city & hackney safeguarding children board

CHSCB Response

Serious Case Review - Child M

March 2018

1. Introduction

1.1 In September 2016, the Independent Chair of the City and Hackney Safeguarding Children Board (CHSCB), Jim Gamble QPM, decided to initiate a Serious Case Review (SCR) into the circumstances leading to Child M's injuries.

1.2 The Chair's decision to undertake the SCR was made in line with Regulation 5 of the Local Safeguarding Children Board Regulations 2006 and consistent with the statutory guidance set out in Working Together to Safeguard Children 2015.

1.4 The SCR itself was not determined by any particular theoretical model and was carried out in accordance with the underlying principles set out in statutory guidance. Its overall purpose has been to look at what happened and why, to identify the learning for organisations and to make recommendations for either improvement or the consolidation of good practice.

1.5 The details of the SCR's findings are set out below and reflect examples of known systemic weaknesses that have previously been identified as evident within multi-agency safeguarding practice. This does not make them easier to address. It does, however, add impetus for the CHSCB and partners to ensure a continued focus on these challenges in order to reduce the likelihood of them featuring in future practice.

1.6 The findings and associated recommendations of the SCR have been accepted in full by the CHSCB.

2. Avoidance and Disguised Compliance

2.1 The SCR identifies a range of examples of parental avoidant behaviour or 'disguised compliance'. These terms are used to describe situations where parents give the appearance of co-operating with agencies to avoid raising suspicions and deflect attention from any concerns. A range of previously published case reviews highlight that professionals sometimes delay or avoid interventions due to parental avoidant behaviour or disguised compliance.

2.2 In the context of this case, such behaviour was primarily demonstrated by Child M's mother. This was not unique to one particular agency, with the SCR identifying a pattern of disguised compliance that related to a failure to engage with services, only

accepting pre-arranged home visits, avoiding contact with professionals and omitting to mention key information to professionals.

2.3 Such behaviour is known to exacerbate risks to children and young people removing the focus from them, missing opportunities to make interventions and through professionals being over optimistic about progress.

3 Insufficient Professional Curiosity / Challenge

3.1 Professional curiosity is the capacity and communication skill of professionals to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. The SCR identified occasions where more robust professional curiosity or challenge would have been justified.

3.2 Of particular significance in this case was the associated vulnerability arising from the mother's immigration status and the fact she was designated as having 'No recourse to Public Funds' (NRPF). The author identified that this issue rendered mother yet more dependent upon her partner and might have been more usefully explored. The significance of this issue is reflected in the author's commentary that he has experience of a number of deaths / serious injuries where parent(s) had NRPF and were anxiously awaiting or avoiding deportation.

4 Optimism

4.1 The SCR identified examples where professional responses appeared more positive than the available evidence would suggest. Again, this was a feature across a number of interactions from different professionals.

4.2 The 'rule of optimism is where professionals wrongly assume positive outcomes for children. It reflects a reluctance to make negative professional judgments about a parent, rationalising evidence that lessens the focus on risk and ultimately leading to professionals concluding good progress is being made.

4.3 Significant in this case was the 'cognitive dissonance' highlighted by the SCR author when the children were being considered at an Initial Child Protection Conference. The '***absence of evidence'*** confirming child M's injuries were non-accidental did not mean there was ***'evidence of absence'*.** The value of the subsequent child

protection plan, developed in consultation with partner agencies, was inevitably limited because it did not explicitly address the possibility of non-accidental injury and how that risk might be mitigated.

5. Communication, Understanding and Practice

5.1 The SCR also responded specifically to three anticipated themes included in the reviews terms of reference. These included.

- Communication: Was this clear within and across agencies?
- Understanding: Was there an agreed and complete understanding of risk across involved agencies?
- Practice: Was practice ad intervention within and across agencies appropriate and proportionate to identified concerns?

5.2 The SCR identifies a range of positive practice alongside areas for improvement arising from these particular aspects.

6. Recommendations

6.1 In respect of the overall findings, the SCR recommends a range of learning and service improvement opportunities for individual agencies and the CHSCB. These include the following that will be subject to scrutiny by the CHSCB for implementation and impact.

- **The ability of professionals to hold in mind the possibility of accidental and non-accidental injury rather than resolving discomfort / uncertainty by moving to an insufficiently-informed conclusion**
- **GPs' appreciation of child protection processes (by means of more effective information sharing, more reflective supervision and linking the impact of an aggressive parent to its implication for a dependent child)**
- **More robust and explicit safeguarding documentation e.g. body maps from the hospital Paediatric Department even in cases not progressing to s.47 enquiries**
- **A shared and clear appreciation of the required responses if parent/s within family cases closed to Children's Social Care, subsequently refuse**

to or insufficiently honour commitments to co-operate with universal services

- **A heightened recognition of and a greater readiness in Children's Social Care to identify and involve all relevant professionals at forums e.g. child protection conferences**
- **Confidence in the lawfulness and expectations of information sharing**
- **Ensuring that probation officers are up to date with safeguarding training and have associated confidence in risk assessments and liaison with Children's Social Care**
- **A clearer appreciation across the network of the role and expectations of probation officers**

6.2 In respect of specific recommendations for the CHSCB:

6.3 The CHSCB should seek reassurances with respect to the responses of non-statutory services in dealing with poor or non-engagement following case closure by Children's Social Care.

