



NEWHAM LOCAL
SAFEGUARDING CHILDREN
BOARD

Serious Case Review

Child L

Executive Summary

November 2018

Serious Case Review (SCR) commissioned and completed for Newham Safeguarding Children Board (NSCB) in order to establish whether any lessons can be learned and to promote and develop good practice following a serious Incident for Child L

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1 Introduction

- 1.1 This Serious Case Review was commissioned by Newham Safeguarding Children Board (referred to as the Board in the report) to examine the practice of the multi agency network surrounding Child L and her family. The following is a brief resume of the circumstances leading to the review.
- 1.2 Child L is a child with complex needs. She has two older siblings who live at home with her. Child L has limited speech and her level of cognition is very limited. Child L has been well known to health services throughout her life by virtue of her complex health needs but the family have also been known to Newham Children's Services since 2008 (prior to her birth). These concerns were in regards to neglect, including lack of supervision, poor home conditions, limited engagement with professionals, poor school attendance and concerns about the children's presentation. In light of these issues the children were subject to two sets of Child Protection Plans during the review period in 2010 and 2015.
- 1.3 In October 2017 Child L was found trapped under her profiling, adjustable height bed¹ and had suffered a cardiac arrest. She was taken to hospital where she was placed in an induced coma.
- 1.4 The home was noted to be in poor condition and particularly Child L's bedroom. The police interviewed the mother and sometime after the event, she acknowledged that she was out of the house when the incident occurred. After some consideration a decision was made that no further action police action was to be taken with regard to neglect.
- 1.5 Child L made a full recovery. After the incident she was placed in foster care whilst the Local Authority made an application for care proceedings. Her siblings were made subject to Child Protection Plans for the third time. At the time of writing the report, Child L had been returned to the care of her mother under a court Order and her siblings remained subject to a Child Protection Plan.

2 Arrangements for the Serious Case Review

- 2.1 After the serious injury to Child L occurred, Newham Safeguarding Children Board took the view that the criteria for a Serious Case Review had been met which is entirely consistent with the guidance in 'Working Together to safeguard Children'² 2015. In this case the following applies as abuse of a child is either known or suspected and the child was seriously harmed (5(2) (b)(i): and there are concerns about how organisations or professionals worked together to safeguard the child.

¹ Special electrically operated bed for children with disabilities

²Working Together to Safeguard Children (Working Together) is the government's overarching guidance on safeguarding.

- 2.2 Arrangements were made to appoint the independent people who are required to contribute to the conduct of Serious Case Reviews. Tony Jobling was appointed to chair the Independent Panel. Tony is the Director of Operations, Adult Social Care in Newham and as such has had no direct management responsibility for the case. Ms Jane Doherty was appointed to produce this overview report. Jane is an Independent Social Work Consultant with a considerable background in Child Protection and Quality Assurance. Jane is accredited as a reviewer using the Social Care Institute of Excellence (SCIE) Learning Together model.
- 2.3 Newham Safeguarding Children Board appointed a Review Panel to oversee the review and ensure that the final report reflected their views as well as those of the independent overview author. The panel was made up of senior representatives from those agencies involved in working with the family, but members were not directly involved in the management of the case.
- 2.4 Those agencies involved with the family submitted Independent Management Reviews and contributed practitioners contributed through learning events.
- 2.5 The Terms of Reference developed by the panel and agreed by the Independent Chair of The Board were that the period under detailed review would be from the birth of Child L in 2009 until the date Child L was injured in October 2017.
- 2.6 Individual Management Reports were an opportunity for agencies to describe and analyse their contact with the family and these form the basis of the Overview Report.

3 Summary of Professional Involvement with the family

Names	Relationship
Child L	Subject
Child M	Sibling
Child N	Sibling
Ms A	Mother
Mr B	Father to Child L
Mr C	Father to Child M and Child N

- 3.1 The following is a very brief account of agencies' contact with the family and Child L. This summary covers a period of eight years and is intended to be a thematic rather than a chronological account of agency contacts.

