Serious Case Review

George

REVIEW REPORT

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1 Introduction to the case and summary of the learning from this review

1.1 This Serious Case Review (SCR) is in respect of a two-year-old child to be known as George. He suffered extensive injuries while in the care of his mother and her partner. George was the subject of a child in need plan that was about to be closed. He had twice previously been the subject of a child protection plan with the category of neglect. The parents initially stated that the injuries were both self-inflicted and accidental[1].

1.2 Mother's partner had lived with George and his mother for around six-months, initially part time. George had occasional contact with his father. He was an only child at the time.

1.3 The response to his injuries resulted in George being appropriately safeguarded and he is currently doing well in foster care. The CPS originally decided that Mother and/or her partner should not be prosecuted for the injuries due to conflicting medical opinion. Care proceedings concluded in February 2019 with a full care order being made. During the proceedings Mother and her partner both admitted they had physically harmed George. They chose not to implicate the other for any specific injury. The court made a finding that one or both of them caused the injuries. The police reopened their investigation in light of the admissions however following a review by the CPS, it was found there was insufficient evidence to establish who had caused the injuries.

1.4 A summary of the learning identified is:

- The need for professionals to challenge themselves and others, particularly when a decision has been made but new information emerges.
- Professionals require support to enable them to challenge family members, themselves, and other professionals.
- There is a need for improved knowledge of and use of the CLSCB escalation policy, to be used when there is a professional disagreement or to challenge another agency.
- Even when improvements are seen, professionals need to be clear themselves, and with parents, that when the parents have a number of pre-disposing vulnerabilities and adverse childhood experiences, there is likely to be a need for on-going support throughout their child's life.

2 Process

[1] Two medical experts had differing opinions, so the CPS decided not to pursue a prosecution.

2.1 The CLSCB recognised the potential to learn lessons from this review regarding the way that agencies work together to safeguard children[2]. It was agreed that this SCR would be undertaken using the SILP methodology, which engages frontline staff and their managers in reviewing cases and focuses on why those involved acted as they did at the time. Agency reports are completed where agencies have the opportunity to consider and analyse their practice and any systemic issues. They provide details of the learning from the case within their agency. Then a large number of practitioners, managers and agency safeguarding leads come together for a learning event[3]. All agency reports are shared in advance and the perspectives and opinions of all those involved at the time are discussed and valued at the event. The same group then come together again to study and debate the first draft of the SCR report. Later drafts are also commented on by all of those involved and they make an invaluable contribution to the learning and conclusions of the review[4].

2.3 It was agreed that the review would consider in detail the period from November 2017 which was the date that Mother's partner was known to be having contact with George who was on a child protection plan at the time, until 22 March 2018 which was the date his injuries were seen by professionals. Detailed case information will not be disclosed in this report[5], only the information that is relevant to the learning established during this review.

2.4 Early family engagement is required as part of the SILP model of review. The lead reviewer met with Mother, whose views are included in the report. She will be updated on the conclusions of the review prior to publication. The lead reviewed spoke briefly to Father and had hoped to engage with him further prior to publication, further attempts were made to contact Father but these were unsuccessful.

3 Family structure

3.1 The relevant family members in this review are:

Family member	To be referred to as:
Subject child	George
Mother of George	Mother
Father of George	Father
Mother's partner	Mother's Partner

3.2 Any other relevant family members will be referred to by their relationship to George.

4 The background prior to the scoped period

4.1 Mother became pregnant with George when aged 17, while she was living in hostel accommodation. She was homeless due to a breakdown in the relationship with her own mother and her recent move to Cumbria from another area. She had lived in Cumbria

[2] The decision was based on: a past history of agency concerns resulting in Child Protection Plans; evidence that there are concerns as to how agencies worked together; the nature of the injuries, the conclusion that it is highly unlikely the injuries were self-inflicted; and the probability that George will be impacted emotionally in the future.

[3] The Chair of the CLSCB agreed the SCR, the lead reviewer was appointed, the terms of reference were agreed, agency reports and a chronology were requested, and two events were held to engage with staff in November 2018 and January 2019. The lead reviewer is Nicki Pettitt, an independent social work manager and safeguarding consultant. She is an experienced chair and author of SCRs and a SILP associate reviewer. She is independent of CLSCB and its partner agencies.

