CAMBRIDGESHIRE SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW USING THE SIGNIFICANT INCIDENT LEARNING PROCESS OF THE CIRCUMSTANCES CONCERNING CHILD J

Final Report

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October 2014
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Cambridgeshire Safeguarding Children Board
Overview Report of a Serious Case Review
Subject CHILD J
Final Report

1. Introduction

1.1 Introduction to the Case

1.1.1 This is the overview report of the Serious Case Review conducted in respect of Child J who was 4 years old at the time of the serious incident prompting this review. She was the younger child of a family of two children; there was also a six year old male sibling. The family had recently arrived in the UK having previously lived in another EU country. She was presented at hospital in August 2013, suffering from bruising to the arms and trunk, a bite mark and evidence of significant trauma in the genital area. Following the incident, Child J and her sibling were taken into care. Child J is currently the subject of a supervision order and in the care of her mother. Her stepfather was convicted of the offence of sexual assault, and has been sentenced to 17 years imprisonment.

1.1.2 Following a recommendation from the SCR subcommittee on 1st October 2013 the chair of the Cambridgeshire LSCB decided that this case met the criteria for a Serious Case Review, and to undertake this review using the SILP methodology. Review Consulting were commissioned to provide an overview report writer to lead the review (see below). Due to the criminal proceedings in connection with prosecution of the stepfather and a perceived conflict in the methodology and the ongoing criminal proceedings, work on the review was delayed until the end of the court proceedings regarding the assault on the subject child. This delay also meant that the first lead reviewer appointed, Paul Tudor, was unavailable to complete the report and so a new reviewer, Brian Atkins, joined the process in February 2014 as overview author.

1.2 Serious Case Reviews (SCRs)

1.2.1 Local Safeguarding Children Boards are required \(^1\) to undertake Serious Case Reviews (SCRs) in every case where abuse or neglect is known or suspected, and either:
- a child dies
- a child is seriously harmed and there is cause for concern as the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

\(^1\) This is a requirement under Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 which sets out the function of LSCBs including their duties in relation to Serious Case Reviews
1.2.2 The statutory guidance ‘Working Together to Safeguard Children (2013)’ makes clear that a case that meets the criteria must trigger an SCR, and that the LSCB should aim to complete this within 6 months. It should result in a report which is published and readily available. Where the criteria are not met, the LSCB may still wish to review and share instances of good practice.

1.3 The Significant Incident Learning Process (SILP)

1.3.1 SILP is a learning model which engages front-line staff and their managers in reviewing cases, focusing on why those involved acted in a certain way at the time.

1.3.2 The SILP model adheres to the principles of:

- Proportionality
- Learning from good practice
- The active engagement of practitioners
- Engaging with families
- Systems methodology

These principles are confirmed and supported in current government guidance (Working Together to Safeguard Children 2013)

1.3.3 SILPs are characterised by a large number of practitioners, managers and Safeguarding Leads coming together for a day, with all agency reports having been shared in advance in order to discuss the emerging learning from the review. The first Learning Event seeks to enhance the understanding of the experience of those in practice with the child and family under review; the second recall day allows practitioners to come together again to study and debate the first draft of the Overview Report.

1.3.4 Working together 2013 states that SCRs and other case reviews should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children; seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did
- seeks to understand practice from the viewpoint of individuals and organisations involved at the time rather than using hindsight
- is transparent about the way data is collected and analysed
- makes use of relevant research and case evidence to inform the findings

1.4 Lead Reviewer and Overview Report Writer

1.4.1 This review, conducted under the SILP methodology, was led by Brian Atkins, and supported by Paul Tudor. Both are accredited SILP lead reviewers.
1. 4.2 Brian Atkins BSc. CQSW, MBA is a Registered Social Worker, who has worked for many years as a practitioner, manager and senior manager in local authority Children’s Social Care and Youth Justice Services. Since 2000 he has worked independently as a Children’s Social Care Consultant working with different local authorities and partnerships across England and Wales. He is the author of this overview report.

2. Process

2.1 Terms of Reference
The full terms of reference are attached at the appendix to this report

2.2 Scope

2.2.1 The time period covered by the review was determined as:
From a date in 2007 (the birth of the elder child) to a date in the summer of 2013 (the discharge of the children from hospital in to foster care).

2.2.2 Agencies were also asked to review and report on any significant events or safeguarding issues in respect of mother and the children prior to February 2013. This material was used primarily to provide a background context and therefore was required to be concise and summarised, highlighting any particular learning points.

2.3 Agency Reports

2.3.1 Agency reports within the scoping period were commissioned from:
• Primary Care Services (General Practice)
• Cambridge University Hospitals Foundation Trust
• Cambridgeshire Children’s Social Care
• Cambridgeshire Constabulary
• Cambridgeshire Community Services (Universal Services)
• The Learning Directorate, Cambridgeshire County Council, covering the school

2.3.2 Relevant information was sought from the equivalent agencies by agencies report authors from a Midlands town and a Northern town, where the family previously lived.

2.4 Learning Events

2.4.1 A full day SILP Learning Event took place in April 2014. All but one of the agencies involved were represented by both the agency report author and staff including managers who had been involved during the period in scope. All of the agency reports had been circulated in advance, to ensure that all staff attending were able to fully understand the multiagency dimension and the focus of the review.
2.4.2 At a Recall learning event held in June 2013, participants who had attended the Learning Event considered the first draft of this report. They were able to feedback comments on the contents, add additional information, and clarify the issues. All of those involved contributed to the conclusions and learning from this review.

2.5 Attempts to contact the family

Letters were sent by the Chair of the LSCB offering the child’s mother the opportunity of discussion with the Overview author during the preparation of the report, but initially no response was received. A further attempt to contact her in August 2014 resulted in a meeting with the Overview author and the LSCB Board Manager in September 2014. The mother’s views have been incorporated throughout this report, and her perspective summarised in Section 6.

