Local Child Safeguarding Practice Review

‘Ava’

OVERVIEW REPORT

October 2023

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Acknowledgements

Governance

The author can declare that he has no conflict of interest in completing this review, and that he is independent to Cambridgeshire and Peterborough Safeguarding Adults and Children Partnership Board and partner agencies. The report has been commissioned by, and written for the Partnership, and overseen by a multi-agency child safeguarding practice review panel of local senior managers and practitioners from the following agencies:

- Children Social Care, Cambridgshire and Peterborough
- Cambridgeshire Constabulary
- Cambridgeshire and Peterborough ICB
- CAFCASS
- Cambridge University Hospital NHS Foundation Trust
- National Probation Service
- Cambridge and Peterborough Foundation Trust
- Cambridge Local Authority, Education
- Cambridgeshire Community Services NHS Trust
- North West Anglia NHS Foundation Trust

The details of the child and their family, as well as the individuals providing care to them, have been anonymised in accordance with statutory guidance and best practice.

Contents

1.0 Introduction

1.1 This Local Safeguarding Children Practice Review (LSCPR) focuses on Ava. Ava is a 2-year-old girl who was discovered in a neglected condition, as was Ava's 8-year-old sibling, in March 2022 by Police who had been asked to undertake welfare visit.

1.2 The review has been commissioned by the Cambridgeshire and Peterborough Safeguarding Children Partnership in accordance with statutory guidance[1] which states that where a child dies or is seriously harmed in an area and it is known or suspected the child has been abused or neglected, the Local Authority for that area must notify The National Child Safeguarding Practice Review Panel.[2] A rapid review meeting will be convened by Safeguarding Partners for that area and as well as identifying immediate learning and action, a decision will be made on whether a Local Child Safeguarding Practice Review is required.

1.3 The Rapid Review process is to gather the facts about the case, as far as they can be readily established at the time, to discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately. To consider the potential for identifying improvements to safeguard and promote the welfare of children and to decide what steps they should take next, including whether or not to undertake a child safeguarding practice review[3].

1.4 The National Safeguarding Review Panel recognise that a well-conducted rapid review can form the basis of an LCSPR and, in some cases, may avoid the need for an additional lengthy review which may result in only limited additional learning[4]. In this case the Rapid Review group identified that there was learning for the Partnership to be achieved from the case.

1.5 The Rapid Review identified that there were a number of areas which had been repeated from previous reviews, where there had either been development or where there were plans to address them. The Rapid Review proposed that the review should be progressed as a strategic workshop with agencies to discuss the recurring themes, what measures could be initiated to address them. The areas identified were:-

- The Recognition of and effective response to cases of neglect
- A change in family dynamics due to new partners and insufficient enquiry into this
- A lack of consideration of the previous family history
- Insufficient credence and enquiry made with regards to concerns raised by third parties
- How covid affected contact with the family
- The lack of strategy discussion/meeting leading to an uncoordinated approach
- Confusion over Child Protection and sexual assault medicals

[1] Working Together 2018, HMG
[2] Section 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017)
[3] Working Together 2018, HMG
[4] National Safeguarding Children Review Panel, 2022, Child Safeguarding Practice Review Panel guidance for safeguarding partners

1.6 Before the reflective workshop could be undertaken another case was referred to the Rapid Review group. This referral involved a 5 week old baby who had admitted to hospital with bruises. Following a Child Protection medical and skeletal survey a rib fracture and two leg fractures were identified. The case was deemed not to meet the criteria for a LSPCR in it's own right but there were similar learning themes identified in the case of Ava.

- Use of pre-existing policies or procedures, in this case pre-mobile baby bruising protocol
- Consideration of new partners on family dynamics
- Consideration of family history in decisions and assessments
- Consideration given to third party referrals.
- Convening of strategy meetings/discussions and the appropriate attendance at the meetings.

1.7 A facilitated strategic workshop took place in November 2022. Where relevant the areas of discussion at the event were followed up with agency or individual interviews.

2. Ava – an overview

2.1 Ava is one of five children, there are three different fathers. The older three children (aged between 20 and 12 years of age) have the same father. Ava's older sibling B, who resided with her, has a different father to Ava.