[4] Working Together 2015 (the legislation in place at the time the review was agreed) states SCRs should be conducted in a way that; recognises the complex circumstances in which professionals work together; seeks to understand precisely who did what; considers the underlying reasons that led to actions; seeks to understand practice from those involved at the time rather than using hindsight; is transparent about the way data is collected and analysed; and makes use of relevant research and case evidence to inform the findings. This review has achieved these objectives.

[5] Statutory Guidance expects full publication of SCR reports, unless there are serious reasons why this would not be appropriate.

before and had family members locally. Cumbria Children's Social Care (CSC) assessed her as a Child in Need (CiN) at the time of the pregnancy, due to her own vulnerabilities.

4.2 Prior to his birth, George was made the subject of a Child Protection Plan (CPP) and pre-proceedings work was started under the Public Law Outline (PLO). The pre-birth assessment undertaken identified risks including Mother's substance misuse, her mental health, rejection from her own family, Father's poor experience of being parented, and the parent's relationship.

4.3 Mother worked with professionals and the PLO concluded as it was agreed that the threshold for care proceedings was not met. George remained on a CP plan until Mother left Cumbria to live with her own mother in another city at the end of 2016, when George was around 18 months old. Despite the recommendation from CSC in Cumbria that George remain on a CP plan, the new local authority undertook an assessment and the transfer-in child protection conference agreed that George should be the subject of a CiN plan. Mother told the review that a plan was never made and that she only saw a social worker once while she resided outside of Cumbria.

4.4 Around six months later Mother and George returned to Cumbria, homeless and with no money. They approached CSC as they were staying with Father whose accommodation was unsuitable. An Initial Child Protection Conference (ICPC) was held and a further period of child protection planning commenced in March 2017, due to concerns about Mother's associations with risky people and the difficult relationship between Mother and Father.

5 Key episodes

5.1 The time under review has been divided into three 'key episodes'. These are periods of intervention that are judged to be significant to understanding the work undertaken with a child and family. They are key from a practice perspective rather than to the history of the child. They do not form a complete history of the case but summarise the relevant activities that occurred, and are a brief outline of the information that informed the review and helpful to the reader of this report.

Key episodes
1. Child protection planning
2. Child in need planning
3. Response to injuries

Key episode 1: (child protection planning)

5.2 The decision to place George onto a CPP for the second time on his return to Cumbria was difficult for Mother to accept, as the other area had previously agreed that a CiN plan was suitable. Practical help and support was provided on George's return to Cumbria, including help with housing. Professionals worked with Mother with the aim of George being removed from a CPP and positive changes were seen. Father had little involvement with George. Mother told the review that George had a number of different social workers and health visitors, and that it was difficult having to go over her background information again on her return.

5.3 At a Core Group on 1 November 2017, around eight months after the family returned to Cumbria, it was noted that Mother had entered a new relationship and was spending considerable time with her new partner. The initial social work observations of him with

George were positive. George was described as a happy boy with a good and increasing vocabulary.

5.4 A Review Child Protection Conference (RCPC) was held two weeks later and it was unanimously agreed that the CPP should be stepped down to a Child in Need (CiN) plan. This was despite the police seeking information during the meeting about Mother's Partner, and finding historic concerns about his mental health, and criminal convictions for arson, violence, and drug related offences. Intelligence was also available about drug taking, domestic abuse, and that he had been remanded in custody but no further action taken for suspected sexual activity with a 14 year old child. This had not been shared with the social worker by Mother's Partner when she had asked him about his history. The social worker later discussed the concerns about the 14-year-old with Mother's partner and it was concluded that he posed a low risk to George.

Key episode 2: (CiN planning)

5.5 Mother and her partner moved with George into a larger home together in December 2017. The CiN planning continued and it was evident that Mother's Partner had an increasing role in caring for George. CiN meetings were held and Mother completed play-based work with Barnardos. There were no significant concerns although Mother's partner lost his job shortly after the move and was stated to be very low due to this, the resulting financial strain, and difficulties in claiming Universal Credits. At the same time Mother informed the social worker that she was no longer taking her ante-depressants[6]. It is now known that Mother briefly separated from her partner early in 2018 following a domestic abuse incident, but this information was not shared with any professionals at the time.

5.6 It was agreed in a CiN meeting on the 9 March 2018 that all of the identified needs had been met and that CSC involvement should cease. Mother did not wish to receive early help support, so George would have only received universal services support. The social worker had not yet closed the case at the time of George's admission to hospital on 22 March 2018.

