were involved with child Q during the time period that is subject of the SCR, along with representatives of some professions that had been involved where the specific practitioner was not available. The views of those professionals informed the report alongside those of the family and the IMR authors.
- 6.2** Only two of the participants had had any direct contact with child Q during the period in question. Those were the Health Visitor Team Leader (HVTL) who held the case at the time and the School's Safeguarding Deputy (SSD) for the establishment where child Q attended nursery. The School Nurse (SN) who attended knew the older siblings and the parents.
- 6.3** The overall feeling from the practitioners was of a complex situation where concerns were high for child Q as well as her siblings, but where information was compartmentalised both between and within organisations and therefore no-one had a whole picture. Concerns were shared with each other at times and attempts made – sometimes unsuccessfully – to share them with the ATM. Significant frustration was expressed during the meeting about the handling of their concerns and of the case in general by CSC.
- 6.4** The Community Paediatrician made reference to the history of the family and in particular their non-attendance record at medical appointments. This had, he felt, led the paediatricians to simply hope that the non-attendance in March 2015 would be followed by attendance at the next appointment. He described a system where paediatric health records were held in different places and not available to all those who should have been able to access them and was 'comforted' when child Q became subject to a CP plan.
- 6.5** The SSD felt that the lack of sharing of information with the school, such as the family's history of missed appointments, delayed their ability to fully realise what was happening to child Q. They saw her needs as purely medical.
- 6.6** The practitioners described the escalation of their concerns following the RCPC in January 2015 and a subsequent meeting with the ATM and the ATM's manager as a significant moment that reinforced their view that the parents' views were allowed to dominate decisions without sufficient corroboration.
- 6.7** Reference was made to the review period being a time of considerable changes within the relevant organisations, heavy CP workloads and communication difficulties which it was felt all contributed to the failure to protect child Q.

7. ANALYSIS OF AGENCY INVOLVEMENT

7.1 Children, Family and Community Health - Children's Social Care

- 7.1.1** During the period of this review all the children were, for some of the time, subject to Child Protection Plans under the category of neglect, due to concerns about the state of the home, non-school attendance and lack of appropriate supervision of the children.
- 7.1.2** In December 2014 the allocated social worker had left and the ATM decided to take on the case. The IMR author notes that the service was undergoing a restructuring during this period and was also using a large number of agency workers with a high staff turnover. (The ATM and manager were both agency employees.) It was not accepted practice at that time for managers to be allocated cases but the ATM's stated intention to allocate to a social worker as soon as possible did not materialise.
- 7.1.3** The IMR author notes a number of significant recording omissions that contributed to the failure to protect child Q and also made it difficult for her to assess accurately what happened in the management of the case. There were no records of any core groups being held during the time child Q was on a CP plan. No CIN review meetings were recorded after the move from CP to CIN plan in March 2015, until the review in late August 2015 where the decision to close the case was made. Although other agencies had some records of core group meetings taking place, no minutes were produced by CSC.
- 7.1.4** No written reports were produced by the ATM, in line with CP procedures, to inform the decision making at the RCPCs in January and March 2015. The chair of the March RCPC did not challenge the lack of social work report, core groups or statutory visits. She had not chaired previous conferences for the family and had not read the previous records.
- 7.1.5** The IMR author notes that the decision making at the March 2015 RCPC would appear to have been flawed and that insufficient account was taken of the additional stresses on the family at this point caused by both having a new baby and also the threat of eviction.
- 7.1.6** In the course of the LCR the author identified that during the time covered by the review, there was a lack of scrutiny in review conferences of the implementation of the CP plans. This was one of the contributory factors leading to the flawed decision to remove child Q from the CP plan. It was one of a number of aspects of the way CPCs were run at that time that were considered as part of a review undertaken by the new manager of the Quality Assurance and Safeguarding Team Manager during 2015, which led to the introduction of improvements during 2016.
- 7.1.7** There was a general lack of assessment and planning for child Q and her siblings. Insufficient consideration was made of the mother's history, the views or capacity of the males in her life or the possibility of support from extended family members.
- 7.1.8** There were many alerts to CSC about child Q, regarding her medical and educational non-attendances and her overall demeanour, but these do not appear to have been acted upon.

