Bradford Safeguarding Children Board

Child Safeguarding Practice Review concerning Emily

Overview Report

1st February 2021

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1. The child and the circumstances leading to the decision to carry out a Child Safeguarding Practice Review

1.1 The decision to undertake a Serious Case Review was agreed following a Rapid Review conducted on 12 September 2019 into Emily. The Rapid Review was undertaken after Emily was taken to hospital, aged 6 weeks, with swelling to her head. Medical investigations indicated that she had sustained serious head injuries which potentially were life threatening or which may have long term consequences for development. The injuries were assessed as non accidental in nature.

1.2 The cause of the injuries has not been established and a criminal investigation is ongoing.

2. The Review Process

2.1 This review followed the process outlined in Chapter 4 of Working Together to Safeguard Children 2018.

2.2 A Review Panel with the following membership was established to oversee the review:

- Peter Ward, Independent Lead Reviewer & Overview Report Author;
- Child Safeguarding Practice Review Lead, Bradford Safeguarding Partnership;
- Deputy Designated Nurse, Bradford and Craven Clinical Commissioning Group;
- Named Nurse, Bradford Teaching Hospitals Foundation Trust;
- Chief Inspector, Safeguarding Partnerships, West Yorkshire Police;
- Head of Service, Early Help, Bradford Council;
- Access to Housing Strategic Policy Officer, Housing Services, Bradford Council;
- Head of Safeguarding, Bradford District Care NHS Foundation Trust;
- Education Safeguarding Officer, Education Safeguarding Team, Children's Services, Bradford Council;
- Service Manager, Safeguarding and Reviewing Unit, Children's Services, Bradford Council.

2.3 The Review Panel decided that the review should consider a period from 24 February 2018 when an anonymous contact was made to Children's Social Care that the mother and father were in the pub and the children may have been left at home on their own, until 23 August 2019 when Emily was taken to hospital with the aforementioned head injury. Agencies which had been involved with the family between these dates were asked to provide chronologies and brief reports of their involvement including relevant background information which pre-dated this time period. The key learning from these reports has been used to inform this Overview Report.

2.4 Reports were provided by the following agencies:

- Bradford District Care NHS Foundation Trust
- Bradford Metropolitan District Council, Access to Housing
- Bradford Metropolitan District Council, Children's Social Care
- Bradford Metropolitan District Council, Education Safeguarding
- Bradford Teaching Hospitals NHS Foundation Trust
- Bradford and Craven Clinical Commissioning Group – regarding General Practice
- West Yorkshire Police

2.5 Chapter 4 of Working Together to Safeguard Children 2018 states that the safeguarding partners should seek to ensure that:

- *"practitioners are fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith*
- *"families, including surviving children, are invited to contribute to reviews. This is important for ensuring that the child is at the centre of the process. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively"*

2.6 In order to comply with the first of these principles, in carrying out this review the Lead Reviewer held a 'Learning Event' to which front line staff and their managers were invited. This helped the Lead Reviewer to gain a greater understanding of the context in which practitioners worked with the family and the reasons for the decisions they made and the actions they took. This in turn has assisted with drawing out relevant learning and recommendations for action and as such has been an important part of the systems approach that has been used.

2.7 The Lead Reviewer wanted to speak with both parents as part of the review. Unfortunately, this has not yet happened due to the ongoing criminal investigation.

3. Family Circumstances

3.1 Following her birth and until she sustained the injuries, Emily lived with her mother and five siblings and half-siblings aged from 10 years to one year. These children are referred to throughout this report as Sibs 1, 2, 3, 4 and 5. Emily has the same father as Sib 5. Sibs 1 and 2 have the same father as each other whilst Sibs 3 and 4 each have different fathers. Agencies involved with the family did not have any contact with the fathers of Sibs 1, 2, 3 and 4 during the period covered by this review and it is believed that none of these fathers had any contact with the children during this time period.

3.2 The mother and father of Emily had an 'on off' relationship with each other during the period considered by the review. They each contacted the police on a number of occasions to report incidents of domestic abuse against the other. They are believed to have separated around April 2019 and not to have reconciled by the time Emily was injured. However, reports alleging domestic abuse between them did continue.

3.3 Records seen by this review make reference to some support being provided to the mother by the maternal grandmother and a maternal uncle.

3.4 The children were the subjects of a Child in Need Plan for 12 months from June 2018 and a Child Protection Plan from June 2019. This Child Protection Plan remained in place when Emily was injured.

4. The Facts - Summary of Agency Involvement

4.1 Introduction

4.1.1 This section of the report provides a factual summary of key areas of agency involvement with the family. It is not a comprehensive record of all contacts with the family but focuses on those episodes that are considered to be significant to the way the case developed.

4.2 Historical Information;

4.2.1 Bradford Children's Social Care (CSC) first had knowledge of the family in February 2013 when concerns were raised about the mother being intoxicated and attending the hospital emergency department claiming her drink was spiked. At this time the mother had three children aged from 3½ years to two months. The children were in the care of their maternal grandmother at the time and no further action was taken. Four contacts were made to CSC during 2014 in which concerns were raised about the family. None of these resulted in ongoing involvement from CSC.

4.2.2 In July 2015, a referral was received stating that the mother was intoxicated in a pub and Sib 3, who was 18 months old was locked in a toilet. The referrer expressed concerns about the mother's use of alcohol. This referral resulted in an assessment which identified that the children's health and educational needs were being met and that there was emotional warmth between the mother and the children. Support was provided to address the mother's alcohol use, previous domestic violence incidents and boundary setting for the children. This was provided via a Family Centre and the case was stepped down to Early Help in April 2016.

4.2.3 Between May 2016 and February 2018 there were a further twelve contacts regarding the family, none of which resulted in further assessment or intervention by Childrens Social Care. The contacts came from a variety of sources and many expressed concerns about the care the mother was providing to the children. During this period, Sibs 4 and 5 were born. Early Help remained involved throughout this time.

4.2.4 West Yorkshire Police have had extensive engagement with both the mother and the father of Emily individually from one another over several years. In January 2018, the month before the start of the period being covered by this review, the mother contacted the police three times making allegations of assault and abusive and threatening messages from the father, whom she described as her ex-partner. On 25 January 2018, the Court issued a non-molestation order forbidding the father from contacting the mother.

4.3 Key Practice Episode 1 – Social Work Assessment and subsequent Child in Need status

4.3.1 On 24 February 2018, an anonymous contact was made to CSC that the mother and father were in the pub and the children may have been left at home on their own. This contact progressed to referral and enquiries with partner agencies and mother ensued. It was believed that the anonymous contact may be malicious but the enquiries raised concerns and the referral progressed to assessment. This included concern that the parents had not sought appropriate medical support when Sib 3 injured her leg or when Sib 4 had blood in his stools, parental hostility at school and domestic abuse between the parents. The assessment was completed in June 2018; records attribute the delay to "worker availability".

4.3.2 The social work assessment identified concerns relating to domestic abuse between the parents. The manager's comments stated that the mother appeared to minimise the extent of the abuse but also that both parents demonstrated some understanding of the impact of domestic abuse on the children and wished to engage with the MAZE domestic abuse agency. Concerns were also identified about parental boundary setting, school attendance and Sib 2's behaviour at school. It was suggested that Sib 2 might have Attention Deficit Hyperactivity Disorder (ADHD).

4.3.3 The assessment resulted in a decision that a Child in Need plan was necessary and this remained in place from June 2018 to June 2019. Records suggest that during this time period six Child in Need meetings were held, in July 2018, August 2018, November 2018, January 2019, February 2019 and April 2019. Child in Need meetings scheduled for October 2018 and May 2019 were cancelled; the first because the social worker did not arrive and the second because no-one was at home when professionals arrived for the meeting. CSC, however, only has records of four of these meetings taking place and only has minutes from the one that was held in February 2019.

4.3.4 Following the Child in Need meeting in April 2019, CSC reallocated the family to a different social worker whose role was to implement the 'step down' to Early Help.

4.4 Key Practice Episode 2 – Progression to Initial Child Protection Conference and Child Protection Plan

4.4.1 In May 2019, before the family had been stepped down from Child in Need to Early Help, a strategy discussion was held as a result of an incident of domestic abuse when the mother reported that the father was

at her property threatening to 'kick the door down' and take Sibling 5. The result of the strategy meeting was that an Initial Child Protection Conference should take place.