Key episode 3: (response to injuries)

5.7 The Nursery that George attended was informed on 20 March 2018 that he would be absent for the week as he had 'a sickness bug'. On 22 March 2018 he was taken to the GP by Mother and her partner with concerns about conjunctivitis and a cough. A viral illness was diagnosed. George had bruising to his head and it was explained by Mother that he had fallen in the bath. The GP listened to George's chest but did not remove the clothes from his upper body so missed the other bruising later seen at hospital. As the GP was aware of the history of safeguarding concerns for George, they contacted the Strengthening Families worker after the consultation. They felt reassured that George was no longer on a CPP and the risks were felt to have reduced, and that George often had bumps and bruises. Mother told the review that the GP did not take George out of his buggy and that they listened to his chest through his clothes, including his coat.

5.8 Later the same day Mother contacted 111 stating that George had been seen by the GP that morning following a head injury, that he remained drowsy, and that he had slept for most of the day. 111 sent an ambulance and George was transported to hospital with Mother and her partner. A child protection medical was completed and a number of non-accidental injuries were identified. Mother and her partner later provided differing and inconsistent explanations for the injuries, but both suggested they were self-inflicted by

[6] First Step had advised her to continue taking her Sertraline (antidepressant).

George. The injuries were not thought to be consistent with the explanations given. George was taken into police protection and both Mother and her partner were arrested.

6 Analysis by theme and learning

6.1 From the information gained from the agency reports, from the discussions at the learning events, and from meeting with Mother, several key themes have emerged. The following are judged to be most significant and enable us to identify learning for the CLSCB and its partner agencies:

Themes
Predisposing risks
Parental self-report
Step down to child in need

6.2 Each theme identifies learning, and each learning point is linked to a recommendation in either this report or within the agency reports. It will be stated if the learning is being addressed elsewhere.

Theme: Predisposing risks

6.3 Pathways to Harm, Pathways to Protection; a Triennial Review of SCRs 2011–14 was published in 2016[7] (to be referred to as the Triennial Review) and states that consideration of a wide range of SCRs shows that there are factors in a parents' background which potentially may present a risk to a child. These include:

- Domestic abuse
- Parental mental health problems
- Drug and alcohol misuse
- Adverse childhood experiences
- A history of criminality, particularly violent crime
- Patterns of multiple, consecutive partners
- Acrimonious separation

The Triennial Review points out that these factors 'appear to interact with each other, creating cumulative levels of risk the more factors are present'. In George's case a number of these were present in regard to Mother, Father and Mother's Partner. They needed to be assessed and considered regularly when working with the family. Other factors are included in the Triennial Review as significant and include; young motherhood; estrangement from the new mother's own parents; temporary housing or supported accommodation; lack of support from the baby's father and/or an unstable relationship with the father.' These were also present in George's case and required consideration.

6.4 None of the relevant adults had positive childhoods. The CSC agency report found that what was missing from the assessments regarding George is the particular consideration of what risk these adverse childhood experiences posed to George. Despite the proactive use of child protection planning, there is no evidence that a thorough assessment was undertaken, including when Mother's Partner joined the family. All three had been living independently by the age of 16 and had limited, if any, family support. Mother's history included neglect, living in a home where domestic abuse was an issue, sexual abuse, and exploitation. Father has a history of parental bereavements and was a victim of interfamilial

[7] P. Sidebotham and M. Brandon et al. (2016)

sexual abuse at a young age. In the case of Mother and Father there was good knowledge of their histories. In the regards to Mother's Partner key information was not initially known and then was not considered adequately. This included his mental ill-health, violence to his mother and siblings when he was a child, and evidence that he used cannabis and illegally sourced prescribed medications.

6.5 The available information about Mother's Partner was not known until after the RCPC as checks had been undertaken within CSC using the wrong spelling of his name. As he was not living with the family police checks had not been prioritised earlier. It was good practice that the decision was made that police checks should be undertaken while the conference was taking place. The issue regarding what information was actually shared by the police at the RCPC is considered below. It is clear from the agency reports that other agencies had access to much of this information, and this was not sought or shared by them when it was known that he was in a relationship with Mother. It is not only the responsibility of CSC to check their records to see what historic information is available, and all professionals working with a family should make relevant and proportionate checks within their own agency records.