- 7.1.9** In particular, an anonymous referral in June 15 expressing serious concerns about child Q suggested that urgent follow-up was required, but none was undertaken, as the ATM believed that the referral was malicious.
- 7.1.10** The IMR author notes that between July and December 2014, the allocated social workers attempted to ascertain the views of the children through direct contact, but there is no record of any direct work during 2015 with either child Q or her siblings. The IMR author also notes a lack of challenge to the parents regarding the information they gave, a lack of challenge between professionals and a lack of professional curiosity.
- 7.1.11** The IMR author makes a number of recommendations that the author endorses:
- In considering progress of the CP Plan at Review CPCs, CP chairs to include what the outcomes were of core groups and statutory visits in deciding progress of otherwise of the Protection Plan.
 - Guidance regarding direct work to be undertaken with children during statutory visits and the recording of this should be reviewed and updated.
 - CSC should review statutory guidance regarding the requirement for assessments and revise and/or reinforce this as appropriate with managers.
 - CSC should confirm guidance regarding managers not holding cases and develop a monitoring system including ensuring staff know how to whistle blow if contravened.
- 7.1.12** Children, Families and Community Health Services within Swindon Borough Council are working with the relevant professional organisations and regulatory bodies to address practice issues identified in the SCR process.

7.2 Children, Family and Community Health – Health Visiting and Speech and Language Therapy

- 7.2.1** The HV service had supported child Q and her mother alongside the Paediatric Community Outreach service on her discharge from hospital and continued to support both her and her younger siblings as they were born, in accordance with the requirements of the Healthy Child Programme.
- 7.2.2** The family HV at the time covered by this review was a senior practitioner, a Health Visitor Team Leader (HVTL). The IMR author notes that she took over the case because she recognised the complexities of dealing with the family and in particular the “challenging and confrontational behaviour” of the mother.
- 7.2.3** The HVTL’s role with child Q during this period was in assessing her development and making subsequent referrals to dietetics and paediatrics to address health and developmental concerns, including weight loss and global delay. She was responsible for a number of actions in the CP plan, including ensuring the family registered the children with a GP and undertaking weekly visits for assessment and support. Due to the lack of appropriate recording it is not clear how effectively these actions were carried out.
- 7.2.4** There were some significant recording omissions which made assessing the role of the HVTL difficult for the IMR author, including there being no recorded home visits beyond late February 2015.

- 7.2.5** It is unclear why the HVTL did not take action when she visited child Q in December 2014 and recorded seeing bruises to her face. This information was shared at the RCPC in January 2015 but there is no evidence that she referred it to CSC at the time of observing.
- 7.2.6** The IMR author notes that when monitoring of the CIN plan did not take place and the HVTL was unable to gain access to the home during the summer of 2015, (she recorded at least seven missed or rearranged appointments), she did not take appropriate action to escalate the situation, either by implementing the existing 'No Access' policy or by using the LSCB's escalation policy. The IMR author notes that she could not give any reason for this other than that she had frequent text communication with the mother and saw that as indicating compliance.
- 7.2.7** The IMR author describes poor record keeping, a lack of evidence of clear analysis, planning or any strategy for escalation of concerns and a lack of follow-up of medical appointments on the part of the HVTL. She questions the HVTL's decision in December 2014 to weigh child Q monthly – suggesting clear concern – but lack of recording of any analysis of the risk or of the outcome of any subsequent weights.
- 7.2.8** The IMR author also noted a lack of evidence of robust supervision or management oversight for the HVTL meaning that poor practice was not identified at the time.
- 7.2.9** The Speech and Language Therapy (SLT) service had supported child Q in her early years but also failed to access the home or to see child Q during 2014, until they observed her at nursery in November that year. This was their only contact with her during the period under review and they recorded that she asked for food on four occasions. The IMR author notes that they did not effectively contribute to safeguarding child Q, not apparently linking the significance of their lack of access to her and her apparent hunger with her CP status. They did alert the HV to the lack of access but not the ATM and did not make a contribution either in person or writing to the CP conferences.
- 7.2.10** During the period under review, there were changes taking place in the system for recording case information, following the previous introduction of an electronic system. The IMR author notes that the HVTL expressed uncertainty about how the records for individual family members linked. She also notes that a dual system was in use for Speech and Language Therapy, which could have been instrumental in a lack of effective communication between them and the HV and CSC services.
- 7.2.11** The IMR author notes that neither the HVTL nor the SLT staff appear to have used supervision to discuss child Q, either through their line management or safeguarding supervision with the Named Nurse for Safeguarding (NNS). (Both forms of supervision were available at the time.) This contravened local policy and procedures.
- 7.2.12** The IMRs' author makes two recommendations:
- The SLT service manager to review the dual recording system and identify the barriers to using the shared case management system.