Pen Picture of Child L

3.2 Child L is described as a happy and friendly girl who is sociable. Her disability severely affects every area of her learning and care, including her fine and gross motor skills, her personal skills, her communication skills and her information processing skills. She needs constant and close 1-1 support for all of these needs.

Explanation of health roles involved with the family and Child L

3.3 In order to try to understand the day to day life of the family and the complexity of Child L's needs, the following section provides the number of health professionals involved in Child L's care.

- 2 paediatricians for her specific conditions and general development
- A dietician to monitor her diet and growth
- An Ophthalmologist for her eyesight
- A dentist
- A team of nurses assess her nursing needs and provisions.
- The Children's Health Occupational Therapy Team assess her specialist equipment
- The Children's Physiotherapy Team advise on exercises and
- The Children's Speech and Language Therapy service provide support for her speech and language
- The Paediatric continence service provide supplies
- The Wheelchair service provide assessment and adjustment to her wheelchair
- The School Health Team advise on general health
- GP

3.4 Child L was born in 2009 with complex needs and received a brief service from Children's Social Care in Newham.

3.5 In 2010 significant child protection concerns emerged and all the children in the family were made subject to Child Protection Plans under the category of physical abuse. The concerns were largely about domestic violence between Child L's parents and issues about neglect – Child L had lost a significant amount of weight and had missed a number of routine health appointments.

- 3.6 The children remained subject to a Child Protection Plan until 2011 when at the Review Child Protection Conference they were 'stepped down' to Child in Need plans. At the point of step down, both parents were said to be working with professionals to improve outcomes for the children.
- 3.7 Later in 2011 the allocated social worker attempted to transfer the case to the Children with Disabilities Team. This was unsuccessful, as Child L did not meet their criteria for access to a service from that team.
- 3.8 Although no longer subject to a Child Protection Plan concerns continued to be expressed about the hygiene in the home and Child L (at times) being in an unkempt state. There were also still concerns about missed health appointments.
- 3.9 Further concerns were raised about Child L's hygiene and contact was made between the School nurse and the Special Education Needs Co-ordinator who addressed this with Ms A. The concerns were around Child L coming to school with torn clothes and head lice. This had been raised with Ms A on previous occasions but this had not improved.
- 3.10 In 2015 Ms A was convicted of two racially aggravated offences for which she pleaded guilty. She received a Community Order sentence.
- 3.11 In the same year the care of Child L was observed to deteriorate further and the Occupational Therapist involved in Child L's care made a referral to Children's Social Care. The concerns were similar to those previously noted e.g non-engagement with the professional network, repeated non-attendance at medical appointments and hygiene concerns. Child L's school attendance was 50%.
- 3.12 Ms A was very resistant to further intervention from Children's Social Care and was aggressive, refusing to let social workers in the house to speak to the children. As a result of these concerns a further Initial Child Protection Conference was held in September 2015 and all three children were made subject to Child Protection Plan's for the second time. The conference noted that there were current and historical concerns regarding Child L's attendance at school, mental health concerns raised about mother and the fact that Ms A was subject to the Community Order. There were also renewed concerns that Child L was underweight.
- 3.13 A further concern in regards to the older children came to light soon after the Initial Child Protection Conference. The girls disclosed, at times, they were caring for Child L.