6.6 Verbal arguments were a regular feature of the relationship between Mother and Father. This was largely seen as a historic issue as Mother and Father were not a couple for much of George's life. Mother had also had other relationships where domestic abuse was a feature. It is known that domestic abuse can feature in further relationships if work has not been undertaken to address the issue. It now appears that the relationship between Mother and her partner was difficult on occasion as she left him shortly after they moved in together, although this was not known at the time.

6.7 Mother had a history of depression, anxiety and panic attacks. She was receiving drug treatment via her GP practice/s for this[8]. The assessment process undertaken by the health visitor identified that Mother suffered with moderate post natal depression following the birth of George and Mother saw her GP regarding this as advised. In November 2017 Mother self-referred to First Step[9] for support with her emotional and mental health. Mother told First Step that she had suicidal thoughts and they thought she likely had some symptoms of PTSD.[10] Mother attended four out of seven sessions offered and First Step did not feel that they had the opportunity to pursue the work required to address Mother's mental health, as the focus of the early appointments was to build a relationship. Mother disengaged from the service and she was discharged before George was injured. First Step believed Mother was self-aware, was managing, and that her issues would not have an impact on her care of George. None of those working with George were aware of Mother's work with First Step, but her mental health issues were known to them and at no stage was there an assessment of the impact of Mother's mental health issues on her parenting by any of those involved with George, including when Mother stated she intended to stop taking her anti-depressants in January 2018. Those involved appropriately supported Mother with her own issues however.

6.8 Mother's Partner had not seen his GP for a number of years, but historic information is available from 2014 that he was assessed by the mental health crisis team for low mood, self-harm and suicidal thoughts. Anger management and substance misuse were also issues

[8] Mother told the review that she was prescribed with a number of different anti-depressants over time, but she found the side-effects difficult to manage particularly feeling sleepy and the weight gain.

[9] First Step Cumbria provides free, talking therapies for a range of common mental health problems including depression and anxiety.

[10] Post-traumatic stress disorder

known to the GP, although it was not stipulated what substances he misused. This was not known by those working with the family at the time.

6.9 During the timescale of the SCR Father was referred to First Step for support with his mental health needs. He engaged with an initial assessment by the Urgent Care Team but did not engage with First Step when ongoing support was offered. There was no consideration of the impact on George of his difficulties. This may have been, in part, because his cooperation with the CP plan and contact with George was inconsistent. It was known however that Mother took George with her to live with Father after her return to Cumbria, and there was the possibility she would do so again.

6.10 Drug and alcohol misuse was an issue identified pre-birth. Mother admitted to drinking and to using cannabis, cocaine and plant food[11]. Father was known to misuse alcohol. Mother's Partner admitted to misusing cannabis, although he stated he had not done so for around 4 months prior to moving in with Mother and George, having 'grown out of it'. It was not known at the time that he also misused illegally sourced prescription drugs such as Diazepam. There was no evidence that there was on-going substance misuse by Mother at the time of George's injuries.

6.11 George had a number of moves when he lived with Mother, and much of their accommodation was insecure and inappropriate. The local authority intervened and provided support to ensure that Mother was adequately housed when they were made aware of the situation. As will be shown below, Mother was not always open with the professionals involved, and there was a feeling that she would only share significant information when pressed or if she required assistance. This included where she was living with George.

6.12 Mother was 17 years old when she had George. The Triennial Review states that the average age of first time mothers whose children were the subject of a SCR was age 19, compared to the national average of age 28 for first time mothers. It is noted that in parts of Cumbria the average age of a first time Mother is also age 19. Mother's young age, the absence of reliable family support, and the family's transient lifestyle and house moves may have adversely impacted on George's health, safety, and wellbeing. The practical help and support provided by professionals was good, but there was not always a step back to consider the likelihood of this pattern continuing and the impact this would have on George going forward. However with an improving picture there was understandable optimism around the time that George was injured. In this case, where the historic concerns and parental vulnerabilities are extensive, there should have been an understanding that the family will require support throughout George's childhood, and to be transparent about this with the parents.

6.13 The predisposing risks were acknowledged and George spent much of his early life on a child protection plan. Care proceedings were considered following his birth via the PLO because of the extent of the concerns. Over time however, and particularly following the involvement of Mother's Partner, the risks to George were thought to have reduced. There were no concerns about his presentation, there had been no specific incidents of concern, and Mother appeared to be cooperating with support. Barnardos had noted improvements and Mother was described as happier. There was evidence she was working on the Barnardos play advice between the play sessions, which is unusual and very positive. It was

[11] Plant Food is the street name of a drug called mephedrone, which is a powerful stimulant that's often compared to drugs like cocaine and ecstasy

understandably believed by all involved that a safeguarding response was no longer required.