4.4.2 The outcome of the Initial Child Protection Conference was that the children were made subject to Child Protection Plans due to emotional harm with neglect highlighted. The resulting Child Protection Plan contained three main areas of concern each of which was sub-divided. The first of these relates to domestic abuse between the parents, the second concerns specific issues about the father's wellbeing and lifestyle and the third concerns the mother's parenting and how she responded to the children's behaviour. This third area made specific reference to the mother not taking Sib 2 to appointments with Child and Adolescent Mental Health Services (CAMHS) and little change to how she responded to the children's behaviour.

4.4.3 Core Group meetings were held in both June and July 2019 but minutes were only written of the first of these. The allocated social worker and allocated health visitor undertook a joint home visit to the mother and children in August 2019 which the health visitor recorded as being a Core Group meeting.

4.4.4 A Review Conference was due to be held in August 2019 but was inquorate because only the chair, social worker and health visitor were in attendance. This was during the school holiday and no-one from school 2 attended. A report from the school nurse was circulated prior to the meeting. It was the day after the inquorate Review Conference that Emily sustained the injuries that led to this Child Safeguarding Practice Review.

4.5 Key Practice Episode 3 – Response to Reports of Domestic Abuse

4.5.1 In January 2018, the mother secured a non-molestation order against the father following incidents of domestic abuse. During the social work assessment the mother said that she had taken this out in haste and had been back to Court on 16 May 2018 when it had been revoked.

4.5.2 West Yorkshire Police was called to four reported domestic abuse incidents between the parents over a five week period in March and April 2018. West Yorkshire Police was also called to one incident in September 2018, one in October 2018 and three on one day in January 2019.

4.5.3 In mid April 2019, the mother told practitioners who were working with her that she and the father had separated. West Yorkshire Police was called to three reported domestic abuse incidents between the parents over the next two days and six more between 6 May 2019 and 8 June 2019.

4.5.4 The mother secured another non-molestation order against the father on 14 June 2019. Five days later this was amended to allow father to have contact with his children. Four more domestic abuse incidents were reported after this.

4.6 Key Practice Episode 4 - Response to concerns about Sib 2's behaviour

4.6.1 In March 2018 school 1 raised concerns about Sib 2's behaviour and wondered if he may have ADHD. Sib 2's behaviour continued to cause concern, particularly at school, throughout the period considered by this review and formed part of the Child in Need Plan and the subsequent Child Protection Plan.

4.6.2 A referral was made to CAMHS whose view, based on the information in the referral, was that Sib 2 did not have ADHD. Nevertheless, a joint appointment was offered to Sib 2 and his mother with CAMHS and the school nurse. Three appointments were offered but the mother and Sib 2 did not attend any of these. The school nurse was told by CAMHS that a new referral was required before another appointment would be offered.

4.6.3 At the Initial Child Protection Conference, the school expressed concerns about Sib 2's behaviour at school and the mother said that it was also a problem at home. Problems escalated in June and July 2019; staff at school 2 were struggling to manage Sib 2's behaviour despite considerable extra support, he was excluded from school 2 for individual days on several occasions and by the end of the summer term in mid July 2019, was at significant risk of a permanent exclusion. At the Core Group meeting in July 2019, the Deputy Designated Safeguarding Lead (DSL) from the school stressed that they were extremely worried about Sib 2's behaviour in school and in the home towards his younger siblings.

4.6.4 In June 2019 the mother contacted the police on one occasion and reported that Sib 2 was damaging property in the house. Officers were despatched and were told by the mother that he had damaged his own television. During a home visit, the mother told the health visitor that she was struggling with Sib 2's behaviour and that CSC was considering a temporary foster placement for him. There is no evidence of this in CSC records.

4.6.5 The end point of the period covered by this review was 17 months after concerns had first been raised about Sib 2 and it was suggested that he may have ADHD. However, he had still not had an appointment with CAMHS.

4.7 Key Practice Episode 5 – Agency Involvement with the family from the Birth of Emily until she was injured at six weeks of age

4.7.1 Emily was born in hospital on 9 July 2019 and discharged home with her mother the following day. The following week a Core Group meeting was held in the family home with the social work and the deputy DSL from school 2 present and at the end of that week, school 2 broke up for the summer holiday.

4.7.2 During this period the social worker visited four times with the last visit taking place two days before Emily was injured. All the children were seen on each visit, most were seen on their own and the older children were spoken to. They reported being happy and appeared to be settled with evidence of a good attachment to the mother. They were playing appropriately and when necessary the mother was observed to manage them in a calm manner, using appropriate strategies. The home was clean if a little disorganised and it was noted that decorating was taking place. The mother appeared calm and did not come across as stressed; she reported that her family were supporting her. Emily was observed to look well and was making appropriate sounds. The third of these visits was a joint visit with the health visitor that incorporated a Core Group meeting.

4.7.3 The health visitor also visited the family home on four occasions during this period with the final visit being on the morning of the day that Emily was injured.

4.7.4 The health visitor observed that Sib 4 had a chesty cough and was crying throughout the first visit and at the second visit, Emily was

coughing and appeared to have nasal congestion. The mother told the health visitor that she had phoned NHS111 the previous evening and been given a late evening appointment for Emily but had been unable to attend because the maternal grandmother could not look after the other children at that time of the evening. Also at this second visit, the health visitor noted that Emily's weight had been at the 25th centile at birth, the 2nd centile at day 15 and was now below the 2nd centile.

4.7.5 At the third visit the health visitor also observed that the home was tidy and there were lots of appropriate toys. This was a joint home visit with the social worker and included a Core Group meeting. Emily was heard coughing a few times but was much improved from the previous week. The mother had taken her to A&E and said that she was recovering from bronchiolitis. She was still below the 2nd centile for weight having gained 4-5 ounces in seven days. At times during the visit, the mother seemed distracted by the demands of the older children.

4.7.6 The final visit from the health visitor was on the morning of the day Emily was injured. During this visit the mother said she felt tired but she did not report any low mood or anxiety and maintained good eye contact. Emily presented as clean and suitably dressed and the mother was observed to handle her gently, with warmth and affection observed. Emily's weight was just below the 2nd centile and the health visitor described this as excellent weight gain and documented that she planned to visit again in six to eight weeks time. The health visitor did not see the other children during this visit and the mother stated that they were in bed upstairs.

4.7.7 Five days before this visit, the mother had phoned 999 and reported that the father had been at the home trying to see his children. The police had visited and completed a DASH risk assessment which identified a number of risks, including that the mother was feeling depressed. The health visitor was not aware of this incident when she visited.

5. Analysis

5.1 Introduction

5.1.1 This section contains an analysis of aspects of this case by considering the key themes to emerge.

5.2 Theme 1 - Multi-Agency Working, Focusing on the Needs of the Children

5.2.1 During the majority of the period considered by this review the children were subject either to Child in Need or Child Protection Plans. Therefore, there was a framework in place for organisations to work together in addressing the needs of the family.

Child in Need meetings

5.2.2 The core membership for the Child in Need meetings was the allocated social worker, the allocated health visitor, the deputy DSL from the older children's school and the parents. School nurses in Bradford do not usually attend Child in Need meetings and do not have the capacity to do so. However, the health visitor should have consulted with the school nurse before meetings and fed back afterwards. It is not documented in the record whether such consultation and feedback took place. The mother was pregnant at the time of the first Child in Need meeting and pregnant again when the last two were held. It would have been appropriate to have involved the community midwife in these meetings but there is no indication that this was considered.

5.2.3 Due to there being no records of two of the Child in Need meetings that reportedly took place it is not known who was in attendance. Of the other four Child in Need meetings, the deputy DSL was unable to attend one because it was held during the school summer holiday. The health visitor was unable to attend one held in February 2019. She has recorded that this was because the meeting was rearranged at short notice and also that none of her colleagues could attend in her place. It is not clear whether updates were provided by any other professionals involved with the family such as the health visitor, the school nurse or the midwife.

Initial Child Protection Conference & Child Protection Plan

5.2.4 In addition to the chair, the Initial Child Protection Conference was attended by a social worker, the allocated health visitor (who had only recently started to work with the family), the designated safeguarding lead from school 2 and a police officer. Neither the recently allocated social worker, the previous social worker nor the team manager was present and it is unclear whether the social worker who did attend had had any previous involvement with the family. The recently allocated

social worker did write a report that was shared at the meeting. Apologies were received from both parents; the school nurse, who sent a report and the GP.

5.2.5 No-one from maternity services attended this Conference despite the mother being pregnant at the time. Following a Care Quality Commission (CQC) recommendation, the expectation is that all Child Protection Conferences are attended by the named midwife or a deputy if the mother is pregnant at the time of the Conference. Bradford Teaching Hospitals NHS Foundation Trust has worked to improve attendance at Conferences and has received funding for an additional whole time equivalent post for vulnerable women to support this. Where the named midwife is unavailable, the safeguarding midwifery team will try to attend on their behalf.