2.2 When Ava's sibling, B was born in 2014 the family was supported by a Child in Need Plan. This support lasted around four months and was closed as positive progress had been reported.

2.3 Ava was born in April 2020, this was during the first national lockdown due to the covid pandemic. The ante natal contact was by telephone due to the restrictions imposed by the national lockdown and therefore there was no assessment of the home environment. This continued after Ava's birth with the new birth contact and 6-8 reviews also being conducted by phone.

2.4 In September 2020, Ava's mother reported finding material on her partners phone which indicated that he had engaged in a sexual relationship with a person aged under 14 years. He was charged with sexual offences, including rape offence and making indecent images. A referral was made to Children Social Care (CSC). A Child and Family assessment was undertaken, completing in October 2020, with a recommendation that the children were supported under Early Help. The rationale for this was that the father had left the home and there were bail conditions, which supported this. The assessment did not consider any aspects of potential neglect and was focused on the father.

2.5 In December 2020, the school which Ava's sibling attended reported concerns of extremely poor home conditions, potential parental substance misuse and neglect of the children. A further Child and Family Assessment was completed, which highlighted that Ava had not been registered with a GP. This had been recognised by Health Visiting but attempts to contact the parents had not been successful. There was also a concern that the father

had returned to the family home. There was recognition that Ava had not been seen by a professional since birth due to Covid restrictions but it appears that this was not addressed. The assessment was closed on the basis that the mother would supervise all the contact between Ava and the father.

2.6 In January 2021, the Heath Visiting service noted that there had been no contact with the family since the 6-8 week phone contact and Ava remained unregistered with a GP. The case was allocated to a Health Visitor for a visit and discussion with CSC.

2.7 In February 2021, CSC received an anonymous referral reporting extremely poor home conditions and that there were concerns regarding the parents relationship. The referral was reviewed by a Team Manager in the MASH who recorded that the case had recently been assessed and reflected that the report may be malicious. It is unclear what the rationale was for this assertion, and none is recorded. There was no further action taken.

2.8 The Health Visiting service spoke with CSC and confirmed that the case was closed to them and that the mother did not wish to engage with Early Help.

2.9 In March 2021, Maternity Services were involved with the mother when she attended hospital having suffered a miscarriage at a reported gestation of 20 weeks. There was no previous record or booking with Maternity Services or the GP for this pregnancy. The mother was supported by the bereavement midwife. During this episode there is no evidence of liaison between the midwife and health visiting service. There was no consideration of the sibling or wider family context. There was no consideration of the father, his ongoing case for sexual offences or any risks associated with this although the information on potential child sexual abuse was apparent on Systm one[5].

2.10 The Health Visiting service continued to try to make home visits for Ava's 10-12 month checks. There had still been no registration with the GP. The case was discussed with Health Visiting allocations, and it was agreed that there would be a further visit attempted at the end of March 2021. There was telephone contact at the end of March 2021, the mother informed the Health Visitor of her bereavement, which the Health Visitor had not been aware of, and she stated that she was being supported by the bereavement midwife. There is no evidence of further discussion with the GP at this time.

2.11 In mid May 2021, The Health Visitor discussed the case in supervision. Lack of observation on Ava possible neglect, potential risks from the father, no registration with a GP and no immunisations, were all discussed. The decision from this supervision was to discharge the case from the Health Visiting caseload back to universal service. A letter was sent to the parents advising that there would be no further appointments offered and advising registration with a GP. The letter stated that it would be copied to CSC but there is no record of this happening.

2.12 In mid-November 2021, the sibling B's school made a referral to CSC concerning presenting with indications of neglect and that B was undertaking a primary care role for their

[5] Systm One is a clinical computer system which lets NHS staff record patient information securely onto a computer.

baby sister, Ava. The case was allocated to a social worker. The health representative in the MASH recommended a section 17 assessment if the parents consented and if not that there should be a strategy meeting. There were over 6 home visits attempted but there was no response and children were not seen. There was no CSC oversight on this until mid-December, which stated that there should be a section 17 assessment but if entry could not be achieved at the address a strategy discussion should be convened.