Learning:

- Information held about parents and those living with or having extensive contact with a child, including historic information, needs to be analysed by **all agencies** and considered in respect of the risks and on-going impact on the child at all relevant points of the case.
- Any new information emerging requires thorough consideration, which may lead to a change in the plan for the child.
- Families like this one should be made aware that they are likely to require on-going involvement with support services due to the challenges they will face because of their own history.

Theme - Parental self-report:

6.14 For most professionals it is standard practice to take the word of a parent who is acting in the best interests of their child. When considering if there is a safeguarding issue, or when providing a child protection response, there needs to be respectful uncertainty and a consideration of whether the parent is providing all of the information. There were a number of occasions in this case where Mother was felt to be either saying what professionals wanted to hear or where she didn't share information. For example she did not tell professionals that she was moving home, she resisted giving the social worker the name of her landlord, she didn't tell them she was seeing First Step, and she did not disclose her pregnancy with her second child until explicitly asked by the social worker.

6.15 When Mother was receiving maternity care very little was recorded about Father other than his name, age and that he was no longer in a relationship with Mother but wanted contact. The social worker involved during the second period of CP planning tried hard to engage with Father but he was avoidant and having limited contact with George, so he wasn't particularly considered in assessments and interventions. Mother and George had lived with him on their return to Cumbria however and there were a number of indicators that they remained in a relationship or at least that there was contact throughout 2017.

6.16 Mother's Partner was not always open and honest. He told professionals (and indeed Mother) that he was the father of two children, and he did not disclose his previous contacts with the police when asked. It has taken a number of months, post George's injuries, for professionals to establish the extent of his deceit. He was seen, at the time, to be a positive influence for Mother and potentially a good carer for George. He appeared to provide the stability that had not been consistently evident prior to his involvement.

6.17 Once a professional has a view of a person or situation it can be difficult for them to change this view, even where there is evidence emerging that it might be based on incorrect information. In this case during the RCPC the police officer in attendance undertook checks on Mother's Partner as it was clear that he was spending a lot of time with Mother and George. Those involved in the case were aware that although the family said he was staying three nights a week, this is a common statement when the family is in receipt of benefits. He may actually have been staying more often or living in the home. In this case however the fact that he was not 'living with the family,' also had an impact on the decisions made, as will be shown below.

6.18 Mother often got angry with professionals. She had been known to shout and swear when she was upset or didn't get her own way. She was very angry when she moved back to

Cumbria and George was put onto a CPP. During this conference she was abusive and aggressive; screaming at one of the workers and calling her a liar. Mother was not seen as manipulative at the time but there were signs of avoidance and use of anger and aggression which could enable her to successfully deflect or diffuse concerns. The social worker largely handled these outbursts well, letting Mother rant then persistently returning later to explain what was required.

6.19 Mother's Partner had admitted to using cannabis in the past, but told the core group he had grown out of it and had given it up prior to meeting Mother. There is no evidence that when he lost his job and was feeling down in late 2017 that it was explored with him that he may feel tempted to start using cannabis again. It was not known at the time, but it has since emerged that Mother's partner also misused illegally sourced prescription medication. Mother's history of misusing substances was well known to agencies prior to the birth of George and in the first year of George's life, and this was a concern which was part of the CPP. More recently there were no concerns in this area. However there were occasions where it was known she had been drunk and in the strategy meeting held in March 2017 when she returned to Cumbria with George, it is recorded that on a home visit that Mother had looked "doe eyed" and she had been asked if she was using drugs. She had stated that she was taking codeine for a back condition and this made her drowsy. It is recorded that the social worker was not convinced by this explanation, but there is no evidence this was checked with the GP or that the danger of misusing prescribed or over the counter drugs was considered.

6.20 Mother opened up to an extent to the GP and to First Step about her mental health issues, but she underplayed it with those involved with George and found it difficult to accept that her behaviour could have a negative impact on her son. Mother's mental health was considered as part of the CP and CiN plans, however the core group did not have all of the relevant information and largely relied on Mother's report. She did not tell the social worker or core group that she was being seen by First Step, and did not initially tell First Step about the involvement of CSC with her child. They wrote to Mother's GP asking for any information to be shared around any safeguarding, risks, and history, but did not receive a response at that time. There is reference made to George within the risk assessment undertaken by First Step, highlighting that he is no longer on a CPP but is open as a Child In Need and that risks have reduced as Mother is engaging well with services including mental health. This appears to have been the report given by Mother in her first face to face session. This was not checked with CSC as would normally be the case.