5.2.6 As with the Child In Need Plan, the Core Group consisted of both parents, the allocated social worker, allocated health visitor and designated safeguarding lead from the school. Neither the school nurse nor the community midwife was part of the Core Group and as with the Child in Need Plan, there is no evidence that relevant communication took place with these professionals before or after Core Group meetings.

5.2.7 The health visitor did not attend the Core Group meetings in June or July 2019 so the only professionals present were a social worker and the deputy DSL from school 2. Records suggest that the health visitor arrived at the office where the first meeting had been scheduled to take place but it had been moved to the mother's home because she was unable to get to the venue for the time arranged due to being heavily pregnant, having three children to get to school and two pre-school children. The health visitor was not invited to the second Core Group meeting and only found out that it had taken place when she phoned the social worker a few days later. No-one from school 2 attended the Core Group meeting in August 2019 because this was during the school holiday.

5.2.8 The limited attendance of agencies at the Review Conference in August 2019 meant that it could not fully consider the children's safety or what progress had been made with the Child Protection Plan.

Addressing concerns about Sib 2's behaviour

5.2.9 Sib 2's behaviour at home and school was an issue of concern throughout the time considered by this review and was included within the Child in Need and Child Protection Plans. The focus of addressing this was on trying to get an appointment with CAMHS. There is evidence of considerable communication between professionals about this but there appears to have been a lack of overall co-ordination. School nurses took the lead on this and spent a great deal of time trying to facilitate the appointment. Because the school nurses were not involved in Child in Need meetings, child protection conferences or core group meetings there was a lack of direct communication between this two processes. Both schools were actively involved in trying to ensure that Sib 2 had an appointment with CAMHS and deputy DSLs from the schools attended the majority of Child in Need and Core Group meetings. However, there was very little evidence of direct communication between the schools and CAMHS.

5.2.10 The process used to refer Sib 2 to CAMHS was that the school nurse provided the school with SNAP (Swanson Nolan and Pelham tool for ages 6-18 years) forms to complete. These are forms which CAMHS use to see if ADHD is indicated. The school and the mother then completed these forms together and returned them to the school nurse who sent them to CAMHS. On both occasions that the schools were asked to complete SNAP forms with the mother there was a considerable delay before these were returned to the school nurse. The first time was when Sib 2 was attending school 1 and the second was when he was attending school 2. It is not clear why these delays occurred but they resulted in significant delay before referrals were considered by CAMHS and consequently a significant delay before an appointment was offered.

5.2.11 A letter with the date of the first CAMHS appointment for Sib 2 was sent to the mother in October 2018 but this was sent to an address that the family had left two months earlier. This review has been told that the reason the first appointment letter was sent to the incorrect address is that this was the address on SystmOne. The family had moved home approximately two months before the letter was sent and staff from the 0-19 service of Bradford District Care Foundation Trust were aware of the change of address. However, Bradford District Care Foundation Trust 0-19 staff do not have authority to change addresses on SystmOne as this is the responsibility of the GP. Therefore, staff from the 0-19 service advise parents to contact the GP and inform them of the change of address. The letter was returned, unopened, to the service before the

date of the CAMHS appointment but there is no indication that anyone took any action to address this.

5.2.12 After the second missed appointment, the school and the school nurse both liaised with CAMHS and a third appointment was offered for Sib 2 to meet a CAMHS practitioner with his mother and the school nurse on 7 February 2019. The mother did know about this appointment but phoned she school on the day it was due to take place and said she could not attend because Sib 4 was unwell that day.

5.2.13 Given that the first appointment was sent to the wrong address, the mother's actions on the day of the February 2019 appointment and Sib 2 being subject to a Child in Need plan, consideration of another appointment, without the need for a new SNAP form and new referral may have been appropriate.

5.2.14 CAMHS staff have told this review that they were not aware that Sib 2 was subject to a Child in Need Plan when the appointments were offered. There is evidence that the school nursing service had knowledge of the Child in Need and Child Protection Plans but it is not clear that every school nurse was aware of this when speaking with CAMHS practitioners. SystmOne has a facility whereby children can be flagged as being subject to a Child Protection Plan but it does not provide a similar facility for children who are subject to a Child in Need plan.

5.2.15 In 2018 Bradford and District Local Health Economy issued best practice guidance for the management of children not brought to medical appointments. This includes guidance that the secondary care response if a child is not brought to an appointment should include the "Existence of multi-agency plans (Child Protection Plan, Child Looked After, Child In Need) when relevant professionals should be notified of the child not being brought." Ideally secondary care should be made aware at the time of referral if a child is subject to any multi-agency plans. However, on occasion the referrer may be unaware or the multi-agency plan will be instigated between the date of the referral and the date of the appointment. It would therefore be beneficial if the existence of a Child in Need Plan could be identified on SystmOne.

Domestic abuse

5.2.16 The Police responded to 20 reported domestic abuse incidents between the parents during the period covered by this review and three involving one parent and someone else. CSC was notified about the majority of these incidents, as required, but on five occasions this was not done. The reasons for each of these incidents not being referred to CSC have been identified by West Yorkshire Police and appropriate action has been taken to minimise the likelihood of a recurrence. Details of these reasons and the action taken are explained in detail in the West Yorkshire Police report to this review.

5.2.17 The incidents comprised a mixture of physical assaults, threats made over the phone from the father to take their child and/or to physically harm the mother, a threat from the mother to physically harm the father, occasions when the father was outside the house kicking the door and shouting abuse and one reported theft of the mother's bank card. In some cases the mother was recorded as the victim of abuse from the father and in others it was the other way round. The physical assaults involved slight or no injury and as such were dealt with by different patrol staff rather than specialist officers. With the exception of attendance at the strategy discussion and the Initial Child Protection Conference there was no ongoing interaction between the Police and other agencies working with the family.

Maternity Care

5.2.18 The mother gave birth to two babies during the period covered by this review, the first whilst the children were subject to Child in Need Plans and the second whilst they were subject to Child Protection Plans. The social worker did consult with the named midwife when she was undertaking the Social Work Assessment but the midwife was not involved in any Child in Need meetings, did not contribute to the Initial Child Protection Conference and was not a member of the Core Group.

5.2.19 When the mother attended her maternity booking appointment for her pregnancy with Emily she disclosed CSC involvement with the family. The midwife made several attempts to contact the named social worker during February and March 2019 to but they never managed to have a meaningful discussion about the case.

5.3 Theme 2 – Recognising and responding to physical and emotional neglect

5.3.1 The Bradford Safeguarding Children Board Continuum of Need and Risk Identification Tool (April 2019) describes neglect as "The failure to meet a child's basic needs." It states "Neglect can happen over a period of time, but can also be a one off event" and that "it is the cumulative effect that is the most impactful." It identifies five types of neglect: physical, emotional, educational, medical/dental and emotional abuse.

5.3.2 The initial referral that led to this episode of CSC involvement was a clear allegation of neglect but was deemed to be a malicious referral. Enquiries made following receipt of the referral identified concern that the parents had, on occasion, delayed seeking medical help for the children.

5.3.3 The injury to Sib 3's leg was a spiral fracture of the right tibia sustained when she was 5 years of age. The presenting history is that it was sustained when she was play fighting with her brother. The mother did not take Sib 3 to hospital until 10 days later despite advice to do so from NHS 111. There was minimal swelling, Sib 3 was able to weight bear and A&E staff had no concern about the cause of the injury. The hospital safeguarding team was notified of the delayed presentation and made enquiries with CSC who confirmed that the case was not open to them. No referral was made to CSC but School Nursing was notified of the injury. A check found the case was not open to CSC and because there was no concern about the cause of the injury, no further referral made to CSC.

5.3.4 Neither the A&E discharge summary nor the orthopaedic clinic letters made any mention of the delay in presentation as a potential safeguarding red flag for neglect, nor made any mention of an assessment of parenting ability.

5.3.5 It is not uncommon for people to delay attendance at A&E with injuries to themselves or their children. These are usually minor injuries where parents monitor the child at home and when no improvement is noted after a couple of days then they often seek advice at this time. If all delayed presentations of children were reported to CSC this could result in several notifications every week. Therefore it is appropriate for safeguarding specialist nurse to consider the circumstances of individual cases, including what is known about the family. Given the circumstances of this injury and the information available to the safeguarding specialist nurse, it is considered that the decision not to refer to CSC was correct.

5.3.6 The concerns about the mother not accessing medical care more quickly for Sib 3 were addressed in the Social Work Assessment and the social worker was reassured by the mother explanation. However, the explanation is not consistent with the information in the health records. This suggests that the mother's explanation was accepted at face value and may have provided false reassurance.