3. The Family

3.1 Family Background and Movements

3.1.1 The family background summarised below is drawn from the agency reports, some of which required considerable research to identify the facts. Key factual information is taken from the Police agency report, supplemented by information from other agencies and the SILP Learning Events. Information from the mother has now been included. It should be recognised that this detailed information was not available to practitioners at the time of their intervention with the family.

3.1.2 The subject child’s mother is from an ethnic minority and she has spent a considerable part of her life in Europe. It is understood that she moved to an EU country from outside Europe when she was 6 years of age. She became an EU citizen, alongside her family, before settling in a different EU country.

3.1.3 In 2005, she returned to her country of birth in order to be married. Her husband was unable to obtain a visa and consequently remained living in that country whilst she returned to live in the EU country, returning on occasions to her husband, where both the older sibling and the subject child were conceived in 2006 and 2008 respectively.

3.1.4 Both children are reported to have been born in a EU country, although this is not confirmed. During 2008, the mother of Child J separated from her husband, who is the birth father of the subject child and the older sibling.

3.1.5 The family continued to reside in the EU country and the mother and children held that EU country’s nationality. The birth father of Child J was reported by the mother to have died in 2012. The details of the exact date and circumstances of his death have not been ascertained. There is no information concerning his contact with the children in the intervening period between their parents’ divorce and his death, although the living arrangements of the
mother and father in different continents suggest that he had little contact with his children.

3.1.6 In 2010, Child J’s mother moved from the EU Country to the United Kingdom and took up temporary residence in a Midlands town. This was as a consequence of her forming a relationship with a new partner who was resident in the UK. The relationship between this man and the subject child’s mother broke down after a relatively short time and she returned to live in the EU country approximately two months later. The subject child and older sibling are understood to have accompanied their mother throughout this time.

3.1.7 Child J’s mother and the subject’s child’s step-father were married in 2012 in the UK.

3.1.8 In May 2013, the subject child was temporarily in the care of her Aunt in a northern town for a period of some 3 weeks. The maternal grandparents were caring for the subject child’s sibling for part of this period; he was at school in Cambridgeshire for two of these three weeks.

3.1.9 In June 2013, the family moved to a different residential address in Cambridgeshire. In order to support the rental costs, additional rooms were sub-let to other tenants. In July 2013, the child’s mother, who had been working since April 2013, was unable to continue to work due to her pregnancy and she consequently remained at home.

3.2 Ethnicity and Language

3.2.1 All members of the family, including the extended and reconstituted family members, were originally from outside Europe. The mother, and the 2 children have EU nationality.

3.2.2 Mother, stepfather and other adult family members speak their first language and English. The mother also speaks two other EU languages. The subject children speak an EU language, English and some of the parents first language.

3.2.3 The family practice a recognised religion.

4. Timeline: Engagement with Services and Key Practice Episodes

This section of the report summarises the timeline of engagement of the family with services, in particular Health and Education. Key practice episodes (KPE) are identified.

4.1 In early February 2013 the family are recorded as living in a Northern town at the address of the Mother’s sister. The family were registered with a GP which generated a visit from a health visitor; a letter had been sent to advise them of this. An unsuccessful visit is recorded in late February, but it is likely that the family had moved to Cambridgeshire by this time as the subject child’s sibling was registered with a school in the area shortly thereafter.
4.2 The subject child’s sibling (Sibling 1) was placed on the primary school roll in Cambridgeshire and started the following week in late February. He was ill for the first two days and thereafter his attendance record shows a medical code as the reason for absence, and his attendance was recorded at 79.5% with 14.8% authorised absence.

4.3 Sibling 1 suffered from an unusual, non-contagious skin condition, which is characterised by blistering to the skin. He was seen by the GP surgery in early March, requesting a prescription for the condition, and the surgery was informed that he was being treated by a Midlands Children’s Hospital.

4.4 The school were initially unaware of this skin condition. Staff noticed that he used dressings and sterile needles to manage his own care. Once this was established the school asked the advice of the School Nurse. A meeting was set up with the Nurse and Mother and advice given. The nurse saw the GP notes and talked through a care plan with the mother.

April 2013

4.5 At the beginning of April 2013 Child J’s mother was seen by the GP registrar: she was diagnosed as pregnant and feeling unwell. No discussion about the home situation was recorded. A medical report from this visit noted a large scar at the base of the mother’s abdomen, apparently for a skin graft when she was burnt on her leg during the previous marriage. No further questions were asked about this at this point, but it is recorded by the GP registrar that she suspected that the injury may have been due to domestic abuse within that marriage.

4.6 Child J was registered with a GP practice in Cambridge in early April. The GP practice did not send a notification to Child Health Services in this case and so there was no referral to or visit from the Health Visitor.

4.7 Child J was seen by the Practice Nurse in mid-April as her mother was worried that the child could not hold her urine. The Practice Nurse recorded her intention to contact the health visitor to provide tips on this problem, but did not do so. There are electronic systems available for referring to the Health Visitor Service, but these were not used in this case.

4.8 The mother attended her first midwife appointment in mid-April. The Primary Care Services report noted that it is normally part of midwifery care to ask about the home situation and domestic violence, but there is no record that this happened on this occasion.

4.9 At the end of April, Child J’s mother visited the GP practice complaining of lower back pain. This was recorded as a routine consultation. The School Nurse requested previous records as these had not yet been received.
May 2013

4.10 In mid-May Child J’s mother attended the surgery for a 16 week appointment with the midwife. On the same day the school nurse met the children’s mother to complete a health assessment for the sibling. She had missed 2 previous appointments. The School Nurse assessment noted there was a warm and appropriate interaction between mother and child. Mother was compliant with treatment and the GP was liaising with the Midlands Hospital about treatment and dressing requirements.