6.21 A report was made by Mother to First Step of an incident where Mother's Partner had had to take a knife away from her as he was worried she may hurt herself. This was discussed with Mother and appropriate techniques to manage difficult feelings and the support she required were explored. Mother presented her partner as protective and said to First Step that he was instrumental in ensuring she did not harm herself. No discussion was had with her about whether George was present at the time of the knife incident however and whether any consideration was given to the potential impact of Mother's fluctuating low mood and thoughts of harming herself on George.

6.22 Mother told the professionals involved with George that she had PTSD, although she had not been explicitly told this, just that she had some of the symptoms. This may have been an understandable mistake, but it was not clarified with Mother or with mental health professionals what the impact may be on George. It is known that children living with a parent who has or shows signs of PTSD can be adversely affected, either due to exposure to

the parent's behaviour or because the parent is likely to be absorbed by their own difficulties and the child can be emotionally neglected. It is a complicated issue that was not considered as George appeared to be living in a more stable environment when the CPP was stepped down.

6.23 George had a number of minor injuries over time that were either sustained at the nursery or seen by the nursery and others involved. George was thought by some to be a slightly clumsy child who often fell over and bruised easily, and it became expected that he would have a certain amount of injuries. The nursery said however that George's coordination and physical development were within the normal age bands for his age/stage, and they did not find him clumsy. The Strengthening Families worker said she observed bruising and she gave Mother advice about safety in the home. Her concerns were more about lack of supervision than physical abuse. Bruises and bumps are common in children of his age in areas that are bony prominences such as knees, shins and foreheads. The social worker has witnessed George head banging when he didn't get his own way at home. The nursery did not see this behaviour in their setting.

6.24 George had changed nursery in around October 2017. Mother informed the new nursery on the registration form that George had a social worker, but when they asked Mother for the name and contact details they were told by Mother that the case was being closed. There was no evidence of contact from the social worker to the new nursery until February 2018, although there was a CPP and then a CinN plan in place at the time George was at the nursery. The nursery told the review they had tried to make contact with the social worker, but found this difficult due to the telephone system in place. The new nursery asked the old nursery for George's record and when they received it there was no reference at all to there being a social worker or George's status as a child on a CPP. The new nursery shared during the review that they had no concerns and that they were aware who the Strengthening Families worker was. The Strengthening Families worker was told by Mother that she had moved George's nursery on 30 October 2017, prior to the RCPC where the step down took place, but the nursery were not invited. Mother also shared her reasons for moving George at the RCPC.

6.25 When George was taken to the GP and the injury to his head was observed, the GP was satisfied that the bruising was consistent with the mechanism of injury reported by the adults, however there was obviously a degree of concern as the GP spoke to the Strengthening Families worker. The GP notes provide very little detail about the injury and the history given. The GP documented that the child was not in distress when he attended with his "parents" and he appeared well in himself. The GP Practice did not receive any minutes from the conferences in June or November 2017, so the GP decided to speak to the Strengthening Families worker which was good practice. After this discussion the GP decided not to make a safeguarding referral, and neither the GP or Strengthening Families worker spoke to the social worker although it was an open case.

6.26 In 2014 the NSPCC published a summary of learning from SCRs about disguised compliance. This involves parents giving the appearance of co-operating with agencies to avoid raising suspicions and to allay concerns. This can be an effective way of ensuring that professionals delay or avoid interventions. Professionals need to ensure they triangulate what parents are saying by establishing the facts, gathering evidence about what is actually happening, and communicating well with all involved. While there were examples of good information sharing in this case, there were also areas where this could be improved and where Mother's reports could have been checked with other professionals.

6.27 It is important that professionals share information and communicate to ensure that they do not rely on self-report. If information is not shared, professionals need to question this and challenge each other. This includes using the Cumbria LSCB escalation of professional disagreement policy if required. There were a number of times in the case where respectful challenge could have occurred. First Step did not receive a response from the GP when enquiring about Mother and the GP did not receive minutes from the June and November 2017 conferences. Neither were challenged at the time[12]. It is noted that CSC in Cumbria sought information from Children's Services in the previous local authority following the return of Mother and George, but it was not provided. The relevant police force also declined to share information with the social worker, stating that Cumbria Police needed to request this. This did not happen and this was not escalated. There was also a general concern voiced during the review meetings regarding how agencies such as nurseries can find out which social worker is involved[13].