- That the quality assurance programme of work being undertaken to ensure that the quality of frontline safeguarding practice among health staff in the council is known, is developed and continues to report to Early Help and specialist health quality and performance boards. The author endorses these recommendations.

7.2.13 Children, Families and Community Health Services within Swindon Borough Council are working with the relevant professional organisations and regulatory bodies to address practice issues identified in the SCR process.

7.3 Early Years Education

7.3.1 Child Q attended a total of three nurseries, the first being before the period covered by this review. She attended the second from March 2014 until the end of July 2014 and the third from September 2014 onwards.

7.3.2 The third nursery was part of a local school that child Q's elder siblings attended. Her attendance there was very sporadic and improved attendance was part of the CP plan. The IMR author notes that there was no improvement during the time of the review and child Q only attended 13 of 177 available sessions, between September 2014 and July 2015.

7.3.3 The IMR author notes that as child Q did not reach compulsory school age until January 2016, the school could not take any legal action to improve her attendance.

7.3.4 The IMR author notes that the school staff were persistent in voicing concerns to CSC but did not always get a timely response. However, they did not use the LSCB's escalation policy to deal with this. She notes the lack of any reference to the escalation policy in the school Safeguarding Policy.

7.3.5 The author's view is that school staff were appropriately concerned about child Q and shared their concerns in a timely way and that their good practice would in future be enhanced by appropriate use of the escalation policy in similar circumstances.

7.3.6 The IMR author makes a number of recommendations for the school, which are all endorsed by the author. She also makes some multi-agency recommendations that are incorporated in the recommendations of the author in section 11.

7.3.7 The IMR author makes the following recommendations for her agency:

- Early Years (EY) settings will transfer CP records within 14 days to a child's new setting. If not known, the social worker or Multi Agency Strategic Hub will be informed.
- EY providers will ensure that all new children have completed admissions forms before their first attendance
- All CP concerns to be recorded on the appropriate template, not in classroom notebooks. All recorded concerns should then be passed to the Designated Safeguarding Lead (DSL).
- All CP files to include a chronology and to be kept updated.

- Where there are multiple children in a family, each child to have an individual CP file with child-specific concerns.
- The DSLs and Deputies to be confident to escalate concerns in line with LSCB procedures.

The author endorses all these recommendations.

7.4 Great Western Hospital NHS Foundation Trust

- 7.4.1** The IMR author notes that this hospital trust had significant involvement with child Q and her family over many years but during the timeframe of this review there was limited involvement.
- 7.4.2** Child Q had six appointments during this time, of which she attended four and did not attend two (one dietetic follow-up and one paediatrics follow-up). In addition she twice attended the Emergency Department.
- 7.4.3** Although there was a clear alert that child Q was on a CP plan on the hospital records, when she attended ED in December 2014 with hypoglycaemia there was no check made with CSC, nor consultation undertaken with any senior colleague in the hospital. In addition, due to the withdrawal of the HV liaison post the previous April, communication between the hospital and the HV and SN service appears to have been less robust and it is not clear that the HV was ever informed of this admission.
- 7.4.4** Child Q attended the dietetics clinic at GWH in January 2015 following referrals from the HV and the Paediatric SHO, which were appropriately fast tracked. Advice was given to continue the dairy free diet trial, as advised by her GP based on the mother's report of apparent lactose intolerance.
- 7.4.5** Child Q attended two appointments during this time with the Community Paediatrician, in October 2014 and February 2015. The second appointment had been brought forward at the HVs request but child Q was seen by a Paediatric Registrar at the Saltway Centre, who did not appear to address the significant concerns reported in the HV's letter. It is not known to the author whether the Registrar ever saw the letter, which was sent to the paediatric department at GWH.
- 7.4.6** A paediatric follow-up appointment was not attended in March 2015 and although a further appointment was scheduled, it was not until October. The IMR author acknowledges that at the time of writing the IMR there was still a potentially long delay when paediatric appointments are re-booked. There does not appear to have been any request to bring this forward.
- 7.4.7** An appointment for an MRI scan, to check whether reported apparent absences were seizures, could not be booked in before October 2015, despite a request for urgency. The author understands that at the time, there was a considerable delay in booking for those MRI's where the patient required a general anaesthetic, as in this case due to child Q's age.
- 7.4.8** The IMR author notes that good safeguarding practice was generally followed. The not attended appointments were dealt with appropriately but with some professional optimism and a lack of curiosity. The ED attendance in December 2014 was the one occasion when the safeguarding process was not followed.