6.4 To meet this recommendations the CHSCB will:

- Review and amend the Hackney Wellbeing Framework and Resource Guide and The City of London Thresholds of Need as appropriate to ensure that poor / non-engagement following case closure is described with sufficient clarity to prompt escalation / further referral to CSC and that there is an expectation of further assessment activity.
- Disseminate any changes via its communication channels.
- Undertake a focused review of referrals and re-referrals and any relevant information / data / learning about escalation as a result of non-engagement.

6.5 The CHSCB should also seek reassurances from member agencies that there exists, or is being developed sufficient:

- **Clarity and confidence about the circumstances in which 'personal data' may lawfully be sought from other sources with and without consent**
- **Appreciation of the role and working practices of Probation Service Providers**

6.6 To meet these recommendations the CHSCB will:

- Require Board partners to respond to this issue of 'personal data' as part of their partner agency updates for the CHSCB. This will ensure consideration and resolution to any issues at Board level and depending on the outcome, guidance will be amended.
- Disseminate CHSCB guidance on Information Sharing via CHSCB communication channels.
- Require Probation Services to provide an update to the CHSCB on its organisational position following restructure, with a focus on how this impacts on their responsibilities to safeguarding children.
- Via the CHSCB Chair and Senior Professional Advisor, attend champions meeting of probation safeguarding leads.
- Ensure that Hackney Children and Families Services engage Probation in discussions concerning how to improve joint working and report solutions to the CHSCB.
- Seek to increase engagement by probation services staff in multi-agency training to broaden the awareness of their roles and responsibilities across the safeguarding network.

6.7 The CHSCB should develop and disseminate best practice guidance to:

- **Support practitioners working with avoidant families, frequently fluctuating circumstance and disguised compliance**
- **Enhance confidence within professional networks in the context of 'respectful uncertainty' / 'cognitive dissonance' , to develop plans and interventions which respond to the possibility of deliberate harm even in the absence of conclusive evidence**
- **Remind practitioners of the need to remain aware of the significance of bruising in pre-mobile children (as per section 3.9 London Child Protection Procedures 5th ed. 2016) (by 30.09.17)**

6.8 Whilst the CHSCB will seek to promote a wider understanding of these complex issues, it will also seek further reassurance that effective management oversight, the provision of reflective supervision, training and

comprehensive information sharing are all essential to mitigating the risk of such weaknesses.

6.9 To meet these recommendations the CHSCB will:

- Disseminate Pan London LSCB guidance on managing work with families where there are obstacles and resistance via its TUSK briefing. http://www.londoncp.co.uk/chapters/manag_fam_obst_resist.html
- Embed relevant learning arising from this SCR in CHSCB training
- Develop guidance for all front-line practitioners highlighting the need for respectful uncertainty in the assessment of risk and development of plans / intervention to protect children and young people.
- Establish reassurance from all partner agencies of the CHSCB that this guidance is disseminated to front-line staff and clarify the mechanisms undertaken to achieve this.
- Disseminate NSPCC guidance on bruising via its TUSK briefing and develop a specific web page on this issue on the CHSCB website.
- Develop a range of promotional material to further raise awareness.
- Review and confirm that CHSCB training material addresses the heightened risk of bruising in pre-mobile children and that this reinforces the need for professional curiosity and practice consistent with the London CP Procedures.

6.10 The CHSCB should also seek reassurance that network checks are comprehensive and engage all key partners at the point of a referral to First Access and Screening Team (FAST)

6.11 To meet this recommendation:

- Hackney Children and Families Services will report on the process of network checks within FAST to the CHSCB as part of the scrutiny of this plan. Any immediate issues of concern to be escalated to the CHSCB Chair.
- The FAST steering group will monitor operations within the FAST and continue to provide updates to Hackney CHSCB Executive.

6.12 The CHSCB should alert the Home Office to the additional vulnerability of those parents who have NRPF status (and thus an associated raised risk to

any dependent children) and urge government to develop policy and practice that more speedily resolves their presence in the UK

6.13 To meet this recommendation, the CHSCB will:

- Write to the Home Office setting out the issues of concern raised within this SCR in terms of parents with No Recourse to Public Funds (NRPF)
- Write to the London LSCB for wider consideration across London.