6.28 Understanding of pressures across services can stop professionals escalating disagreements and make them less likely to complain about the system or practice of others involved in a case. In this area of Cumbria there are GP vacancies, capacity issues for Health Visitors, Social Workers and the Strengthening Families service. All of those involved are aware of this and do not wish to add to the difficulties by raising issues and taking exception with other agencies. It is understood that the time it takes to recognise issues, take up concerns and use the escalation process is also an issue. Those involved reporting the lack of time even for reflection. Practice needs to be child focused however and appropriate challenge improves services for children. The review found that those involved worked very hard with the family within the context of high demands on their time.

6.29 **Learning:**

- Professionals working in safeguarding need to exercise respectful uncertainty, healthy skepticism and be supported to always consider if they have the whole picture.
- Good information sharing is key, as is professional curiosity. However there are a number of barriers such as time, staffing, data systems, protocols and concern about consent.
- Not all practitioners are aware of, or use, the CLSCB escalation policy[14].

Theme: Step down to and closure of child in need

6.30 During the RCPC that unanimously agreed George should be on a CiN plan rather than a CPP, information about Mother's Partner was established by the police who undertook the required checks during the conference. The minutes show all of the relevant information was shared verbally towards the end of the meeting by the police officer attending. Most of those present only remember that the issues regarding an alleged sexual assault on a 14 year old, that now appear to be unfounded, were disclosed and discussed. The minute taker confirmed that the minutes only reflect what was said at the conference, as they operate on a 'if it's not said, don't put it in' basis. The focus of the discussion following the sharing of the information was on the allegation made by a 14 year old girl, and did not include a robust consideration of the other information shared. All of the police information

[12] The GP agency report noted that there has been a reduction in the number of Vulnerable Child Meetings happening within GP Practices in this area of Cumbria which has an impact on information sharing and professional challenge.

[13] Other information sharing issues were identified. George presented with a head injury in July 2017 for which he attended the Emergency Department at the hospital and was referred on for a Paediatric assessment. The information from the discharge letter indicated that the Safeguarding Hub had been contacted but the hospital clinician had been told that there were no safeguarding concerns. This was not the case, as George was on a CP plan at the time.

[14] http://cumbrialscb.proceduresonline.com/chapters/p_conflict_res.html

had previously been concealed by Mother's Partner from the professionals and from Mother herself. Despite the potential for the information to be significant, the fact that it had not been shared previously, and the need for it to be considered in light of any risk to George, the decision to step down was made. There was no suggestion of a shorter period of on-going CP planning while the new information was assessed.

6.31 The conference was chaired by a different IRO to the one who had chaired the previous meetings, and they told the review that this had an impact on the lack of challenge. However the IRO had been in post for four months and was an experienced chair, and although the previous chair remained in the service, no hand over took place. The new chair remembers it being a very positive conference and had no reservations about agreeing to the CPP ending, having stipulated that an assessment of the new information available about Mother's partner must be part of the CiN plan.

6.32 Mother's Partner was seen as a positive and stabilising factor for Mother and George by all those involved. The required CSC checks had previously been completed on him but using the wrong spelling of his name. The checks showed no previous involvement with the department, which was not the case. Despite the involvement of a new adult in the life of a child on a CPP, no updated Child and Family Assessment was undertaken before or after the RCPC. It was acknowledged in supervision in October 2017 that the presence of a new male in the home "increased the vulnerability for George" but no re-assessment was commenced. This was largely because things were thought to be going well and because George was observed to be comfortable and happy when in the care of Mother's Partner. In this case the social worker was newly qualified and this was her first allocated child protection case. She had inconsistent managerial support, having had a number of agency team managers over the course of the case and very few formal supervision sessions.

6.33 In the months that followed, no concerns emerged, until immediately prior to Christmas of 2017 when the social worker visited and was told that Mother's Partner had lost his job. He was observed to be feeling very down and they were waiting for a Universal Credit payment. Despite this George was physically well cared for, the home was in a good condition, and there was a Christmas tree and Christmas presents evident. This was reassuring to the social worker, who ensured the family had food bank vouchers to use on Christmas Eve in case the benefit payment did not arrive. This was good practice.