4.11 During mid-May Child J was temporarily in the care of maternal grandparents in the northern town for a period of 3 weeks. They also cared for her sibling for part of the same period.

June 2013

4.12 In mid-June Child J was bought by her mother to be seen by the GP. She had been living for a three-week period in the care of her maternal grandparents in the northern town. Child J had returned, according to the mother “happy but subdued”. The mother also said she had noticed significant hair loss over the scalp and one bruise to the anterior chest. On examination, no bruises were seen on the body but some hair loss was noted. The mother was asked by the GP to take Child J to have a blood test, but reported later that she had lost the forms and did not do so. A blood test taken later showed no major abnormalities.

4.13 Later in June mother failed to attend an antenatal appointment.

4.14 In late June the mother bought Child J to the surgery for a minor illness appointment and was seen by the Practice Nurse. The mother stated that the child gets lesions on her skin which look like a bruise. She said that Child J woke that morning complaining of all over body pain. Child J appeared to be alert and happy, and looked well. The mother also discussed Sibling 1’s skin condition. No further action was taken.

July 2013

4.15 In July 2013 the mother was unable to continue to work through her pregnancy and was feeling unwell. It was reported later that the stepfather took over more of the personal care of the children during this period.

4.16 In early July the School Nurse met The Mother at school

4.17 Blood test results for Child J were returned in July and were normal; no further action was taken.
4.18 The following day in July, Child J was taken by her mother to the GP surgery with a history of 4-5 days rash on her scalp. On examination this was thought to be shingles and an antibiotic was prescribed.

4.19 Key Practice Episode 1 (mid-July)

In July 2013, Urgent Care Cambridge (UCC, commissioned to provide the out-of-hours GP service) received phone call from Child J’s mother at 11:12 am on a weekend morning. The mother reported that Child J had been prescribed antibiotics, now had a swollen face and that her “eyes and everything” were swollen. A clinician returned her call. The mother said she was worried and thought Child J had bumped into something.

4.20 The doctor explained that this could be an allergic reaction and arranged an appointment at the Primary Care Centre. The mother and Child J attended for a face-to-face assessment at 11:50 am. The doctor recorded this as “an interesting case”, being treated by antibiotics to prevent infection of shingles to her scalp. The assessment identified that the child was complaining of pain in her right thigh and difficulty in weight-bearing although there was no localised tenderness. She had a bruised and swollen face, bruising to trunk both front and back and to her arms, facial swelling and scalp infection. A bloodshot right eye and a high level of allergy white cells were noted from the blood test results in the GP record.

4.21 The doctor advised the mother to take the child to the Emergency Department for further assessment. She did not send her with a letter of referral, and did not telephone the Emergency Department to advise that the mother and child would be attending.

4.22 The doctor from Urgent Care Cambridge had full access to the subject child’s GP records which she reviewed accordingly, and which showed that Child J had been seen by at least two other GPs recently before attending the out of hours service, neither of whom had raised safeguarding concerns. There was nothing of concern on the notes from the GP surgery, school nurses or Children’s Social Care.

4.23 The mother and Child J attended the emergency department at the Hospital later on the same day with a swollen face and bruising. She had started antibiotics 2 days prior. An initial Safeguarding Assessment was completed by hospital staff. The nurse undertaking the assessment recorded that the child did not attend the Emergency Department frequently with injuries and that the history did not give rise to any safeguarding concerns with an arrangement for review at the hospital the following day.

4.24 Child J was fully examined by a doctor at the hospital, in particular the facial swelling around the eyes. Bruises were noted on the child’s feet, wrists, under the eyes and on one cheek. These were drawn onto a body map. Within this examination the doctor confirmed that she had considered child maltreatment.
using NICE guidance, and wrote that she was not sure if she suspected child maltreatment.

4.25 The case was discussed with the Paediatric Consultant within the hour and a full CT scan of the child’s head was undertaken. Later that evening the eye examination and CT head scan were reported as normal.

4.26 Children’s Social Care Emergency Duty Team (EDT, out of hours social care service) recorded a first contact from the Hospital at 8:49 pm on the same day to ask if Child J was known to social care. The notes were recorded on CSS (electronic record system).

4.27 In this discussion the doctor described the swelling around the child’s eyes and bruising to the arms, which were thought to be an allergic reaction to the prescribed penicillin. The EDT worker confirmed that CSC had no record of this family, but pointed out that ‘this should not matter as for some children there would be a first episode and a child with no involvement with social care should not be prevented from being kept safe’.

4.28 Another doctor later completed a discharge summary stating that a discussion with social services EDT had taken place due to the bruising. Detail and time of the discussion are not recorded other than “no concerns” on the typed discharge summary to the GP. No written referral was made to Children’s Social Care which prevented the usual pathway of concern being flagged to the hospital safeguarding team.

4.29 Based on information about the CT head scan result, eye examination result and “no concerns” in the discharge note, and the discussion with Children’s Social Care EDT, a decision was made to allow the child home with her mother on the same evening, with a plan for the same paediatric consultant to review her on the ward the following day.

4.30 A hospital nurse present through this episode later expressed her concern that she had had misgivings about the safeguarding actions but felt that staff with more experience would have better judgement.

4.31 The child was brought back by mother to the hospital for review as arranged. She was seen by a different Paediatric Registrar. The Consultant Paediatrician checked the child’s mouth, chest, abdomen and genital area for the evidence of trauma and concluded that it was likely that the child’s eye swelling was due to an acute reaction to the antibiotic. Mother consented to photographs being taken by the medical photography unit and attended the same day.