Procedures require a check with CSC for further information, which did not happen.

7.4.9 The IMR author notes that mother's account took precedence in the communication with GWH staff and there may have been a lack of forensic analysis due to assumptions made regarding the impact of child Qs prematurity.

7.4.10 The IMR makes the following recommendations for her agency:

- Review the junior and senior doctors' safeguarding induction to ensure that peer review and safeguarding supervision is included and that it is important to consider potential abuse as outlined in NICE guidance CG89. Also to ensure that the risks in relation to 'Disguised compliance' and 'The rule of over optimism' are covered in this training.
- When there are safeguarding concerns with a child subject to Child Protection Plan that the Social Worker is notified alongside the GP and the implications for Health stated as outlined in the Missed Appointments policy for Children.
- Ensure that children of a verbal age are actively spoken to and their voice heard and documented.
- Review the process for seeing children with specific safeguarding needs at an earlier opportunity if specifically requested by another health professional or social worker.
- The IT department to look at the Medway PAS system to enable an easier process for readily identifying safeguarding information/communication on the system.
- A clear pathway should be developed for processing information when patients are no longer registered with a GP.
- There are difficulties with children who have multiple health issues requiring a number of Health Professionals. The paediatric department needs to identify a way to ensure that complex patients have one health plan encompassing all health needs.

The author endorses all these recommendations.

7.5 Swindon Clinical Commissioning Group (CCG) – General Practitioner services

7.5.1 Child Q was not routinely taken to a GP during the period of this review. She attended the surgery only once during the period under review, in November 2014, regarding possible dairy intolerance. Several immunisation dates were missed.

7.5.2 Child Q's parents accessed medical care for her and her siblings routinely through either Out of Hours services or the Emergency Department at GWH. The IMR author notes that this can be a symptom of disguised compliance. It has the effect of diffusing professional intervention and make continuity of care more difficult. However, it can more simply be seen as a symptom of a chaotic family and this could equally have applied in this situation.

- 7.5.3** Child Q's family had moved prior to the period under review and were not registered with a new GP at the time of the ICPC in July 2014. Consequently there was no GP report made to that conference.
- 7.5.4** The GP surgery records show that child Q was registered in October 2014 but there was at that time no facility to transfer large electronic records and therefore six months' records were missing. (Such transfers are now possible.)
- 7.5.5** The IMR author notes that the service offered was in line with national and local expectations and there are no issues regarding the surgery's Safeguarding Policies and Procedures.
- 7.5.6** However there was insufficient communication between the GP and other services. The GP did not know who the family HV was and the IMR author noted that there 'is little liaison between the HV service and the practice'. During the LCR, the author identified that when the prescription for food supplements requested by the dietician was not collected from the surgery, the practice did not inform anyone. The author also notes that GP did not attend any CP conferences and did not submit any written reports.
- 7.5.7** The IMR concludes there was a failure by GPs to recognise that non-attendance of medical appointments can be an indicator of disguised compliance and closely associated with neglect.
- 7.5.8** The IMR also concludes that the failure to share written information between GP practices, either through electronic transfer or available backup procedures, meant that there was incomplete health information available to the CP conferences.
- 7.5.9** The IMR author recommends:
- That the previously recommended single safeguarding policy for all GPs to refer to is developed and implemented within six months of the publication of this SCR.

The author endorses this recommendation.

- 7.5.10** The IMR author refers to two further recommendations made by recent SCRs which address some of the issues related to this case regarding GP services:
- The Board should ensure that expectations about minimum requirements of GPs' involvement in child protection processes are agreed with the CCG and that their implementation is monitored.
 - The Board should ensure that the South West Child Protection Procedures and the Swindon Procedures Manual concerning strategy meetings (notably the involvement of health professionals in these meetings), child protection conferences, child protection plans and core groups are being implemented effectively, through regular audit.

The author also endorses these recommendations.

8. THE KEY ISSUES

8.1 Organisational and resource factors

8.1.1 Use of agency staff in Children's Social Care

Recruitment problems and the resulting use of agency staff within CSC was clearly a contributory factor. It resulted in frequent changes of staff and the inappropriate allocation of the case to a manager, which compromised the ability of the team to understand the whole picture about this large and complex family. Coupled with changes at the time within the Safeguarding and Quality Assurance Team and in practice within CPCs this appears to have led to a decision to take child Q off a CP plan that, with hindsight, was based on misplaced optimism and inadequate multi-agency risk assessment.