2.13 In Mid-January 2022, a social worker from CSC was able to get a response from the mother at the home address. The mother was spoken to at the front door but access to the house was not gained and the children were not seen. Two weeks later a referral was received from police that there was drug dealing taking place at the address. A visit which gained access to the address was made by a social worker. The house was seen to be in a very poor condition. There was no electricity, hot water or heating. It is not clear whether the children were seen. There was a room that the social worker was not able to gain access to as the mother stated that it was locked and she did not have a key.

2.14 On the same day as the visit a strategy discussion was convened. The concerns discussed were the children being exposed to neglect, poor adult mental health and adult criminality. There was a history of non-engagement by the mother. Ava remained unregistered with a GP and had cancelled numerous home visits requested by professionals.

2.15 The day following the strategy discussion a CSC child practitioner visited the home to complete work on finances and home conditions with the mother.The home conditions were found to be very poor. The sibling B was seen but it is not recorded where this discussion took place. B shared that everything was messy and she was scared of the dark, that the house was cold and when the father was in the house he shouts.

2.16 A week after the home visit there was an Initial Child Protection Conference (ICPC). The meeting heard that Ava had not been seen by a Health Visitor since birth. The sibling B had poor school attendance and frequently presented with signs of neglect. The mother acknowledged that her mental health had deteriorated since her miscarriage and she was on anti-depressant medication. The house was said to be uninhabitable. The father was still under investigation for sexual offences against a child and there were currently no restrictions on his access to the children. Ava was placed on a Child Protection Plan under the category of neglect. The plan included the completion of Graded Care Profile[6] (GCP). Health Visiting services to complete an assessment and to support GP registration. The father was not to stay at the home address and access to the children should be supervised by the mother. At the time of the conference the children had not been seen for two weeks and this was not acknowledged.

2.17 Following the ICPC two home visits were attempted by CSC which were unsuccessful but this did not initiate any escalation. On 23rd February 2022, a week following the ICPC, the school reported that the sibling B had attended school with a bite mark, which they stated was caused by Ava. The school requested a further strategy meeting but this was declined by CSC on the basis that the allegation was that the mark was caused by a child and not an adult. Ava was not seen by a social worker.

[6] Graded Care Profile - An assessment tool to help identify and measure risk of neglect .

2.18 In the following days four visits were made to the address by CSC with no access gained and numerous phone call were made to no avail. At this point Ava had not been seen since 8th February 2022. On 2nd March 2022, CSC requested police to undertake an urgent safe and well visit. On attendance the police found the home conditions in a very poor state. Ava was found in a neglected state, both Ava and her sibling were protected by a police protection order and the mother and father, who was present, were arrested for child neglect.

2.19 On admission to hospital Ava was found to have sores from a lack of care and nappy changes and urine burns. Both children were found to be very hungry.

3.0 Case Discussion

3.1 Some of the areas of learning are identified directly from this case and recommendations for development are recommended from this. There are other areas which formed part of the wider strategic discussion that followed this case, and another case coming to the attention of the case review sub-group.

3.1.1 - Information sharing

The ante-natal care was undertaken by phone due to the covid pandemic and due to this there was no face-to-face contact with the mother or an assessment of the environment. The mother suffered a miscarriage in March 2021. The Health Visiting service was not aware of this and was continuing to try to achieve a health check for Ava. This only became apparent when it was disclosed by the mother.

Recommendation 1
The agencies providing ante-natal care and health visiting services in Cambridgeshire and Peterborough should ensure that there is clear communication between the services, this should include significant events.

3.1.2 – Assessment

There had been a family history of neglect and the mother struggling to cope which resulted in CSC involvement. The eldest three children were moved to the care of their father in 2014 as a result of a family arrangement which was supported by CSC. Very soon after this the sibling B was born and the involvement with the family under Child in Need ended as it was considered that there had been positive progress made.