4.32 There is no evidence that the child was spoken to separately from the mother throughout this process.
4.33 Children’s Social Care Integrated Access Team followed up the work of the EDT the previous weekend night, and completed a threshold document\(^2\) during the working day. They made phone calls to the hospital, the school (to get mother’s telephone number), and the child’s mother, who was contacted by telephone on her way to the paediatric appointment. The consultant paediatrician was consulted, who said that she was certain that this was not non-accidental injury (NAI), and believed that the injuries were as a result of reaction to penicillin. Children’s Social Care assessed this as Level 1 on the Model of Staged Intervention (MOSI) and decided that it did not meet the threshold for Social Care intervention. CSC later contacted the mother to inform her of this decision, and the view that the swelling and bruising was as a reaction to medication. The mother said that she was relieved and said that she would never hurt her child. This follow up from the overnight episode was part of the ongoing case management process.

4.34 Child J was discharged home and a letter sent to the GP asking for follow-up in one week. Information was given in the letter that Children’s Social Care had been contacted and the GP was asked to note that child is now allergic to the antibiotic Flucloxacillin. The main diagnosis was an allergic reaction. Details of bruising were provided to the GP.

4.35 In the same week in July the GP received the hospital discharge letter saying that Child J had been seen in the Emergency Department with swollen eyes and bruising. The letter said that her case had been discussed with Children’s Social Care at the time due to additional bruising on the arms and feet. A CT scan was normal and the swelling was thought to be due to an allergic reaction. There was no reference to the pain in her right thigh and difficulty weight-bearing. The GP thought that the diagnosis of an allergy did not seem plausible but no challenge was made to hospital colleagues. The Doctor added the code “Child protection report submitted” so that this would be visible to other clinicians using SystmOne. (A Health Service Information System)

**August 2013**

4.36 **Key Practice Episode 2:**

In early August Child J was seen at the surgery by a trainee GP registrar in the afternoon. This was following a call in the morning from the mother that had been ‘triaged’ by the GP surgery that morning to say that Child J had blood in her urine and a mild fever. She was seen with her mother who stated that Child J woke up that morning in a “pool of clots and blood”. She had not been able to open her bowels or urinate since then. Child J told her mother she had fallen out of bed. A history was taken from the mother as Child J was said to speak only an EU language. Child J was reported as quiet and shy. She had scratches around the neck, a bruise on her face and with a red left eye. Abrasions were noticed on her left buttock and thigh and a bruise was present on her left knee.

\(^2\) A document used by IAT team in Cambridgeshire to record whether the threshold criteria for social care intervention are met, and the evidence and reasons for making this decision.
Vaginal bleeding was evident with fresh blood. The case was discussed immediately with a more senior doctor who suggested a referral to the on-call Paediatric SHO in view of safeguarding concerns. No contact was made with Children’s Social Care or the Police at that time.

4.37 The mother was given a GP referral letter and asked to go to the Paediatric Emergency Department at the hospital, where she arrived at 7 pm, after an interval of several hours. During this time it is now known that she had met up with the stepfather before taking Child J to the hospital. The content of any discussion is unknown.

4.38 The initial nursing assessment at the hospital was linked to the earlier report in July where safeguarding concerns had been considered. The mother advised the nurse that the child had been to hospital with spontaneous bruising before and that she wanted answers this time.

4.39 A second nurse became involved later and spoke directly to Child J. Contrary to what the mother had said, Child J could speak and understand English to a level which the nurse described as “understandable”. The child stated that her sibling had told her not to tell her mother about it (her bleeding). This was documented and the nurse in charge was advised.

4.40 At 9.45 pm EDT received a phone call from a paediatric consultant to the effect that Child J was in hospital with bruising to legs and arms and cheek, following a presentation to the GP earlier in the day regarding blood in her urine. The consultant said that the bruises were different to those present in the previous presentation in July. A further phone call from the hospital was received by EDT later to say that Child J had an adult bite mark on her back. EDT arranged a Strategy Discussion with Police.

4.41 During the phone calls to EDT, hospital nurses became concerned about the safety of Child J’s sibling, as the initial response from social care had been to review this child the next working day.

4.42 At 0.15 am on the following day a Strategy Discussion was held between Police and Children’s Social Care EDT. A decision was made that the threshold for a Section 47 enquiry was met, and that Police Protection would be used in respect of the sibling who would be brought to the hospital as a ‘Place of Safety’. The discussion did not include the construction of a plan of action to guide the investigation, or clarify the role of staff in looking after the children whilst in hospital. Information continued to be gathered overnight.

4.43 The sibling was subsequently was brought to the hospital by police as a ‘Place of Safety’ under Police Protection. He was examined and admitted. His whereabouts in hospital was kept confidential from his mother and step-father and a pseudonym used.

4.44 Child J remained on the ward throughout the following day for further investigations. The child played with staff and had her mother in attendance.
The stepfather was permitted to visit without restriction. The child was calm and appeared to enjoy her stay on the ward.

4.45 Hospital nursing staff directly involved in the care of the children were unsure about what information they were able to give the mother about Child J, especially at the time of the forensic medical examination of the child under anaesthetic, as this was not clarified by any party in the Strategy Discussion. There were also not clear about the information they could give regarding the sibling. They did reassure the mother that he was being cared for and was not distressed. Staff witnessed several heated discussions by telephone or face-to-face with mother’s husband. These took place in their own language and were not understood by staff.

4.46 During the day, Child J had further investigations, an eye examination, interviews with the police and social care and an examination under anaesthetic late in the afternoon, some 24 hours after admission. These examinations confirmed evidence of a very serious sexual assault.

4.47 Both parents were arrested on the ward on the basis of evidence from the examination under anaesthetic. Police later arrested lodgers at the family home and took forensic samples.

4.48 A foster care placement was found for the children with carers who spoke the same EU language, and Agreement for Accommodation and legal Proceedings was given by the Head of Social Work the same day. The children were placed together in the same placement.

4.49 Two days after Child J was admitted in August, Looked After Children paperwork was completed by Children’s Social Care. Requests for information were made to Children’s Services in the relevant Midlands and Northern towns. Patient records and a paediatric consultant report were received. An Emergency protection Order was granted.
5.0 Themed Analysis

The analysis section of this review considers the information documented above, which was obtained from the Agency reports and from the staff who worked with Child J and her family, and who attended the Learning Event. Further information came from discussion at the Recall SILP event, when Agencies were able to consider the implications of the first draft of this overview report.