5.3.7 The multi-agency best practice guidance 'Management of Children not brought to medical appointments' (referred to in paragraph 5.2.15) notes that the terminology 'Did Not Attend' of 'Failure to Attend' when children miss healthcare appointments "does not put any emphasis on the parenting requirement to bring the child." It further notes that "in a small number of cases (the) failure to attend may be detrimental to the child and may also be a missed opportunity for identification of underlying medical or safeguarding concerns." For these reasons, the guidance suggests that the terminology should be changed to 'Was Not Brought' which "puts the emphasis on the issue that the parent did not bring the child."

5.3.8 Section 4.6 of this report describes the response to concerns about Sib 2's behaviour and identifies that he was not taken to appointments that were offered by CAMHS. Similarly, in March 2018, , Sib 3 was not taken to an appointment with Speech and Language Therapy (SaLT) that had been offered as a result of concerns raised by the school.

5.3.9 Notwithstanding the multi-agency 'Management of Children not brought to medical appointments' best practice guidance, neither CAMHS nor SaLT have a written 'Was Not Brought' policy in place at the present time. Bradford District Care Foundation Trust has a Trust wide 'Failure to Attend Appointments' policy which was issued on 30 May 2018 and includes CAMHS service specific guidance. This includes guidance for CAMHS staff about considering the circumstances of the case and the potential risk to the child when deciding what action to taken in connection with the missed appointment. However, it does not emphasise children's dependence on others to bring them to their appointment.

5.3.10 The most recent discharge policy for SaLT is dated 2016 but the service reports that it is common practice in the service that if a child does not attend an appointment, it is recorded on SystmOne as "was not brought

to appointment" and if the child is subject to a Child Protection Plan SaLT contacts the services that are involved with the child.

5.3.11 The Bradford Safeguarding Children Board Continuum of Need and Risk Identification Tool (April 2019) describes Medical/Dental Neglect as:

> *"Failing to provide appropriate health care, including dental care and refusal of care where a child/young person has been diagnosed with a health condition e.g. Asthma, or ignoring medical recommendations and/or persistent not attending key appointments."*

5.3.12 This review shows that although there were occasions when the children were taken for medical appointments, there were other occasions they were not. It suggests that services did not always consider whether the non-attendance might indicate neglect. It further suggests that 'Failure to Attend' policies do not encourage staff to consider neglect.

5.3.13 The Social Work Assessment addressed possible areas of neglect and provided a balanced view of the children's lived experiences. The assessment rightly identified the risk of the children experiencing emotional harm as a result of their exposure to the parents' domestic abuse. The assessment did not identify physical neglect of the children and this review has not found evidence that signs of physical neglect were overlooked. Considering the assessment alongside the Continuum of Needs, the outcome of a Child in Need Plan appears to have been appropriate.

5.3.14 It is well established practice for police officers to record their observations regarding child welfare on DASH assessments. The observations were generally positive about the children's presentation and officers never identified a need to remove the children from their mother's care. The emotional impact, on the children, of domestic abuse incidents between the mother and the father were identified but police did not express any concerns that any of the children were otherwise subject to neglect or abuse or at risk of harm from their mother.

5.3.15 The decision to hold an Initial Child Protection Conference in June 2019 was due to an incident of domestic abuse, not because of increasing concerns about the care of the children. Indeed, prior to this incident of domestic abuse, CSC was working to step the case down to 'Early Help'.

5.3.16 When the children were made subject to Child Protection Plans this was recorded as being due to emotional harm with neglect highlighted. The Child Protection Plan shows that the social worker recommended this category of plan whilst the other attendees at the Initial Child Protection Conference recommended the category of emotional harm. It appears that the concern about emotional harm was due to the domestic abuse between the parents. Areas of neglect are not spelt out but concerns identified in the Child Protection Plan included outstanding health appointments for some of the children, Sib 4 still drinking milk from a bottle which might affect his teeth and the mother not responding appropriately to the children's behaviour at home. In addition, the Signs of Safety summary from the meeting noted problems with school attendance and punctuality and Sib 1 sometimes being dishevelled in school. All of these factors are potential indicators of neglect. It was however, also recorded that there were no concerns about the mother's day to day care of the children, that their basic needs were being met and the home conditions were good.

5.3.17 Records show that over the next few weeks Sib 2's behaviour deteriorated at home and school. At the second core group meeting the children were playing with a hammer at home which raises concern about the level of supervision and potential risk. The health visitor's records of the four home visits she undertook during the school holidays suggest a chaotic home environment where the mother was struggling to meet the varied needs of her six children.

5.3.18 The inquorate Review Conference was held 11½ weeks after the Initial Child Protection Conference and the day before Emily was injured. At that meeting it was recorded that the home was chaotic due to the number of children and that the mother had a limited support network and was struggling to prioritise Emily's needs over the other children's competing demands. The minutes note that the mother was a single parent to 6 children, 3 of whom were under 3 and that whilst she was trying hard, it was a struggle for her to care for so many children. This suggests that concerns about neglect had increased during the period since the Initial Child Protection Conference when it was recorded that there were no concerns about the mother's day to day care of the children and that the home conditions were good.

5.4 Theme 3 - The Response from Children's Social Care to Other Concerns Raised Regarding the Family

5.4.1 The referral that led to the social work assessment was an anonymous contact. Subsequent enquiries suggested that this referral might have been malicious. The enquiries, however, revealed other potential areas of concern that had not been referred to CSC (see Sections 4.3 and 5.3).

5.4.2 During the period covered by this Child Safeguarding Practice Review, West Yorkshire Police notified CSC of 16 domestic abuse incidents that had taken place between the parents. Three of these were received before the social work assessment was completed and were considered within the assessment. Three incidents occurred during the period when the couple were in a relationship and the Child in Need plan was in place and the remainder took place after the couple separated in April 2019, including the one in May 2019 that resulted in the strategy discussion and Initial Child Protection Conference.

5.4.3 The incident in September 2018 is worthy of particular consideration. The police reported to CSC that the father had alleged that the mother had hit him and had also told Sib 2 to punch and kick him. Furthermore, that the father had said that approximately two weeks before this, the mother had said that she felt like slapping Sib 5 when he was crying and not sleeping. Sib 5 was just a few weeks old at the time. The referral from the police noted that the children were highly distressed at the time of police attendance and seemed to be heavily involved in, or witnessing the domestic incidents between their parents. The police assessed this incident as high risk and report that the only reason it was not referred into MARAC was because of the level of agency engagement already being undertaken. A social worker spoke to the parents about this referral and it is recorded that the parents minimised what had happened. There is no evidence of further follow up. Unlike the majority of domestic abuse notifications in this case, this referral included first hand observations of the children being 'highly distressed', and specific allegations linking the children to possible physical abuse. These allegations warranted robust challenge of the parents and consideration of holding a strategy meeting. The record suggests that CSC may have been too ready to accept the parents' minimisation of concerns.

5.4.4 On 18 August 2019, police officers visited the mother after she called and reported that the father had been at her address breaking his non-molestation order. He had left but had been shouting and swearing when she asked him to leave. A DASH risk assessment was completed which identified a number of risks, including that the mother was feeling depressed. A multi-agency referral form was submitted by the police but

CSC has no record of this referral and the health visitor did not know about it. This incident occurred five days before Emily was injured. The health visitor undertook home visits around this time and consistently recorded that the mother did not report any low mood or anxiety.

5.5 Theme 4 - The quality and application of care and support plans and their effectiveness in protecting and supporting Emily and her siblings

5.5.1 The principal care and support plans put in place with the family were a Child in Need Plan that was in place from June 2018 to June 2019 and a Child Protection Plan that was in place from 3 June 2019 and was still in place when Emily was injured on 23 August 2019.

5.5.2 The Child in Need Plans do not provide a clear record of the concerns, what action needs to be taken to address them and what will represent success. This is partly due to the way the pro-forma is set out and partly due to how it has been completed. Many of the outcomes are generalised statements of what should be expected for all children. For example, “children to live in a stable home free from violence” and “children will grow and thrive with appropriate routines and boundaries at home”. There is almost no record of what is to be done to achieve the required outcomes and in almost every case the service provision is simply stated as ‘mother’ or ‘mother and father’.

5.5.3 The Child in Need Pans were updated in July 2018, November 2018 and February 2019 and these show little change from one to the next. This reflects the lack of clarity in the plans and means that one cannot gain an understanding of whether any progress was being made. This problem is exacerbated by the absence of minutes from most of these meetings.