8.1.2 Demand on Hospital services

Demand on paediatric services and MRI scan waiting times within GWH meant that there was a gap in up to date information about child Q's medical condition during the summer of 2015. This did not help other professionals in the CIN network around child Q in their assessment of her condition.

8.1.3 Lack of consistent policy and practice regarding missed appointments

Non-attendance at medical or other appointments was recognised by most professionals as a possible indicator of neglect. However, apart from GWH, no organisation directly involved with child Q had, at that time, a specific policy or a strategy for dealing with non-attendance by children where safeguarding concerns existed. Although GWH did have a DNA policy, it was not explicit enough regarding who to contact when a child on a CP plan missed appointments and therefore practice was inconsistent regarding the notification of CSC. Non-attendance at medical appointments was raised as an issue for child Q and other children in the family and was referred to in the CP plan, but inadequate monitoring of this meant that concern was not raised sufficiently enough or addressed in any coordinated way.

8.1.4 Allocation of family support resources

The reason given to the family and other professionals by the ATM for proposing the closure of the case to CSC and referral to the Family First service was that they would receive a higher level of support across a wider range of needs. The author raises the question whether this was accurate and if so why such support was not available for a family where the children were considered to have been at serious risk of harm?

8.2 The Child and Family

8.2.1 Prematurity

Child Q's prematurity, resulting medical needs and developmental delay made it more difficult at the time under consideration for non-health practitioners to assess her risk factors. Hence her weight loss, frequent falls and general perceived lack of strength were assumed to be related to her developmental delay and no-one appears to have considered whether she was being fed adequately and asked her parents. Her multiple needs meant that many different medical professionals saw her, which made it harder for anyone to see the whole

picture. Prematurity is a known indicator for possible abuse and as such practitioners needed to be more alert to other possible explanations for her condition.

8.2.2 The child's voice

Due to child Q's age, all services used information given by parents to inform their understanding of her views, which is not unusual. However, she had no independent representation with the CP processes and there are no recorded attempts to ascertain her views within those processes or indeed in her dealings with any health professionals including in the hospital setting. (It is noted by the author that the lack of representation in CP processes also extended to all the other children in the family - despite this omission being raised in the ICPC it continued throughout the period under review.) Some of her observed experiences were recorded within HV and nursery records, but the author's view is that the HVTL's belief that the child was virtually invisible within the family was, at times, replicated within the service that she received.

8.2.3 Family complexity

The number of children in the family and the complexity of the family situation meant that it was very difficult for any one professional to understand and manage the needs of each individual child. No consideration appears to have been given within either CSC or HV to allocating more than one worker. Such action would have not only enabled more focus on each individual child but would have given the opportunity for professionals to cross-reference their individual perceptions of the situation for the children and added to the depth of the analysis of risk for child Q.

8.3 Professional Practice

8.3.1 Lack of analysis and professional curiosity

Most of the IMRs noted the lack of sufficient analysis or critical thinking in this case. A lack of professional curiosity, in particular within CSC and the health visiting service allowed practitioners to take the parents' views and explanations at face value without further exploration. Professionals need to have an ability to question and evaluate, an unwillingness to take what is heard or seen at face value and an ability to notice flaws and inconsistencies.

This lack of curiosity allowed inaccurate assumptions to be made about the causes of child Q's loss of weight and of the reasons for the difficulty in accessing the home or seeing the child. It led the ATM in particular to ignore crucial information that should have alerted them at a much earlier stage and to hold a falsely optimistic view of parental motivation and level of cooperation. This view was at times shared by the HVTL.

There was no evidence of any assessment of the mother's history, nor of the impact of the extreme prematurity and extended hospitalisation of child Q on the attachment between mother and child.

The author also notes that this issue is one that is frequently identified in Serious Case Reviews and is particularly challenging to address within organisations. Addressing the issues of professional supervision and management oversight (see following sections 8.3.2 and 8.3.3 and recommendation 11.3) is crucial to

ensure the strengthening of the skill of critical thinking within the workforce, both at frontline and managerial levels, as well as the rigour of all those involved in CPCs, both chairs and attendees.