5.1 The impact of Ethnicity, Identity and Language

Ethnicity, Religion and background

5.1.1 All members of the family, including the extended and reconstituted family members, are originally from outside Europe. Although clearly stating that they adhered to their religion, the mother described herself as “Modern” in respect of her religion.

5.1.2 In the interview with the mother she described being modern as not being religiously conservative, thus offering an explanation of some of her actions as being outside the norm.

Ability of family members to communicate in English

5.1.3 Analysis of agency reports suggests that the mother could speak four languages. The stepfather could speak his own first language only. The sibling was quite fluent in English and could also speak the EU language and the first language. Child J could speak English at least to a limited extent at the time of the incident. In her interview with the author, the mother had said that at the time she thought that Child J could speak the EU language and a little of her first language, but only a little English. It may be that Child J learned some English to the mother, as she was described by hospital ward staff as having understandable English.

5.1.4 While at the hospital the parents conversed in their first language between themselves. However, when interviewed by Children’s Social Care the couple opted out of using an interpreter and were able to speak in English.

5.1.5 It is important for both universal and specialist services to clarify with the family and children at an early stage what languages are spoken, and to what extent they are spoken within the family. This will help to clarify areas where interpreters are needed, and where direct verbal communication with children can take place.
5.2 Marriage and Relationships

5.2.1 The mother’s history of marriage and relationships appear to fall outside normal cultural boundaries. The Mother states that she raised the children in the EU country as a single parent.

5.3 Identity Checks and Background Records

5.3.1 The agency reports show that different names and spellings were used by agencies for the mother and both children in this case. The mother says that she showed the birth certificates for the children, issued by the EU country, to the NHS (General Practice), but that they recorded the name of Child J incorrectly. Requiring formal documentation as part of the registration process with agencies was not a key issue in this case as family members were clearly identified. However it does raise a more general issue about proof of identity which may be a factor in other cases and deserves some discussion by the LSCB.

5.3.2 A Unique Pupil Number (UPN) is allocated to children when they register at a school, which will follow them if they move to different schools. In this case it was assumed that there was no previous school, or if there had been it would have been in the EU countries for which no records were realistically available. However, according to the mother, the children attended nursery or school in these countries from the age of 3 to 4 years old.

5.4 Health Visitor Involvement

5.4.1 Neither the GP or the Practice Nurse referred the family to Universal Child Health Services (Health Visiting) although she intended to do so. This demonstrated a lack of communication between General Practice and Universal Services and was a missed opportunity to engage the mother to discuss any concerns she may have had with a health professional specialising in family issues.

5.5 Support for the sibling

5.5.1 The sibling had a poor attendance record at school (80%), the majority of which was authorised by the parent. The Education Service has confirmed that this would have been investigated in more detail had he returned for a further term, but given his skin condition they were less concerned than might be the case for another child.

5.5.2 School staff and the school nurse provided positive support for sibling and his mother in managing his skin condition within the school setting, including the construction of a care plan. When his skin condition was under control he was an active boy, played happily with friends and presented well. The condition is known to flare up with stress, and may have been an indicator of what was happening in the family. It may be relevant to note that the Foster Carer with
which he was eventually placed was a nurse, and that the skin condition improved when in this placement.

5.6 The voice of the child

5.6.1 Throughout early agency involvement with this family there was an assumption, thought to have originated from the mother, that the subject child could not speak English. There were many opportunities for professionals to talk directly to the child, but this was not done until after her admission to hospital. It is not unreasonable of staff to believe what the mother told them, or alternatively to attempt to engage directly with the child.

5.6.2 Examples of this are documented in the timeline of engagement:

17.6.13: GP did not attempt to speak to the child
26.6.13: The Practice Nurse did not speak directly to the child
14.7.13: The child was not spoken to directly during the medical examination
5.8.13: A ward nurse at the hospital became involved in the care of the subject child during the medical examinations and spoke directly to her. This was documented and the child’s English described as “understandable”.

5.6.3 In all potential child protection and safeguarding situations, the role of professionals hearing the voice of the child is critical. The perceived language barrier may have prevented this, but as emphasised in most safeguarding training there are other ways apart from formal language for communicating with young children. Attempts at communicating in other ways may have led to direct communication in English, or the need to engage an interpreter. This lack of direct communication does represent a missed opportunity for agencies and organisations, particularly within the health service, to understand what may have been happening with respect to Child J. The LSCB should seek assurance from member Agencies that their processes for engaging with children and families clearly identify the languages spoken by adults and children, and identify where interpreters are needed for effective communication.

5.7 Multi-disciplinary assessment / diagnosis of child maltreatment, and professional challenge

5.7.1 A key finding from Serious Case Reviews nationally is that identification and diagnosis of maltreatment should be undertaken on a multiagency basis, and that the view of one professional should not override others. Professional challenge in these circumstances is seen as healthy and productive in securing safe judgement. In this case the view of the consultant paediatrician was accepted within the health service and by Children’s Social Care EDT in their threshold judgement. Evidence of this is contained within the key practice episode from July below:
5.7.2 The view given by the consultant paediatrician that this was “not NAI” was accepted by other parties, and was not challenged either by staff within the hospital or by Children’s Social Care, despite reports of bruising on arms and trunk. This is not to say that the Doctor’s view was incorrect, but a professional and respectful discussion would have helped clarify the reasons for this view, and supported multidisciplinary agreement on the risks and the way forward.