Prior to Ava's birth a referral was made by health to CSC due to the family history. This did not result in a pre-birth assessment. The Cambridgeshire and Peterborough Pre-birth Protocol show as a criteria for referral *'A parent has had a child previously removed from their care or has a child voluntarily accommodated'.*

Once Ava was born concerns were raised, these included the father being charged with offences of sexual activity with a child and Ava not being registered with a GP. CSC undertook an assessment which focused on the father's criminal investigation and did not consider the previous history of neglect.

The case was closed and the decision made that Ava would be supported under Early Help on the basis that the father was not in the home due to bail conditions. The Early Help was not accepted by the mother. There was an over reliance on the bail conditions. Due to changes in the time that bail can be kept[7] in place it is unwise to rely on bail conditions alone

[7] Policing and Crime Act 2017 – limited bail conditions to 30 days, extendable by a senior police office to 3 months.

as being a long-term measure to limit contact and if used this should be reviewed at regular points.

There was a further opportunity for meaningful assessment in December 2020, when a referral regarding neglect was made by the school reporting extremely poor home conditions, potential substance misuse in the home and a concern that the father had returned to the home. Another Child and Family Assessment was undertaken by CSC, this highlighted that Ava was still not registered with a GP and that Ava had not been seen by a professional since birth (6 months earlier). This assessment was closed on the basis that the mother was to supervise contact with the father. Again there was not a focus on the neglect in the home.

There was too much reliance placed on what the mother was telling professionals, without the children being seen. There was no enquiry with the police on the current position on the investigation into the father, a lack of consideration of the historical information and lack of enquiry into the levels of neglect.

'Assessment is a dynamic and continuous process that should build upon the history of every individual case, responding to the impact of any previous services and analysing what further action might be needed.[8] *'*

Recommendation 2
Cambridgeshire and Peterborough Children Social Care should ensure that Child and Family Assessments consider and address all areas of concern and fully consider the relevant history of a case. Assurance should be achieved by focused audit activity.

3.1.3 – Management oversight

There were instances in agencies where clear management oversight was lacking. In May 2021, the Health Visitor had 'ad hoc' supervision where they were advised to write to the mother and inform her that there would be no further attempted visits and to include CSC that this had been done. This was set against a background of the mother not engaging, Ava not being registered with a GP and not being seen since birth. This was a missed opportunity to escalate the case by making a safeguarding referral.

In December 2021 there was CSC management oversight which stated that should visits continue to be unsuccessful that a strategy meeting should be considered. This lacked clarity and timescales. As a result, there were numerous unsuccessful visits with no decisive action.

In January 2022, a strategy discussion did take place where it was stated that should CSC still have difficulties gaining access to the property to see the children they should request a police welfare check. The position stayed the same with numerous unsuccessful contacts and yet a welfare visit was not requested until early March 2022.

A lack of authoritative practice[9] has been recognised recently in two previous Safeguarding Practice reviews[10].

[8] Working Together ,2018 HMG

[9] Authoritative practice places the child's needs as paramount and involves challenging service provision on behalf of the child.

[10] LSCPRS into the case of Stephen (2022) and case of Chris (2022), CPSCP website

Recommendation 3
All agencies should ensure that there is in place effective management oversight, which is recorded with clear timescales and where appropriate, escalation. The management oversight should encourage a curious and authoritative child centred approach.

4.0 Strategic Discussion on repeated themes

4.1 Strategy Discussions and meetings

4.1.1 Previous reviews both locally and nationally have identified that there has been a more recent trend for strategy discussions or meetings not to be convened and where they are convened that they often do not have all the necessary agencies represented to effectively discuss the case.

4.1.2 In this case a strategy discussion did not take place until January 2022, there were previous opportunities for this to happen which would have allowed agencies to determine Ava's welfare and plan rapid future action.
In December 2020, there was reason suspect that Ava was likely to suffer significant harm, if that was not already the case.

4.1.3 The case that was noted as being similar to this one also featured the lack of a timely strategy discussion. Also, locally the recently published Local Practice Review in the case of Child D, identified the lack of a timely strategy meeting[11].