5.5.4 The minutes of the meeting held on 28 February 2019, are brief and built around the signs of safety headings of ‘what is going well’, ‘what are we worried about’ and ‘what needs to happen’. Specific reference is made to both parents and to Sibs 1, 2 and 3 but there is no reference to Sibs 4 or 5 or to the mother being pregnant. There is some overlap between the list of ‘what needs to happen’ and the ‘outcomes’ in the Child in Need Plan but several of the required actions are not carried across to the plan.

5.5.5 It is recorded in the minutes of the Child in Need meeting that the family would be "stepped down to early help once all tasks are completed". The list of what needs to happen does not include any reference to the parents addressing the domestic abuse. Whilst it is the case that no significant incidents of domestic abuse had been reported since the previous Child in Need meeting, there was a long standing history of domestic abuse and the parents separating and reconciling. Domestic abuse was a key reason the children had been made subjects of Child in Need Plans and the agreed action to address this, which was for the parents to engage with MAZE, had not been implemented.

5.5.6 The Child Protection Plan following the Initial Child Protection Conference in June 2019 is more robust than the Child in Need Plans in the sense that for each danger statement there is a clear record of what needs to happen, who is responsible, the timescale and the safety goals/desired outcomes. Where the plan referred to concerns about Sib 2's behaviour, the focus was on the mother having not taken him for CAMHS appointments and needing to do so. There could have been more focus on agencies ensuring that the child received the assessments and services that he required. There is no indication that professionals considered whether family factors were impacting on Sib 2's behaviour even though he was living in a household where there was numerous domestic abuse incidents involving the parents and concern about boundary setting.

5.5.7 Although meetings were held in June, July and August that have been termed as Core Group meetings, there is no indication in the records or from any other source that the Child Protection Plan was referred to during the meetings, that progress with the Child Protection Plan was ever formally reviewed or that the plan was updated as it should have been. In effect the first two of these meetings appear to have been joint home visits by the deputy DSL and the social worker and the third was a joint home visit by the health visitor and the social worker.

5.5.8 At the Initial Child Protection Conference in June 2019 it was reported that the parents had separated. This was viewed as being positive, due to the concerns about domestic abuse between them. However, a worry was identified that when the baby was born the mother would be a single parent with three children under the age of three. This was not explicitly carried over to the Child Protection Plan and no support plan was put in place to help the mother to care for all the children.

5.5.9 The concern that the mother would be a single parent with three children under the age of three did not recognise that within seven weeks of the Initial Child Protection Conference the school summer holiday would begin and that all six children would be at home for six weeks. There is no indication that any consideration was given to how the mother would manage this situation.

5.5.10 One of the actions was for the social worker to explore support networks and family tree with the mother and the children within the next two weeks. It seems likely that this action had been completed by the time of the Review Conference as the record from that meeting refers to the maternal grandmother, a maternal uncle and a friend of the mother, all of whom could provide some support. There is, however, no indication of the amount of support these people were actually providing or the impact this was having. It is of note that the social work assessment undertaken more than 12 months earlier had not considered wider family support.

5.5.11 The Core Group meeting in July 2019 was held at the family home and School 2's record of the meeting makes reference to the children playing with a hammer. Within the meeting the deputy DSL stressed that they were extremely worried about Sib 2's behaviour in and out of school and in the home towards his younger siblings. The mother of Emily was aware that school were looking into possible permanent exclusion for Sib 2. This meeting took place within the first week after Emily was born and just a few days before the school broke up for the summer holiday. It was recorded that the mother was to be referred to a parenting course and the Freedom domestic abuse programme but as before, there is no indication that any consideration was given to how she was going to manage with the children during this period, the risks were not assessed and no support plan was in place.

5.5.12 There was a high level of input from the social worker and health visitor during the school holidays with them visiting the family home three and four times respectively. This included a joint visit during which a Core Group meeting took place. The case recordings suggest there was some difference between their views as to how well the family was functioning over this period with the health visitor noting a chaotic environment where the mother was struggling to meet the needs of all the children. However, there is no indication that the health visitor had significant concerns over the short-term welfare of the children or raised concerns with the social worker.

5.5.13 Concerns about the care of the children increased during the period between the Initial Child Protection Conference and the Review Conference 11½ weeks later. Core Group meetings with the social worker, school, health visitor, midwife and school nurse in attendance and with consideration of the Child Protection Plan may have enabled changes to be made to the Child Protection Plan to address these concerns. By the time of the Review Conference, the mother had agreed for the social worker to make a referral to the Intensive Family Support Team to carry out work on routines and boundaries in the home. The parents' ability to set clear routines and boundaries had been identified as a concern in the original Child in Need Plan more than a year earlier and it is unclear why this had not already been addressed. Furthermore, this was not going to be a quick solution and at the time the problem was the mother was struggling, as a single parent, to cope with six children, including a new born baby.

5.6 Theme 5 – The extent to which the views of the children were appropriately sought and understood

5.6.1 There is evidence throughout the social work assessment of the social worker seeking the views of Sibs 1, 2 and 3 as part of the assessment. This was undertaken when Sib 4 was just over one year old and before Sib 5 and Emily were born.

5.6.2 Following completion of the assessment, social workers saw the children on their own at home and at school as well as observing them within the family. They completed direct work sheets with the children, so there was an element of play within some of the sessions. The record of the Initial Child Protection Conference suggests that since the parents had separated, Sibs 1, 2 and 3 had started to open up to the social worker and at school regarding domestic abuse that they had witnessed.

5.6.3 Sibs 1 to 5 were all present when the first Core Group Meeting was held; Emily had not yet been born. The minutes make reference to how each of the children presented during the meeting and brief comments about their view of school.

5.6.4 Sibs 1, 2 and 3 all attended School 1 and School 2 and were seen regularly by staff within the school settings. There is evidence from both schools of occasions when staff spoke to the children to ascertain their views and, where appropriate raised these with the mother and, on

occasion with CSC. Both schools ensure that the class teacher or another trusted adult is present when a member of the safeguarding team talks to a child. They use Signs of Safety tools, such as 'three houses' to ascertain children's wishes and feelings in a child friendly manner.

5.6.5 The named health visitors consistently made observations of the younger children during home visits. During the school summer holiday of 2019, health visitor 1 undertook four home visits when six children were at home. She recorded her observations of the children and their interactions with one another. There is some evidence of her engaging with the older children to ascertain their views at that time.

6. Previous Serious Case Reviews

6.1 In carrying out this review, the Lead Reviewer has read previous serious case reviews concerning Alice, completed in 2016 and Kieran, completed in 2019. The Lead Reviewer has also read the Bradford Safeguarding Children Board Challenge Panel Outcome Report concerning Non Accidental Injuries and Head Injuries from 2016.

6.2 Three significant findings in the review concerning Alice also apply to this review:

1. Key information was not recorded by Children's Social Care;
2. Key agencies were not represented at the initial child protection conference.
3. The risk to the child was increasing, but professionals were holding on their original decision despite clear evidence that the protection plan was not working effectively.

6.3 Two recommendations from that review also apply to the review of Emily

1. It is crucially important that all key professionals and agencies attend the Initial Child Protection Case Conference. Attendance at this meeting is pivotal in terms of sharing information and knowledge of the child and their family. It is an opportunity for professionals to weigh up all the relevant information, and to make a decision about risk with the full knowledge and understanding that is collectively shared and owned.
2. There needs to be continued awareness raising through professional training and development that highlight the risks associated with

fixed thinking and the need for professional inquisitiveness and challenge.

6.4 The review concerning Kieran found that agencies sometimes had difficulty contacting Children's Social Care staff. It was told that Children's Social Care has made changes to address the issue of people having difficulty making contact with individual social workers. This includes systems that allow managers to override voicemails and access email accounts if staff are absent from work. In addition, a duty system is now in place in each social work team so that practitioners can contact the duty worker if the allocated staff member cannot be contacted. However, practitioners from other agencies are not confident that these changes have resulted in significant improvements. It is suggested that Children's Social Care should ensure that partner agencies are informed that there is now a duty system in each locality team and that the duty officer can be contacted if there are difficulties contacting the named worker.

6.5 The review recommended that:

1. Children's Social Care should ensure that partner agencies are aware of the changes made to contact arrangements for social work staff and the action that should be taken if someone is unable to make contact with the allocated worker within a reasonable timescale.

6.6 This review was told that these same problems sometimes still apply when attempting to contact Children's Social Care staff. The issue has been exacerbated by rapid staff turnover and high numbers of agency staff within the service. Staff should set specific voicemail messages and out of office email replies when they are away from work but this does not always happen. The message to practitioners from all agencies should be to escalate their concerns if they are having difficulty contacting a colleague.