8.3.2 Supervision

Professional supervision including safeguarding supervision was available within the agencies employing the ATM, HVTL, SLT and hospital staff and at the school nursery. The IMR authors for the hospital and nursery indicate that this facility was used appropriately in those settings. However, it is not clear to the author whether the Community Paediatric registrar, or the SHO who examined child Q in the ED at GWH in December 2014, were accessing supervision at the time. Within the HV, SLT and CSC settings there was identified an insufficient use of supervision and a lack of awareness of this by managers. The issue has been addressed within the Early Help Service where the Health Visiting and SLT teams are located. The issue within CSC was that the case holder was a manager and managers' supervision did not address casework issues, though in this situation it clearly should have done so.

8.3.3 Management oversight

This case raises clear questions about managerial oversight of practitioners and the responsibility to monitor compliance to CP procedures and best practice. The IMRs for Health Visiting and CSC provided evidence of poor management practice and a lack of systems to support monitoring within CSC which the IMR author reported have since been addressed. Supervision and management issues were not considered relevant for comment within the CCG's IMR, which is questioned by the author as all services with responsibilities for protecting children require such support and monitoring mechanisms. No system appears to have been in place to alert GWH managers to the failure of the SHO to follow up the ED attendance appropriately.

8.3.4 Non-adherence to 'No Access' policy

There was a 'No Access' policy within SBC Community Health services that required the notification of a manager and a plan to address the lack of contact. This was not adhered to by Health Visiting and SLT staff and could have led to earlier intervention.

8.3.5 Escalation policy

The LSCB has an escalation policy, in existence at the time under review, which requires the notification of managers and the review of a situation by those managers, where one agency believes that insufficient action is being taken to safeguard children or young people. This formal process was not initiated by any of the professionals involved in the case, although they were all aware of it. The author believes that this may have been due partly to the lack of robust supervision, within which this option could have been raised by supervisors, coupled with the professional optimism that was engendered by the apparent cooperation of the parents.

Discussions with practitioners indicated that some misunderstood the process they were required to follow, believing that the escalation would have to be to the ATM's manager, rather than their own.

8.3.6 Lack of adherence to CP policies and procedures

All the IMR authors identified practice that did not adhere to multi-agency CP procedures.

In addition to the examples of not sharing information and not reporting concerns already referred to and summarised in 8.4 below, a number of the IMR authors noted other areas of lack of adherence. There was a lack of evidence of statutory review meetings taking place to monitor the CP and CIN plans. Clearly from other agency records, a number did take place but were not minuted and therefore there was no shared understanding of the lack of progress, further actions agreed or who was responsible for any actions.

The CPC chairs allowed the conferences to take place without written reports being completed and appear not to have adequately reviewed progress on the CP plans. This combined to produce a lack of any shared, accurate picture of what was happening to child Q and the level of risk to her.

8.4 Communication

8.4.1 There were a large number of professionals involved in keeping child Q and her siblings safe and therefore the need for effective communication and timely and accurate information sharing were crucial. All of the IMRs raised issues in this area. The key issues that contributed to the situation for child Q are noted here by the author.

8.4.2 Key information not shared

Key incidents during the period under review were not always shared in a timely way with all those who needed to know. The failure of the SHO to inform CSC of child Q's hospital admission in December 2014 and the failure of the ATM to share the anonymous referral information in June 2015 with the other professionals involved meant that professionals who could have intervened earlier did not have the whole picture.

8.4.3 Health information systems

During the LCR, it emerged that in 2015 there was no sharing of information between the paediatric service at GWH and the Saltway Centre where Community Paediatricians conducted many of their appointments. The paediatricians at the hospital did not at that time have access to the information that was held by the Saltway teams. Medical letters were copied to the GP and to parents, but not to any other professionals.

8.4.4 Use of information

When significant information was shared by other professionals with CSC, during summer 2015, the case holder (ATM) does not appear to have taken appropriate action. The author notes that the professional assessment of the value of information and the subsequent use of it, is as crucial as the initial sharing of it.

8.4.5 Lack of information/evidence to make decisions

Information available to the CP conferences, core group meetings and CIN meetings was incomplete due to a combination of a lack of assessment, a lack of robust record keeping and a lack of attendance by key practitioners. Neither the dietician nor the Community Paediatrician appears to have been invited to the

initial or review CP conferences and the Speech Therapist, though invited, did not attend. The hospital paediatric service sent written reports which would have included the letter from the Community Paediatrician who examined child Q during early 2015, but no detail from dietetics other than the appointment dates, due to separate recording systems. It appears that at the time there was a reliance on the health visiting service to collate and pass on the knowledge and views of other health professionals to conferences. The lack of attendance and written reports does not appear to have been questioned by the conference chairs. Therefore the accuracy of the ongoing risk assessment for child Q was compromised.