4.1.4 Nationally the cases reviewed by the Child Safeguarding Practice Review Panel in their report into two cases identified that:

'*The opportunity for professionals to consider information altogether and see the bigger picture was also missed in both cases when Strategy Meetings were not held.*[12]'

The reason for this decline in the discipline of convening and attending strategy discussions was explored and it was thought that it may be a perverse side outcome of the development of more integrated multi agency working environments where 'corridor conversations' between agencies overshadowed the necessary and vital strategy discussion.

Recommendation 4
All agencies in the Cambridgeshire and Peterborough Safeguarding Children Partnership should ensure that the necessity for timely strategy discussions is re-enforced within their agencies. The process within the Integrated Front Door and MASH should reflect this. The Partnership should audit this on a 6 monthly basis until there is confidence in good and safe practice.

4.2 Third Party Referrals

4.2.1 In reviews there is often reference to 'anonymous referrals', and further enquiry into these sources of information often reveal that the source is a family member, neighbours or another person close to the family, not wishing their identity to become known to the subject of the referral. There should be a careful use of language to both protect the source of the

[11] LSCPR Child D, 2022, CPSCPB - https://www.safeguardingcambspeterborough.org.uk/download/child-safeguarding-practice-review-child-d-overview-report/ (accessed 25/01/23)
[12] Child Safeguarding Practice Review Panel, 2022 – Child Protection in England – A National Review into the murders of Arthur Labinjo-Hughes and Star Hobson

information but also to indicate the credibility it deserves by not dismissing the information as anonymous or malicious.

4.2.2 This again has been recognised both locally and nationally in reviews. In the Cambridgeshire case of Stephen[13] it was recognised that '*the response to neighbours' escalating concerns about the children was not sufficiently robust, reflecting previous findings from a national study that 'insufficient weight is given to concerns raised by neighbours' (Brandon et al., 2020:70*)
This theme was also seen in the similar case discussed where an 'anonymous' referral was made that the father was shaking the baby.

4.2.3 Often information passed on this basis is dismissed as malicious as it was in this case, although there was no rationale given. The National report into Child Protection made a recommendation that:
'No referral is deemed malicious without a full and thorough multi-agency assessment, including talking with the referrer, and agreement with the appropriate manager '

Third party referrals should not be dismissed but should be used as part of the holistic assessment of a case. Where there is an ability to develop the information, to enhance it and add credibility to it, this should be taken.

Recommendation 5
The Cambridgeshire and Peterborough Safeguarding Children Partnership should ensure that the significance of third-party information is recognised in protocols on receiving information. The Partnership should audit the theme of cases involving 'anonymous' referral to understand how this information was managed.

4.3 Partners in the relationship

4.3.1 Both locally and nationally there has been a recognition that partners in relationships, particularly men, are often not considered effectively when assessing the needs of a family. In the previous Cambridgeshire and Peterborough LSCPR case of Stephen, it recognised that where there is a change of partner this can significantly alter family dynamics and risk, and this should be considered.

4.3.2 In this case the partner was known to agencies but the consideration of risk did change when he was arrested and charged with sexual offences against children. The initial response to mitigate any risk was to rely on police bail conditions (already discussed). A responsibility was put on the mother to supervise any contact. It was recognised that the mother did not have a family network on which she could rely. Information was then received from the sibling that the partner was back at the address (December 2020). This was addressed again by placing the emphasis on the mother to supervise contact.

4.3.3 The National Child Safeguarding Review Panel's report on the Myth of Invisible Men concluded in part that:
'*One of the consequences of the failure to routinely find, engage and assess men is that the protection of children to whom they present a risk often falls on mothers. Too often mothers are left to manage those risks on their own and are faced with the potential or real removal of their children'*

[13] LSCPR into the case of Stephen, 2022 - https://www.safeguardingcambspeterborough.org.uk/children-board/serious-case-reviews/ (accessed 25/01/23)

In this case there was an ineffective response to the potential risk that the partner may present. The Cambridgeshire and Peterborough Safeguarding Partnership need to prioritise a greater understanding on partners in relationships and how significant changes in relationships during pregnancy and the life of young children may impact on the safety and wellbeing of the child and wider family.

Recommendation 6
The Cambridgeshire and Peterborough Safeguarding Children Partnership should prioritise across its membership the learning from recent reviews which highlight the need to understand and be professionally curious about changes in relationships.