5.7.3 This view formed part of the Children’s Social Care judgement by EDT when it was decided that the case did not meet the Social Care threshold. The case was followed up by the CSC Integrated Access Team the following day to obtain more information, which has been noted as an example of thorough practice. This information was considered and assessed as level 1 (least risk or need) using Cambridgeshire’s threshold criteria, the Model Of Staged Intervention (MOSI), when the view of the consultant paediatrician was known i.e. it was decided that the case did not meet the social care threshold.

5.7.4 The hospital discharge letter was received by the GP surgery. The GP thought that the diagnosis described in the letter of an allergy did not seem plausible and discussed concerns with colleagues in the medical practice. The GP’s lack of confidence in the diagnosis was demonstrated by adding the code “child protection report submitted” to the record so this would be visible to other clinicians using the computer system.

5.7.5 However, no direct discussion was held with hospital colleagues to clarify the issues. In their subsequent review the medical team were reminded that such a discussion or challenge could have been routed through the Designated Doctor.

5.8 Communication between and within Agencies

In this case, the prevalent means of communication within and between agencies is written through notes, email or fax. In some cases direct conversations take place between and within agencies, either by telephone or face-to-face discussion, which can help improve understanding through dialogue. The means of communication are identified in the sections below.

5.8.1 Communication between the Hospital and Children’s Social Care EDT

Initial contact between the Hospital and Children’s Social Care EDT team in July took the form of a telephone call which did not identify any safeguarding concerns, and was recorded by EDT as a ‘contact’.

5.8.2 The discussion with Children’s Social Care EDT team did not result in a referral to Children’s Social Care, and information was not transmitted to the hospital safeguarding team who consequently could not undertake follow-up action. New electronic systems in the hospital are being introduced in October 2014 to ensure that the safeguarding team is notified of concerns whether or not Children’s Social Care is contacted.
5.8.4 The later contact in August between the Hospital and Children’s Social Care was characterised by generally good communications and effective joint working, together with the police, to safeguard the children in the family and undertake the necessary investigations with the adults concerned. This is demonstrated in KPE2 (August) when EDT were involved, and a Strategy Discussion organised for later in the day. Unfortunately, information available to the strategy discussion was limited as the emergency department nurse, who had some key information regarding the abuse from direct discussions with the child, was not on duty at the time of the discussion. Despite this appropriate action was taken to secure the safety of the children and take the police investigative action.

5.8.5 Communication between General Practice and Children’s Social Care

The lack of contact from General Practice to Children’s Social Care in August, when essential safeguarding information was not shared, may be in part explained by the experience of a previous safeguarding case at the surgery, when staff were criticised for not emphasising medical needs over safeguarding needs. The surgery now accepts that both elements are of equal importance and is making changes to practice.

5.8.6 Communication between the hospital and the GP surgery

Following discharge from the hospital in July, a letter was sent to the GP asking for a follow-up in one week. Information was given that Children’s Social Care had been consulted. The main diagnosis was an allergic reaction and details of the bruising were provided. The GP Agency report suggests that more direct communication between the hospital and the surgery would have been helpful.

5.9 Ensuring attendance at essential medical appointments

On five occasions over the period, the mother was advised by health organisations to bring her daughter for further medical examination, some of which had clear safeguarding implications. No follow-up mechanisms were put in place to ensure that she did attend.

5.9.1 On the first occasion, following a medical examination at the GP surgery when Child J returned from relatives in the northern town, the mother was asked by the GP to take her daughter for a blood test, but lost the forms and did not do so.

5.9.2 On the second occasion the mother was advised by UCC following a telephone consultation to bring her for a face-to-face assessment at the primary care centre. The mother did as she was asked, but there was no mechanism in place to ensure that she did so.

5.9.3 Following this assessment the mother was advised to take the child from UCC to the hospital emergency department for further assessment. This was not
followed up to ensure that she had attended the appointment. Mother did attend later that day with the child. Following this appointment she was asked to bring the child back to the hospital the following day for a review by the same consultant.

5.9.4 The mother brought the child back to the hospital for review the next day as arranged with the hospital. The review was planned to be undertaken by the same paediatric consultant, but in the event was undertaken by a different registrar. There is no evidence that any process was in place to ensure that the mother attended this appointment.

5.9.5 When Child J’s mother took her to the surgery in August she was seen by the GP, and safeguarding concerns were very evident, including bruising, trauma and vaginal bleeding. Despite this she was given a GP referral letter and asked to take the child to the Emergency Paediatric Department at the hospital herself, where she was seen at 7pm. The revised report from the GP surgery states that the doctor phoned the on-call paediatric registrar before sending the mother and child to the Emergency Department. This was not made clear in the original Agency report. Neither the Police nor Children’s Social Care were notified by the GP surgery.

5.9.6 On each of these occasions there was the opportunity for the mother not to co-operate with the request to attend medical appointments. There were no clear mechanisms in place to ensure that she did attend. The episode in August in particular provided significant safeguarding risks to the child, where the mother had the opportunity to discuss issues with the stepfather, and to leave the Cambridge area.

5.10 Care of the Children in Hospital as a Place of Safety.

5.10.1 During the period of intense activity in August when Child J was admitted to hospital, arrangements were made to bring her sibling to the hospital as a place of safety and accommodated on a ward anonymously. During this period hospital nursing staff had the task of looking after the children. There was a significant lack of clarity about the role of the staff and what could be said to the parents about their children. This issue should have been addressed by participants in the strategy discussion as part of their action planning.

5.10.2 Mother and stepfather were allowed unrestricted access to Child J, the subject of the enquiry, but not to her sibling. The nursing staff were given no clear instructions as to their role. In the event they carried out an exceptional job in looking after the children, but in circumstances of considerable anxiety about not knowing their appropriate role in the circumstances. Their actions clearly helped the children to settle in these traumatic circumstances.

5.10.3 To help provide a safe service and reduce anxiety for staff, the Hospital, Police and CSC should ensure that such practice issues are discussed and
agreed at the Strategy Discussion, as part of the plan of enquiry and safeguarding.