8.5 Disguised Compliance

- 8.5.1** A number of the IMR authors raised the question of whether the parents were demonstrating 'disguised compliance'. This is defined by the NSPCC as 'a parent or carer giving the appearance of cooperating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention.
- 8.5.2** There is some evidence from the IMR authors of possible disguised compliance. The author notes that child Q's parents attended medical appointments with her while she was on a CP plan, but within three weeks of her removal from that plan they did not take her to scheduled appointments with paediatrics and dietetics, (one was the day following the review conference at which she was removed from the plan), neither did they attend a medical appointment for her younger sibling.
- 8.5.3** Although Child Q's parents expressed a need for support, they consistently failed to engage with a range of professionals including those who could offer support in the home – a Nursery Nurse and a Social Care Worker. Their compliance to the CP and CIN plan appears to have been sporadic. Mother repeatedly cancelled and rearranged appointments with the HVTL during the summer of 2015, effectively preventing child Q from being seen.

9. GOOD PRACTICE

Some examples were identified by IMR authors of good engagement in multi-agency working, clear understanding of CP policy and procedures and adherence to those procedures, including appropriate information sharing. These expected levels of professional practice are to be commended.

10. CONCLUSIONS AND LEARNING POINTS

- 10.1** Child Q was a vulnerable child due to her prematurity and resulting health and developmental issues. Additionally, she was part of a large family that was experiencing multiple difficulties and her parents were struggling to meet the needs of their children. They were dealing with health, social, educational, financial and housing issues and required support and advice from a number of agencies.
- 10.2** Child Protection procedures were initiated due to ongoing concerns about neglect and a plan to address these put into place. However the implementation and monitoring of the plan were inconsistent and the specific needs of child Q were not given sufficient focus within the multi-agency planning and monitoring

processes. Changes to the way conferences were managed, conducted and recorded at that time – designed to make the processes better for families – appear to have reduced the rigorousness of the protective nature of those processes for child Q.

- 10.3** Professionals were not always curious enough about what was happening to child Q and too quick to accept her parents' explanations for what happened without considering the whole context of her life. A lack of analysis and critical thinking was compounded by a lack of robust professional supervision and, in some agencies, of effective management oversight. No-one questioned whether child Q was receiving sufficient food and due to subsequent medical evidence and the fact that she put on weight very quickly once she was in a foster home, it appears that she was not.
- 10.4** The number of children in the family and the number and range of professionals and agencies involved inevitably posed a considerable challenge to efficient and effective communication. This was a significant contributory factor in what went wrong for child Q, coupled with difficulties in assessing the motivation and compliance of the parents.
- 10.5** There was a notable lack of joining up of the various health services that child Q was involved with. Health professionals within Swindon Borough Council, the GP practice, Saltway Centre and GWH struggled with inadequate information systems and often failed to take proactive steps to find alternative solutions to this. A lack of engagement in CP processes by some of the health professionals compounded this. There is evidence that the responsibility for protecting child Q was often seen to be the prime responsibility of the ATM which led to a failure by other professionals to take sufficient additional action when their concerns were not addressed. They allowed the ATM's false reassurances to allay their appropriate concerns.
- 10.6** All agencies that contributed IMRs to this review have highlighted learning from this case and have implemented a range of improvement actions to help to reduce the risk of a similar situation in the future. The author is reassured by these actions and notes the willingness of all to contribute with openness and honesty to the review process and the learning.
- 10.7** Many of the lessons learnt relate to improving the adherence to processes and procedures already in existence at the time under review. The quality of management oversight and supervision, as well as monitoring and communication systems, are as fundamental a part of protecting children as individual frontline practice and are the focus of most of the recommendations from this review.

11. RECOMMENDATIONS

The author has previously endorsed a number of single agency recommendations. In addition a number of recommendations are now made to reflect the learning from this review and these are focussed on multi-agency working and policies and procedures:

- 11.1 **Swindon LSCB** should initiate a review of the current Child Protection Conference processes to ensure that statutory requirements are routinely met and no decisions are made without adequate assessment, the required written reports and the relevant professional expertise to ascertain an accurate risk of harm. This recommendation is to address the issues identified in 8.4.5. It should include a review of attendance requirements to ensure that the relevant professionals are present as well as consideration of whether current quoracy rules are sufficiently robust. It should also include a review of the role of the chair to ensure it offers appropriate independence and challenge.
- 11.2 **Swindon LSCB** should review current provision of multi-agency training to ensure it gives sufficient weight to the responsibility of each individual to protect children and young people and importantly how this responsibility should be carried out in day to day practice. This should include training regarding CP conferences and core groups.
- 11.3 **Swindon LSCB** should initiate a review, by all agencies involved in child protection, of policy, practice and training in supervision (both management and safeguarding), at all levels of those organisations, to ensure the rigorous application of procedures and best practice guidance. Action plans to address any issues identified should be rigorous and be closely monitored.
- 11.4 **Swindon LSCB** should initiate a review of information sharing systems between GWH, GP practices and child health professionals working in SBC. This review should address the communication difficulties highlighted in 6.4, 7.2.10, 7.5.6 and 8.4.3 and recommend further developments to improve safeguarding.
- 11.5 **Swindon LSCB** should review the appropriateness and effectiveness of its Escalation Policy, in consultation with practitioners and managers, make any necessary changes and re-launch it to ensure that all managers and practitioners are fully aware of and compliant with the policy. Its ongoing use should be monitored and regularly reviewed.
- 11.6 **The Safeguarding and Quality Assurance team within SBC** should ensure that the requirements for all children's voices to be heard at CP conferences are met and those who cannot speak for themselves, due to age or ability, are adequately represented at all initial conferences and reviews.
- 11.7 **Child, Family and Community Health Services within SBC** should review their case allocation and caseload management systems to ensure that large and/or complex families are weighted appropriately, with consideration given to the allocation of more than one worker. This is in order to allow allocated

professionals sufficient time to meet statutory requirements for assessment and direct work with each individual child.

- 11.8 Swindon CCG**, in partnership with other relevant agencies in Swindon LSCB, should develop a multi-agency policy and protocol for the management of non-attended appointments across a spectrum of services. This should include undertaking a joint assessment of the impact of missed appointments and the development of IT solutions to share relevant information so that a clear and contemporaneous picture is available to all who need to know.

Liz Evans
12.09.17

APPENDIX A - TERMS OF REFERENCE

The review Terms of Reference are in line with the principles for SCRs set out in *Working Together 2015* and aim to contribute to learning and improvement through consolidating good practice and identifying where practice can be improved.

The author was required to consider the following questions:

1. Did agencies communicate effectively and work together to safeguard and promote the children's welfare?
2. Was the level and extent of agency engagement and intervention with the family appropriate?
3. Are the multi-agency procedures and policies for following up children who miss medical appointments effective?
4. Is repeated non-attendance at essential appointments viewed as possible medical neglect, and understood organisationally as a multi-agency safeguarding concern?
5. How effective are multi-agency child protection procedures in managing risk where there is a family with large numbers of siblings?
6. Was decision making in this case around discontinuing Child Protection plans appropriate and robust?
7. Was the quality of Child Protection and Children in Need plans adequate and did they include fathers, extended family and all historical information?
8. Were the children's views and wishes sought and taken account of in assessments and planning?
9. Were there any organisational or resource factors which may have impacted on practice in this case?
10. Were appropriate management/clinical oversight (supervision) arrangements in place for professionals making judgments in this case?

APPENDIX B - KEY TO ACRONYMS

ATM	Assistant Team Manager
CCG	Clinical Commissioning Group
CIN	Child/Children in Need
CP	Child Protection
CPC	Child Protection Conference
CPCC	Child Protection Conference Chair
CSC	Children's Social Care
DSL	Designated Safeguarding Lead
ED	Emergency Department
EY	Early Years
FF	Families First
GP	General Practitioner
HV	Health Visitor
HVTL	Health Visiting Team Leader
ICPC	Initial Child Protection Conference
IMR	Individual Management Review
LCR	Local Case Review
LSCB	Local Safeguarding Children Board
NNS	Named Nurse for Safeguarding
RCPC	Review Child Protection Conference
SCR	Serious Case Review
SHO	Senior House Officer
SLT	Speech and Language Therapy/Therapist

APPENDIX C - DETAILS OF THE INDEPENDENT REPORT AUTHOR

Liz Evans qualified in residential childcare and management and has a post-graduate certificate in Child Protection. She worked in a variety of residential childcare, early years and integrated children and young people's services for 38 years, employed variously by charitable, NHS and local authority employers. She now works as a consultant.

She worked for Swindon Borough Council from 2007 - 2012, but did not manage any of the individuals involved in this review.