7. Learning from the Review

7.1 As a result of inconsistencies around attendance at meetings and the way meetings were conducted, there was never a clear, shared understanding of the quality of the parenting and the children's lived experiences, including the risk of cumulative neglect

7.2 There were no suggestions within the review period of the children being hit by their mother and no clear indications that any of the children were

at risk of a non accidental injury whilst in their mother's care. However, there was one occasion when Sib 5 was very young and the father told the police that the mother had said she felt like hitting Sib 5. This was not fully explored or risk assessed.

7.3 The parents' separation was viewed as positive because the main concern had been about the domestic abuse in their relationship. However, no assessment was made of the mother's ability to care for her children as a single parent.

7.4 There was no assessment of the likely impact of a new born baby in the household.

7.5 It should have been anticipated that the mother might find it difficult to provide suitable care for all six children during the school summer holidays and a support plan should have been put in place before the holiday.

7.6 Key people were missing from Child in Need meetings, Child Protection conferences and Core Group meetings. Some were not invited and others did not attend. In some instances the non-attendance was due to late changes of meeting date or venue not being communicated.

7.7 All members of a Core Group have responsibility to ensure they are aware of the date and venue for the next meeting. If an individual misses one meeting they should take responsibility for ensuring that they find out the outcome and the arrangements for the next meeting.

7.8 CSC must take responsibility for ensuring that minutes are written of Child in Need and Core Group meetings and that these are distributed to all members of the group whether or not they were in attendance at the meeting.

7.9 Notwithstanding a Child in Need Plan for 12 months followed by a Child Protection Plan for two months there is little evidence of any change being affected. The Child in Need Plans are difficult to follow and do not provide a clear account of what needs to be change and how this is to be achieved. There is no measurement of what has changed. This is due to the pro-forma that is used and how it was filled in.

7.10 The Child Protection Plan is more explicit than the Child in Need Plans in respect of concerns and how these will be addressed.

7.11 Child in Need and Core Group meetings must be used to review the support and protection plans that are in place. There is no indication that this happened in this case.

7.12 Sib 2's behaviour was reported as being difficult throughout the review period but this was never addressed. Possible reasons other than

ADHD were not considered. There was no consideration of whether issues such as parenting and domestic abuse were impacting on his behaviour.

7.13 The referral process to CAMHS was not pursued suitably quickly.

7.14 The process for changing patients' addresses on SystmOne is too reliant on the patient informing their GP that they have moved home.

7.15 'Did Not Attend'/'Failure To Attend' policies are not appropriate for children who are dependent on an adult to take them to an appointment.

7.16 Neither CAMHS nor SaLT had 'Was Not Brought' policies in place which emphasise children's dependence on others to bring them to their appointment.

7.17 Possible indications of neglect were missed when there were delays seeking medical attention and when health appointments were missed.

7.18 The mother's explanation for the delayed presentation of Sib 3 with a broken leg was accepted at face value by the social worker and this may have provided false reassurance.

7.19 CSC did not challenge the parents sufficiently strongly over the incident of domestic abuse in September 2018. Consideration should have been given to holding a strategy meeting in respect of this incident.

7.20 The decision in April 2019 to step the case down to Early Help was not appropriate because the agreed action relating to domestic abuse had not been implemented.

8. Recommendations

8.1. Individual agencies have already made changes to practice which address some of the learning from this review and single agency recommendations within their individual reports. Summaries of the action taken by agencies are included in Appendix 1.

8.2. The Lead Reviewer suggests that Bradford Safeguarding Partnership seeks to assure itself that partner agencies have taken action to address gaps identified in this review. The following areas have been identified. In implementing these recommendations, it is important that agencies focus on practice issues such as observation, analysis, professional curiosity and information sharing; not just on process.

1. All key professionals and agencies attend Child Protection Conferences.
2. Child in Need Plans clearly describe areas of concern, action that needs to be taken, who is responsible, when this will be achieved and the measurement of success.
3. Child in Need Plans are reviewed at all Child in Need meetings and Child Protection Plans are reviewed at all Core Group meetings.
4. Key professionals are members of Core Groups and attend Core Group meetings.
5. Changes in the composition of a household where there is a Child in Need or Child Protection Plan in place lead to an updated social work assessment.
6. Schools seek to put arrangements in place to contribute to Child Protection Conferences and Core Groups during school holidays.
7. 'Was not brought' policies are written and implemented for all health services offering appointments and home visits to children, in line with Multi Agency Best Practice Guidance (2018) 'Management of Children not brought to medical appointments'.
8. Consideration is given to how Child in Need status can be noted on SystmOne.
9. Health professionals who become aware that a family has moved home ensure that relevant professionals are informed of the change of address as soon as possible.

Appendix 1 - Actions Taken by Agencies related to the findings of this review

Bradford and Craven Clinical Commissioning Group

CCG GP actions relating to the findings from the CSPR for Emily.
Actions already taken.
Safeguarding Children training for GPs includes

- CCG GP Safeguarding Children training covers documentation in the child safeguarding node. The training specifically advises making corresponding entries in family members' records as well as making an entry when an adult with parenting responsibilities suffers a significant episode of mental illness/mental distress.

- All GP practices have a Did Not attend Policy and this policy is reinforced within training. In March 2018, the CCG safeguarding team provided all GP practices in Bradford and Craven with model 'Was Not Brought' policies. This policy is promoted in Level 3 child safeguarding training for GPs and at the GP Lead networks. There is also an over-arching multi-agency Was Not Brought policy in Bradford.

- GP safeguarding children training also includes the use of the Multi Agency professional Disagreement Policy and information on the use of this policy.

Use of SystmOne safeguarding children's node.

- Multi-agency SystmOne Safeguarding guidance document has been drafted by a working group from the SystmOne Safeguarding meeting attendees and is currently being edited. This will be completed by February 2021 ready for dissemination to staff. This document supports GPs understanding and use of the safeguarding children node. This includes recording of significant mental illness or severe acute mental distress in adults who have parenting responsibilities.

Contribution of all key professionals and agencies attending Child protection Conferences.

- The CCG have representatives supporting the Multi Agency working group reviewing the contributions and capacity of the School Nurse service ability to attend /contribute to Child Protection meetings and the impact of this on health and CSC.

Actions to take forward:

10. CCG to lead on understanding the mechanisms for address changes on SystmOne
11. To include key learning points from the review for Emily in safeguarding children's training for GP's.

Bradford District Care NHS Foundation Trust

1. Actions Already Taken by Agency and submitted in Agency Report

BDCFT Safeguarding Team have developed and communicated information for staff in the format of 7-minute briefings. These have included

Think Family which includes Silo working
Disguised compliance
Using chronologies to inform safeguarding practice'
Cumulative Harm / Neglect

The briefings have been disseminated to staff as a key message during safeguarding supervision sessions and staff have been signposted to the Safeguarding Intranet page on CONNECT where the briefing can be located. Think Family and chronologies have been disseminated in Safeguarding Level 3 Children's training.

Specialist safeguarding practitioners have also disseminated information regarding the Neglect Strategy and Neglect Toolkit to staff during safeguarding supervision sessions. A PowerPoint presentation was produced and disseminated to the 0-19 service from November 2019 regarding the Continuum of Need following its launch, delivered to 178 attendees.

The Bradford Continuum of Need document (this is the local threshold document) was made available as a resource for attendees to familiarise themselves with and Staff were signposted to the document. The document as available to assist professionals to accurately identify any concerns whilst working with children and has significant guidance around the identification of neglect.

BDCFT Safeguarding Team have also disseminated to staff as a key message during Safeguarding supervision sessions the importance of routine enquiry of domestic abuse. Routine enquiry of domestic abuse is also covered in the coercive control total regime domestic abuse training package which has been delivered by the Safeguarding team since July 2019. This training has been delivered to 373 attendees since this date. Between July-August 2019 the training was delivered to 87 attendees.

BDCFT Safeguarding Team have ensured that the Clinical Records Management Guidance 2020 has been sent to BDCFT Team Leaders to cascade to Staff within the Trust.

2. Areas of Further Action taken in 2020

2.1 Implications of Record Keeping on Safeguarding Practice

During 2020 a guidance document was produced to support staff regarding the implications of their documentation on Safeguarding practice and is relevant to this review. Has been agreed at BDCFT Safeguarding Forum, circulated across BDCFT

Care Groups, communication in Quality and Operational Meetings (QUOPs). Embedded into QUOPS templates. Is also included in the appendix of the Safeguarding Adult Policy and Safeguarding Children Policy to guide staff in their safeguarding practice. Shared as a training resource and as a Key Message in Safeguarding Supervision.