5.11 Professional Curiosity, undue optimism / false reassurance

There are a number of occasions during the review period when professionals demonstrated a lack of professional curiosity when presented with potentially worrying but unclear information. Examples of this are summarised below.

5.11.1 There was lack of curiosity when Child J returned from a stay with relatives in the Northern town, and was seen by the GP. Child J appeared subdued, and the mother said that she thought she had been bruised. It is good practice to routinely ask about the domestic situation in such circumstances, and follow-up the mother’s concerns in more detailed discussion.

5.11.2 Similarly there was a lack of curiosity from the school about periods of absence, although in this case the sibling was absent for only one week of the three-week period. The Agency report advises that schools need to be more curious about periods of absence of families, if they are new or unknown to them.

5.11.3 The mother frequently presented Child J to the GP surgery in May and June for a variety of issues. There is no evidence to suggest that the GP and nurses were not concerned by the frequency of presentation and the child was not spoken to directly. There was no health visitor involvement with the family, which may have helped identify any concerns.

5.11.4 An example of these presentations took place in late June when the mother bought the child to surgery for a minor illness appointment, saying that the child had lesions on her skin which looked like a bruise. She said that the child woke that morning complaining of all over body pain, despite looking well, alert and happy. More than one doctor had been involved in seeing Child J and her mother, and sharing information and consulting with each other may have been beneficial in identifying any possible patterns in the symptoms.

5.11.5 In Mid-July the child was taken to UCC and seen by a doctor. She was described as an “interesting case”. Raised levels of white blood cells associated with allergy from the blood samples were confirmed in the GP records. It may be reasonable to conclude that other causes of the bruising to trunk and arms, and the facial swelling should have been explored, and possible safeguarding concerns considered. The doctor concerned, who had undertaken level 4 safeguarding training, has concluded that with hindsight she could have been more suspicious and made a subsequent referral to social care.
5.12 Agency actions to secure the safety of the children once maltreatment was identified
There is significant evidence from Agency reports that Agencies worked together very effectively to secure the safety of the children once maltreatment was clearly suspected. Police and Children’s Social Care worked effectively with hospital staff. Strategy discussions formulated a plan for effective interagency intervention. Nurses in the hospital provided good care of the children in a very difficult situation. CSC worked effectively to immediately secure a foster placement with the appropriate language, and also a carer with a nursing background.

6.0 The Mother’s Perspective

6.1 The mother of the subject child, Child J, was interviewed at her new address in the Northern town in September 2014 by the Overview Author and the Cambridgeshire LSCB Board Manager. She presented as an intelligent and articulate woman, who demonstrated good and relaxed care of her youngest child who was present during the interview. The interview took place after the overview report had already been drafted; her comments have been incorporated into the main report as appropriate, and the key issues she raised are summarised below. It should be noted that some of her comments are not consistent with Agency reports of her reaction to events.

6.2 The mother felt that had the GP being more actively involved the abuse to her child could have been stopped. She said that she had taken Child J to the GP surgery on several occasions, but received no adequate explanation as to what could be happening. She was concerned about the continued bruising, but thought there was a medical explanation. Child J had several tests but nothing happened. She had no idea that someone was hurting her child. She felt that the GP should have been more alert, and checked previous notes, and that they should have followed her up following the discharge from hospital in July. She said that doctors should be trained to report concerns to Social Services.

6.3 She also felt that Children’s Social Care should have visited her in person when they had concerns, and not just communicated through telephone calls. She described the call from CSC on the Monday morning to the effect that the hospital had referred Child J to them and that they were going to look into the matter. Mother attended hospital and subsequently received a further telephone call from CSC to say that they would not be taking any further action and that the file would be closed. She said that if they had visited to discuss concerns with her in person she would have welcomed this and accept any help offered.

6.4 The mother has reported that when in the hospital she felt discriminated against. Staff did not ask her any direct questions (which may have been connected with gathering evidence), but that not having her questions answered was the worst thing for her. When she was asked to take the child
to hospital on 5\textsuperscript{th} of August she did so, but was not told about any type of abuse being suspected. When in hospital she became more and more anxious, and was feeling tired, pregnant and the need to have a wash. She could not understand why Child J had to go for a blood test when she was bleeding, and was concerned when she was put into a private room with a closed door. She felt that Child J was well looked after by staff but as a parent felt left out of the process. When she was arrested by police she states that she was still not told why she was being arrested.

6.5 She said that professionals have never looked into her husband’s past. She thought it would be hard for people who had never had children to adopt another child. She felt that whatever he did there must be some explanation; possibly mental illness. She would have liked to have had some explanation of this but these questions remain unanswered. She has no had no contact at all with her husband and would find it helpful even now to help her understand why things had happened.

6.6 She said that after August, Children’s Social Care, and in particular her last social worker in Cambridgeshire were very helpful, supportive and understanding of her feelings and the impact of what had happened to her. She said that the school was also very helpful and supportive.

7. \textbf{Examples of Good Practice}

There have been a number of examples of good practice from partner Agency staff emerging through this review. A summary of these follows below, and more detail can be found in the timeline and Key Practice Episodes.

7.1 \textbf{Children’s Social Care}

Good practice by Children’s Social Care was shown by the day service (IAT) following up the EDT contact with the hospital on 15\textsuperscript{th} July to discuss with staff, undertake further enquires and ensure completeness of the record. From 5\textsuperscript{th} August 2013 when maltreatment of the subject child was established, there was good and effective working with both police and hospital staff, and the sourcing of well matched, EU language speaking foster carers, one of whom was a trained nurse and who could look after both children in this family.

7.2 \textbf{The Hospital}

7.2.1 There was caring and sensitive practice by nursing staff in looking after the children when they had been admitted to the hospital as a place of safety despite difficulties and uncertainties concerning the role. The nurses spoke directly to the child and obtained information about the abuse from the child’s perspective. There is no doubt that they significantly contributed to the well-being of the children in these circumstances.
7.2.2 The hospital records were very comprehensive in recording what had happened, and proved very helpful to the police investigation and the subsequent court process.