6.34 The conference agreed that when the CPP ended that there should be on-going CiN support, and an assessment should be completed regarding the new information available on Mother's Partner. A clear plan to discuss the full police history and Mother's partner's lack of candour regarding this history needed to be fully considered following the conference. It was agreed that the CiN plan needed to be in place for three months and Mother was focused on this timescale. She was determined that there would be no further social work involvement following this time. A CiN meeting was held after three months and concerns remained, these included Mother being pregnant and the fact that she was not on the tenancy agreement for the new accommodation, leaving her and George potentially vulnerable to becoming homeless. The Strengthening Families worker[15] had assessed George's development and identified a need for monitoring in a couple of areas. He was also observed to be head banging and biting. This information was not discussed with the nursery or with Barnardos who continued to be involved however. They reflected during the

[15] The health visiting role was provided via the Strengthening Families Team who deliver a holistic health service to families including parents/carers, children and/or young people, aged pre-birth to 18 and in some instances to age 25, that according to the CLSCB multi-agency threshold guidance 'require a statutory intervention'.

review that this would have been helpful information so that they could pursue these issues in their work with the family. The Strengthening Families worker missed two of the CiN meetings. Firstly due to not being told the family had moved (the meetings were held in their home) and then because of the delayed start to one of the meetings. There are capacity challenges for both health visitors and Strengthening Families workers in this part of Cumbria and this wider issue is being reviewed.

Learning

- Professionals need encouragement, support and confidence to reconsider their position when new information is shared during a meeting.

7 Conclusion and recommendations

7.1 George was injured while in the care of his Mother and her partner. While Mother acted protectively by taking George to hospital, he had injuries that had been sustained over at least a 4 week period. It is not known what impact the abuse will have on George as he grows up. He had injuries that shocked and upset those involved in the case. The care proceedings found that George had suffered significant harm from either Mother or her partner and that he should not return to Mother's care.

7.2 There is a local context, parts of Cumbria have a high number of young parents where there are predisposing vulnerabilities and risks evident. This poses a challenge for the partner agencies of the CLSCB due to the resources required to manage the demand. This has been identified in other SCRs undertaken locally and continues to be an issue.

7.3 Good practice has been identified in this case both in the agency reports and during discussions with the professionals involved in the case. They include:

- George had continuity of health visitor (who moved into a Strengthening Families role at the time) and social worker following his return to Cumbria.
- Cumbria CSC challenged the decision to step down to child in need when the family moved to another area.
- There was a timely strategy meeting and child protection conference on George's return to Cumbria.
- Despite George's young age, there was a lot of direct interaction with him.
- The social worker, who remains involved, was in her first year of practice and this was her first child protection case. She has shown an excellent commitment to George and has managed to maintain a challenging yet supportive relationship with Mother.
- There was a timely response from First Step following Mother's referral.
- The care George received at the hospital was excellent and timely.
- George was protected quickly. An Emergency Protection Order was obtained the next day and Interim Care Order 5 days later.

7.3 There has been a high degree of cooperation and engagement from agencies with the SCR process, which has been important in identifying the learning.

7.4 It is recognised that actions have already been taken in relation to some of the individual agencies' identified learning, and that changes have been made which will be outlined in the CLSCB's response to this SCR. For example First Step and health visitors (both those providing a universal service and those within Strengthening Families) have an improved relationship and have developed expectations and a system for information sharing.

7.5 The agency reports have made recommendations which have largely been completed by the conclusion of the SCR. Some of the learning identified within this report will have been addressed by the single agency actions plans. For example the nursery now ask explicitly, on their Registration Form, for the name and contact details of any other agency involved with the child.

7.6 The purpose of providing additional recommendations is to ensure that the CLSCB and its partner agencies are confident that any areas identified as being of particular concern, and not included in the single agency plan, or which require an interagency or LSCB action, are addressed.

Recommendation 1:

The learning from this review should be disseminated widely.

Recommendation 2:

This report should be shared with the LSCB in the area where Mother and George lived prior to time period considered by this SCR.

Recommendation 3:

The CLSCB to seek assurance from partner agencies regarding their promotion of and confidence in using the CLSCB policy for escalating professional disagreements.

Question for the CLSCB:
How can you be assured that the level of service provision to children with young parents who have predisposing vulnerabilities is sufficiently focused and resourced to meet the need in certain areas of Cumbria with high needs?