2.2 Review of Safeguarding Supervision Model

The supervision model for registered staff that are caseload holders for children is currently being reviewed. This will align the safeguarding supervision model for case load holders for children to 4 times a year minimum across BDCFT, promoting intra agency groups being 'mixed' i.e., Health Visitors, School Nurse and CAMHS to promote BDCFT information sharing and communication across the staff who may be working with same families.

2.2.1 Plan

The BDCFT Safeguarding Children Supervision Policy is due for update in early 2021 and these changes will be included in BDCFT policy.

2.3 Groups & Relationships/Household Composition

The BDCFT safeguarding team undertook a clinical audit of 0-19 records (2020-21 0734) regarding household composition and the documentation of groups & relationships on the clinical health record (following a SCR Kieran 2018), further audit was completed by 0-19 services and based on data between April – June 2020 the findings indicate there was an improvement in compliance (84%).

2.3.1 Plan

BDCFT 0-19 Children Services intend to
Review SystmOne Guidance to reflect routine enquiry of Domestic Abuse & where & how to record in the health record.
Develop updated staff guidance to support the documentation of Routine Enquiry of domestic abuse & Groups and Relationships.

2.4 Was Not Brought Approach

The Was Not Brought Approach has been re visited at BDCFT. An Info graphic (poster) was reproduced in 2020 with the permission of Leeds Safeguarding Children Partnership, Safer Leeds, and Leeds Safeguarding Adult Board. This has been disseminated throughout the Care Trust, via Care Group QUOPs, Safeguarding Forum, Staff eUpdate Communications and the Safeguarding Intranet Page.

2.4.1 Plan

- Further work is planned in January 2020, to revisit the BDCFT Failure to Attend Appointments Policy to align to The Was Not Brought, Multi Agency Best Practice (2018) Guidance and be formulated as a Trust wide Policy to include failed home visits.

2.5 Training

The Level 3 safeguarding children training product is currently being updated and the participative training product will include the importance of Information sharing and communication within BDCFT services, to include Child in Need, Child Protection,

Was Not Brought Approach, change of address and implications of record keeping on safeguarding practice.

2.6 Safeguarding Children Policy & Procedures
Was routinely updated during 2020, Was Not Brought principles, Info graphic and The Implications Record Keeping on Safeguarding Practice included in this policy.

2.7 Child Protection pathway and School Nurses
A report to the BSCP from the Children's and Young People's System Board in September 2020 described the Impact of Child Protection Work on the BDCFT 5-19 School Nursing Service in July 2020. This provided an overview from BDCFT 0 -19 Service Assistant General Manager and Public Health of the current pressures on the School Nursing Service for Bradford District, why this has occurred and a proposed solution to allow the service to develop its statutory child protection and universal elements. Currently being overseen by BSCP and the Designated Nurse for Safeguarding Children CCG.

2.8 Child in Need Flags
BDCFT Clinical Systems Specialist Children's Services Lead has requested in Nov 2020
A SystmOne TPP request:

- Request 1 – Development of an alert within the system (like Child Looked After and Child Protection Plan) for children subject to a Child in Need Plan – Request number e5f20000
- Request 2 – To have the option to record child 'was not brought' when saving a record Request Number 71130000

This may improve information sharing and communication if documented within the SystemOne Clinical Health Record.

2.9 Change of address
It is acknowledged that the historical agreement that the General practitioner is the only practitioner that can change a child's address on SystmOne requires review. This will be led by the Deputy Designated Nurse for Safeguarding Children in CCG as appears to be a Bradford district wide challenge for all health providers BDCFT 0-19 staff currently update the 'correspondence address' for the child.

2.10 Learning Event October 2020
The report should note that there was good representation of BDCFT staff at the Learning Event from this case. Attended by Health Visitor, School Nurses, Speech & Language Therapist and CAMHS. Each staff member has fed back to their own BDCFT service.

Given work has progressed during 2020 during the COVID:19 pandemic it is difficult at present to provide evidence of the impact on changes. The CSPR recommendations will be monitored via BDCFT Safeguarding Forum and included in the BDCFT Safeguarding Team annual audit plan.

Bradford Teaching Hospitals NHS Foundation Trust

1. All key professionals and agencies attend Child Protection Conferences and key professionals are members of Core Groups and attend Core Group meetings.

There has been a positive change in practice in relation to attendance at Initial Child Protection Conferences since the time of this incident. Following a Care Quality Commission (CQC) Inspection in February 2019 a recommendation was made to ensure that midwives are regularly contributing to the safeguarding process by consistently attending child protection conferences and submitted good quality reports to facilitate decision making and robust safety planning.

Process

Ideally most unborn babies are considered at Initial Child Protection Conference between 29 and 34 weeks gestation following a pre-birth assessment but this can be much later in the pregnancy depending when and why the referral was made. Invitations to all Initial Child Protection Conferences where an unborn baby is being considered are sent to the safeguarding midwifery team. The named safeguarding midwife will notify the named community midwife to facilitate attendance at these conferences. The Local Authority safeguarding administration team has details of all the community midwifery team's. Anything **up to** 15 working days' notice of the meetings is provided. Attendance is dependent on a number of factors such as clinical commitments, leave or being absent from work due to being out on call the night before a meeting. The actions below detail how the Trust supports the midwives to attend.

Actions

- Changes implemented in maternity (continuity / case loading) mean that the midwives caring for the most vulnerable women have a smaller caseload, which will support attendance at child protection conferences, core groups and reviews.
- In early 2020 the formation of a new team to support vulnerable women was implemented.
- In October 2020 an additional full time midwife was added to this vulnerabilities team to assist in meeting the conference requirement.

Safeguarding training

- All trust safeguarding level 3 training includes the themes which have been identified within this review. Trust training is reviewed each month to ensure that it is current and following up to date guidance and best practice.
- The Trust has delivered specialist training around ACE's

Safeguarding checks using CP-IS (Child Protection Information Service)

The Child Protection - Information System (CP-IS) is a system that connects Children's Social Care (CSC) IT systems with those used by the NHS in England. CP-IS gives health professionals the ability to see whether a child is subject to a Child Protection Plan (CPP) , a pre- birth CPP or is a Child Looked After (CLA)

regardless of which local authority the child resides in. In turn, Local Authorities can see where, when and how often a child in their care has made an unscheduled visit to the NHS through emergency departments, minor injury units and other unscheduled paediatric and maternity settings.

This allows staff to trace the patient via the National Spine which will display the child care alert tab if:
• The child is on a Child Protection Plan (CPP)
• The Mother is pregnant and the unborn child is subject to a Child Protection Plan (CPP)
• The Child is Looked After (CLA)

The information shared by CSC will be:

- Type of plan (CPP or CLA)
- Start date and end date of plan
- Local Authority (CSC) name and code
- CSC Emergency Duty telephone number
- CSC office hours telephone number

Each time the Summary Care Record is accessed and there is an active alert the Local Authority will receive information that the pregnant woman/child has accessed an unscheduled care setting. It is therefore expected that the health practitioner shares any child protection concerns direct with children's social care (CSC) using the contact numbers that are detailed on CP-IS at the point of contact and prior to discharge.

Actions-

- **In December 2018 the Trust signed up with NHS Digital to implement CP-IS into the all unscheduled care settings within the Trust.**
- **CP-IS checks are completed in the Accident and Emergency Department, Children's Clinical Decisions Unit and Maternity services. Every child or pregnant mother attending any of these departments for unscheduled care will have a CP-IS check to alert staff caring for them that they are either on a CPP, CLA, unborn is on a CPP or that within the past 12 months they have been subjected to one of the following orders.**
- **Note this does not replace any safeguarding actions or checks with CSC at the time of attendance.**

Bradford Metropolitan District Council, Children's Social Care

There have been changes made within the LCS system for ensuring things like CIN reviews and plans and assessments are more useable documents and direct the social worker to explore the issues raised within the learning (Section 7). Additionally, there has been the production of practice standards and practice guidance on all aspects of CIN/CP planning, when to update assessments etc How to write an assessments and this is all being embedded across the authority.

Additionally we have undertaken an audit of partner agencies attending CP conferences (not CiN meetings) to look at what attendance is like and there is a training programme planned for partner agencies to highlight the importance of attending such meetings.

There has also been an updated supervision policy and a new template for supervision built within LCS to target recommendations and follow up of actions for cases.

There is a new re-structure coming into place in January – streamlining the assessment and long term teams created too much pressure because of the high volumes of cases that come through Bradford's front door and the impact this had on being able to balance assessment and long-term work as a single team – so it is being split again.