7.2.3 Following the admission of Child J to the ward, hospital staff expressed concern and challenged about the safety of her sibling, subsequently leading to the police exercising their powers of protection, and bringing him to the hospital.

7.3 Cambridgeshire Constabulary

7.3.1 An exceptionally thorough agency report significantly enhanced the review’s understanding of the background of this family

7.4 The Cambridgeshire Learning Directorate

7.4.1 School staff proactively identified the need for support for the sibling to manage his treatment and medication for his skin condition. This included the school nurse making contact with the hospital, and discussing a care plan with the mother. The mother felt well supported by the school.

7.4.2 The school also identified the sibling’s educational and language needs, and ensure that effective interventions were in place, including the provision of additional support for a child with English as an Additional Language.

7.5 Community Services NHS trust

The school nurse undertook research to understand the nature of the sibling’s medical condition, and helped the mother to develop a care plan.

8. Findings

8.1 This is a tragic case of a very serious sexual assault on a four-year-old girl. There is no clear evidence that it could have been prevented, although with hindsight it is likely that deliberate harm was a factor in the mid July presentations to hospital, which would have justified some challenge and an assessment of potential risks. There were no evident systemic failures within the multiagency safeguarding process.

8.2 There was one potential opportunity in mid July 2013 to identify the risks to the subject but these were missed. There were other occasions when professionals could have been more curious as noted below:

8.2.1 The lack of follow-up by the GP and the practice nurse to involve Primary Care (Health Visiting). This may have been a missed opportunity for the Health Visitor to get to know the family well, which may have enabled the mother to express any concerns she had about the child.
8.2.2 Medical professionals not talking directly to the child due to a perceived (and incorrect) language barrier. This review has identified the need for all professional Agencies to identify the language spoken by families, including children, as part of the service uptake process. Lack of direct communication at the surgery, at UCC, and the hospital were other missed opportunities to engage directly, and potentially understand the family situation better.

8.2.3 Lack of pro-active curiosity is understandable in the context of busy professionals working in services under pressure to achieve tasks and activities within prescribed timescales. Routine tasks are undertaken and targets met in this way, but skilled and trained professionals should be encouraged keep their minds open to exploring the unusual and seeking to understand uncertainty, particularly in the context of their duty to safeguard children. This would be in addition to following required procedures, and can help to clarify the thinking and evidence which inform important professional decisions.

8.3 There were also some professional practice issues which potentially impact on safeguarding, and may have put the child at additional risk. These include:

8.3.1 A reluctance to challenge other professionals, particularly within the medical profession. This is understandable in the context of status differentials within the medical profession, and between the medical profession and other Agencies. A preferred culture would be one of respectful discussion between junior and senior professionals, where it is seen as part of the learning experience to seek clarification, and the reasons for the professional judgements of more senior staff. The importance of the Cambridgeshire LSCB's Escalation Policy – Resolution of Professional Disagreements in Safeguarding Work should be emphasised.

8.3.2 The prevalent means of communication within and between Agencies is written, through notes, email or fax. Some of the Agency report authors have identified the benefits of more direct verbal communication, in person or by phone which can help clarify any areas of debate or uncertainty. A key message must be for professionals to talk to each other when uncertain about what they are seeing rather than relying on electronic communication.

8.3.3 The undue level of trust placed in the mother to take her child to medical appointments was potentially dangerous, and may have exposed the child to the risk of the mother not complying and potentially taking her out of the area. This practice was evident even when serious abuse could have been suspected. It appears likely that medical professionals did not recognise the potential safeguarding issues until the incident in August, but still did not take the necessary steps. In such circumstances it is necessary for all professionals to make arrangements to ensure that children do get to
appointments, and that systems are set up to ensure that Agencies are quickly alerted in the event of this not happening.

8.4 There were also some key areas of good practice shown by all Agencies involved as documented in section 7 of this report. Throughout the SILP process, partner agencies have become aware of shortfalls in their practice, and have taken steps to address them, without waiting for the conclusion of this review. They were thoroughly engaged in discussions with their partner agencies and professional colleagues at both of the learning events, were not defensive about their practice, and were, without exception, anxious to make immediate improvements where necessary. It is understood that improvements to practice in primary care services are taking place outside of this process.

8.5 Areas of good practice which should be reinforced

A number of issues have emerged from this Serious Case Review which the Board may wish to disseminate and manage through the LSCB Learning and Improvement Framework. In particular:

8.5.1 The focus on the care of the children involved while investigations are proceeding which was amply demonstrated in this case. Remembering the welfare of the child(ren) while complex investigations are taking place is important at the time, and to help the children feel safe and able to cooperate with professionals from caring agencies in the future.

Areas where continual reinforcement is required

8.5.2 The need to clearly ascertain the languages spoken within families, particularly those families which have recently migrated to the UK health language spoken by the children. This will help ensure that there are no barriers to direct communications and talking to children, and will help identify where an interpreter is required.

9. Recommendations for the Board

9.1 The Board should seek assurance that hospital staff working out of hours and those in Emergency Departments are familiar with the process of making contact with Children’s Social Care, and what and what does not constitute a referral, following existing guidance.

9.2 The Board should seek assurance that medical practices are aware of the need to ensure the notification to Child Health services of families with young children living in their area, particularly Health Visiting, and promote awareness of Universal Services which could provide support.
9.3 The Board should seek assurance that member agencies have procedures which emphasise the need to ensure follow up appointments in the safeguarding context. GPs should follow LSCB procedures in relation to making referrals to Children’s Social Care and the Police, and ensure that missed appointments where there are safeguarding concerns are followed up and escalated as appropriate.

Brian Atkins
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10.11.14