4.4. Re-occurring learning themes

4.4.1 At the strategic workshop the discussion focused on cases where we see well established processes, procedures and policies not being routinely considered (examples of which are Pre-birth protocol, Graded Care Profile (GCP) and Bruising Policy on pre-mobile babies). The Partnership wished to gain an understanding on why of key procedures were not being followed.

4.4.2 There was a recognition that there had been a higher turnover of staff than previously and that some areas, in particular areas of Children Social Care, carried a higher number of agency staff than before. That said it was recognised that the staff were qualified staff and should be aware of core functions, even if not fully conversant with local procedure. The discussion sought ways which could assist staff with orientation when joining Cambridgeshire and Peterborough.

4.4.3 There was a strong feeling that the reduced face to face contact between professionals that was a symptom of covid pressures had led to more strained inter-agency relationships and communication, which was on occasions disrespectful. A starting place in addressing some of these concerns was to seek to re-commence face to face meetings where it is appropriate and operationally possible. It is recognised that this is not always possible, and the growth of virtual meetings has also presented benefits.

4.4.4 The Partnership should focus on how key information can be given effectively to new members of staff. This could be achieved by providing a partnership induction pack with key information and signposting and a partnership induction briefing (sway), which should include the key areas of development and learning identified from LSCPRs.

4.4.5 Where there is some confusion over the use of a particular procedure across the partnership, for example GCP, the position should be clarified. There is other work currently ongoing to assist practitioners with other approaches such as joint health/CSC workshops on pre-mobile bruising protocol and work on the GCP with the neglect strategy.

Recommendation 7
The Cambridgeshire and Peterborough Safeguarding Children Partnership to develop a partnership staff induction pack (sway), which includes recent key learning from reviews.

5. Conclusions

5.1 This case raised concerns regarding the individual circumstances of the case and wider concerns as to why the Partnership continues to see some repeating areas for development. The strategic discussion has sought to better understand why these may occur. Apart from the specific recommendations made, it is incumbent on all agencies within the safeguarding partnership to familiarise themselves in their repeating themes and ask themselves how these can be reduced in their own agency. This may be by using this and other cases to highlight areas, undertaking specific audit, or increasing and ensuring effective management oversight.

The Partnership should focus on how these important areas of re-occurrence can be readily communicated to professionals and in particular new staff to Cambridgeshire and Peterborough. A suggested example is below.

Strategy meetings – convene, timely and effective.

Third party information

Other Partners

Pre-birth protocol

Pre- mobile bruising protocol

6. Recommendations

Recommendation 1

The agencies providing ante-natal care and health visiting services in Cambridgeshire and Peterborough should ensure that there is clear communication between the services, this should include significant events.

Recommendation 2

Cambridgeshire and Peterborough Children Social Care should ensure that Child and Family Assessments consider and address all areas of concern and fully consider the relevant history of a case.

Recommendation 3

All agencies should ensure that there is in place effective management oversight, which is recorded with clear timescales and where appropriate escalation. The management oversight should encourage a curious and authoritative child centred approach.

Recommendation 4

All agencies in the Cambridgeshire and Peterborough Safeguarding Children Partnership should ensure that the necessity for timely strategy discussions is re-enforced within their agencies. The process within the Integrated Front Door and MASH should reflect this. The Partnership should audit this on a 6 monthly basis until there is confidence in good and safe practice.

Recommendation 5

The Cambridgeshire and Peterborough Safeguarding Children Partnership should ensure that the significance of third-party information is recognised in protocols on receiving information. The Partnership should audit the theme of cases involving 'anonymous' referral to understand how this information was managed.

Recommendation 6

The Cambridgeshire and Peterborough Safeguarding Children Partnership should prioritise across its membership the learning from recent reviews which highlight the need to understand and be professionally curious about changes in relationships.

Recommendation 7

The Cambridgeshire and Peterborough Safeguarding Children Partnership to develop a partnership staff induction pack (sway), which includes recent key learning from reviews.

An action plan will be developed to ensure that these recommendations are taken forward and monitored.