There is nothing in the learning / recommendations made that CSC isn't aware of already and the focus on practice guidance / assessments / Section 47's is there – so there is a bridge – but there are competing demands of high staff turnover, high level of referrals and caseloads that make it very difficult to embed.

1. Practice Standards for all aspects of social work have been written and are being embedded within the organisation.
2. There is an LCS (IT) review which is streamlining and developing forms/processes which promotes better recording this includes core group meetings and the conferences. The change in Conference reports is in place, core groups are at the testing stage.
3. There is on-going work between Safeguarding and Reviewing Unit and the Safeguarding Board about representation at meetings; there has been a review.
4. There is a comprehensive auditing process which routinely audits cases and feeds back required changes to practice directly to the social worker and team manager to improve standards. Including targeted audit areas.
5. There is greater emphasis for challenge from the CP chairs – improved by the appointment of a designated CP Team Manager
6. The screening for ICPC's has been streamlined; with greater emphasis on the CP Chair having oversight
7. There is an overview of training taking place which will target specific training areas for social workers / team managers (this includes Section 47 training).

The senior management team are also in constant dialogue with CAMHs in regard to services on offer and waiting lists for the children we serve.

In respect of the recommendations

1. All key professionals and agencies attend Child Protection Conferences.

This is a collective responsibility – but from CSC perspective there has been an audit undertaken in regard to the contribution of partner agencies within the CPC process, following this training is being reviewed to build upon partner agencies understanding – due to be presented at the board in February. Alongside this, CSC are adapting their LCS process to have clearer recording of which partner agencies attend to enable greater overview and improved communication with the Board.

2. Child in Need plans clearly describe areas of concern, action that needs to be taken, who is responsible, when this will be achieved and the measurement of success.

There has been an LCS overhaul of all the plans for children open to CSC, to make them more user friendly and clearer in terms of actions and outcomes. It is too early to fully tell what the impact is as we are in the 'go live' phase and this means that we are looking at any snagging that occurs when new IT process go live. However all plans are audited under the thematic approach undertaken by the auditing team.

3. Child in Need plans are reviewed at all Child in Need meetings and Child Protection Plans are reviewed at all Core Group meetings.

As above – there has been an LCS overhaul of CIN and CP reviews, as well as a plan to ensure that core groups are signed off by a team manager to improve the quality of what is written within the meetings. CIN meetings already have a team manager sign off. There has also been a complete production of Practice Standards, the Practice Standards are being embedded across CSC within individual areas as Practice Standards are the basis for all work provided by CSC as well as the benchmark for all auditing work of cases. The auditing team does thematic audits and reports on the quality of work to the strategic management group in regard to files and work undertaken on cases. Thus it is another measure of quality and compliance.

4. Key professionals are members of Core Groups and attend Core Group meetings.

The key members for core groups are identified at the CPC, and always have been so there is no change to this. Attendance at core groups is a collective responsibility, but from CSC perspective the format for reporting on LCS has improved and feeds into the response for Q1.

5. Changes in the composition of a household where there is a Child in Need or Child Protection Plan in place lead to an updated social work assessment.

The single assessment has also been updated within the LCS project, the whole assessment is now updated for each review or every 6 months (or when needed) as cited within Practice Standards. Again the changes within LCS are in its infancy and we cannot report of the success or not. However as cited above, assessments are a key area for the auditing team and there is a drive to improve practice.

Bradford Metropolitan District Council, Education Safeguarding

School 1 and School both provided full CPOMs (safeguarding) records for the children whilst they attend their respective schools, these included the concerns and the actions carried out by staff. They have engaged well with the process of the safeguarding review and provided staff members to be available for meetings and discussions as part of this.

Since the children attended School 1, they have now employed a school based social worker who works with children and their families in addressing safeguarding concerns.

School 2 have been proactive in ensuring that when they break up for holidays, the contact details of the DSL are shared with all social workers involved with their children, to ensure that they have a point of contact if any significant safeguarding concerns arise outside of term time. The Safeguarding team's out of office email reply also provides contact details for the DSL who s contactable via phone outside of school hours.
Both schools are accepting of providing a written update for the purposes of CIN and CP reviews, where these occur outside of term time.

West Yorkshire Police

Two areas of learning are suggested:

i. In order to ensure that information about attendance at domestic incidents is shared with partners in all cases Bradford District Senior Leadership Team (SLT) will communicate to supervisors the need to confirm that the domestic abuse Niche template has been completed and if not to ensure that this is done and appropriate referrals made when finalising domestic abuse occurrences;

This action was completed by BD SLT September 2020. An Acting Superintendent requested for a reminder to be sent out to all supervisory staff and the new domestic abuse template was to be used when finalising domestic abuse (DA) occurrences to show that additional considerations had been made.

ii. That DAU staff are advised that where a notification is received from another District that a domestic abuse incident has occurred in that other District and there are children in the family resident in the Bradford District the reviewing staff member confirms that notification to social care has taken place and if not undertakes that task;

This has been taken as a Force issues, it has been recognised from the learning in this case and following an additional dip sample conducted in September which identified that there was areas for improvement around cases where cross districts were involved @ action 3 below. that this may occur in other district areas and therefore the Central Safeguarding Governance (CSGU) Team are working on implementing the following process and updating the Force policy in relation to this area and endeavouring to future proof this for when the new PPN (public protection notices come into force). From our CSGU specialist; We are about to add a dedicated section into the DA policy to make it clearer around referrals to Children's Social Care.

Basically we propose to reinforce in the policy that districts will ensure that Children's Social Care (CSC) are notified (in line with local multi-agency processes) of <u>all</u> children present at or living in a household where DA has been reported, regardless of DASH (Domestic abuse stalking and harassment) risk grading. This is already happening, as I have been advised by each district, although slightly different mechanisms and processes for doing so.

The policy already covers the need to make a formal referral to CSC where there are certain criteria, for example, a child is injured, a child is used as a shield, the victim is pregnant etc. It also asks for attending officers to consider police protection where it is believed that the child will suffer immediate significant harm. Whilst this is already captured, we wanted to add it to a dedicated section within the policy and also remind officers of the need to document children on the DASH, speak to them and accurately record their demeanour, school, GP etc..

Public Protection Notices (PPN) is a Niche functionality which works alongside Pronto to ensure that officers and staff can submit timely concerns to Social Care via

their handheld devices and/or Niche. This process ensures a consistent approach across the force but is also a simpler and more effective process for officers and staff. The current PPN module on Niche has the ability to share concerns with Social Care for several areas of safeguarding, for example Adult at Risk, Child Concerns, Domestic Abuse, Stalking and Harassment and Honour Based Abuse.

When using PPN, an occurrence is created on Niche which documents the notification, ensuring a consistent and auditable mechanism for sharing concerns with social care. However, at the moment, we have only gone live with Adult at Risk and Child concerns in Calderdale District – not DA. We are currently evaluating the pilot and hope to produce the findings in early February, once we have 3 months of data (at the end of January.) Once the report is finalised we will be sharing with Districts to discuss opportunities to consult with partners.

When we expand this to domestic abuse, the DASH risk assessment is completed via PPN where there are children present, this would then allow officers to submit the notification of the domestic incident to children's social care whilst at the scene. Again, this would all be recorded on Niche.

The challenge with PPN is that we need to have the buy in from partners, which may take some time. The feedback we have received in Calderdale, which will feature in the report, has been really positive, particularly around the quality of the notifications they receive and the standardisation of the process.

A 3rd area of learning was also identified and can be detailed as below;

iii. That the Safeguarding Central Governance Unit repeat the dip sample process in September and confirm that reports are being properly referred.

A dip sample of 20 occurrences was carried out 15/09/20 and 24/09/20. It found that 13 were endorsed with the template and showed a notification to CSC. Of the remaining seven the following circumstances were found:
Summary:

1. Two supervisors have agreed that individual omissions were oversights on their part. Both are acting sergeants with around four years' experience at the time of reviewing the occurrences (one joining June 16 and one November 16). A third supervisor who was tasked but did not create a template who has not been contacted yet has similar experience, having joined in March 16. This appears to be an issue of new and relatively inexperienced supervisors learning procedures while in acting roles and a product of the Force's current demographic;

2. One report was as the original circumstances – created Calderdale District and re-allocated to Bradford District where dealt with by DAU who assumed referrals would have been made by the attending response officers;

3. In one report a supervisor made an active decision not to notify. This does not appear to be contrary to policy;

4. Two occurrences were not tasked by the attending officer to their supervisor although they were tasked to Bradford District Safeguarding partnerships (attending officers similarly experienced as above).