- 3.14 **NB** throughout 2015 Child L's father (no longer living in the family home) came to the notice of the police a number of times. These incidents were mainly petty disputes or drug related offences. An Adult Safeguarding Merlin was created on one occasion and police assistance was needed to take him to hospital.
- 3.15 In 2016 the children were stepped down from a Child Protection Plan to a Child In Need plan having been subject to Child Protection Plans for 9 months. The professional network agreed to the 'step down' due to the improvements Ms A had made during the Child Protection Plan.
- 3.16 In the Review Child Protection Conference, amongst the positive progress that had been made, it was also reported that Child L had fallen out of bed earlier in the year. Child L's current bed was assessed as not suitable for her any longer and presented a risk to Ms A in terms of lifting and handling.
- 3.17 There was a delay of eight months getting the new bed in place and this was due to delays in the decision about which bed was most suitable. Further delays occurred in ordering it from the manufacturer.
- 3.18 A few days prior to the new bed being in situ, Child L was taken to the Emergency Department at Newham University Hospital as she had a burn to her leg that she reported was caused by the old bed. Ms A, mentioned the injury to the nurse from the Diana Team in a routine phone call. The team were concerned that Ms A had not given an adequate explanation about how it had happened but this was not followed up with Ms A until some weeks later. There is no further action recorded about the injury.
- 3.19 Throughout 2017 Child L continued to receive health care from the various professionals involved with her and the family but they did not report any significant dealings until the events that led to this Serious Case Review unfolded and Child L was placed in the care of the Local Authority.

4 Key Lessons for Newham Safeguarding Children Board

- 4.1 Prior to this incident, Child L was never allocated in the Disabled and Young People's Service and as a result she did not receive the wrap around service that catered specifically to her needs as a disabled child. Although there is now a draft policy addressing this there was no clear pathway for access into this service that was understood by practitioners or the professional network. Work has taken place to ensure that the Disabled Children and Young People's Team is more integrated in to the mainstream safeguarding services and this good work needs to be developed.

- 4.2 Newham's policy of one worker, one family, is good practice but needs to take into account the nuances of families where the needs of a disabled child have parity with their (and possibly other siblings) safeguarding needs. Further, the fact that disabled and non-disabled children in the same family may be using different resources or have differing needs (e.g. may be at different schools; may be classed as 'young carers') makes it even more essential that the professional network take all the children's needs into account.
- 4.3 Good practice in response to children who are consistently not taken to health appointments is not evident in this case. This indicates that Newham does not yet have a reliable system for identifying, and responding to, vulnerable children who are not having their health needs met. GP practices hold the ring in terms of having all the information available to them but do not consistently act to recognise them and act accordingly. Newham Safeguarding Children Board need to consider how this could be strengthened and the approaches that could support this. This may include holding multi-disciplinary meetings in the GP practice and / or revisiting the role of a lead paediatrician or Child Development Specialists. This would increase oversight of the on-going health needs for children with vulnerabilities such as complex health needs
- 4.4 Ms A was convicted of a racially aggravated offence during the review period that was never assessed in its own right. It would appear that this is because the violence was in relation to another adult and happened out of the family home. Another, (albeit more minor) incident happened later in the period which was not treated as a safeguarding issue. Adults capable of such assaults towards others should be considered in the context of their parenting capacity and suitability to care for children. It is important therefore that practitioners have a broad understanding of the risks posed by adults who are violent and that they assess risk based on the level, frequency, motivation and history of violence in its many forms.
- 4.5 The review has highlighted that the specialist equipment provided to Child L and her family was not always fit for purpose and there were no clear arrangements for it to be reviewed either routinely or after an incident. Furthermore information from Ms A would suggest that she did not know how to go about getting the equipment checked. The review has prompted an evaluation of how specialist equipment is procured, delivered and maintained. The relationship between commissioners in the local authority and Disabled Children and Young Persons Service has been re-established. This problem was exacerbated by the lack of a co-ordinated approach (discussed in next section) present in the latter stages of the review period.

4.6 The review has highlighted the importance of a co-ordinated approach for children with complex needs. This resonates with other Serious Case Reviews both locally and nationally. The panel accepted that there is more work to do in this area to make it more effective and as such is subject to a recommendation for The Board to oversee. Newham's policy of not providing Education, Health and Care Plans to children in specialist provisions potentially acts as a barrier to multi agency networking as this is a natural forum on which to build the Team around the Child. Children with complex needs are entitled to request an Education, Health and Care Plan and the Local Authority should provide these.

5 Family Contribution

- 5.1 Ms A was informed about the review and was keen to participate.
- 5.2 Ms A initially found it hard to be positive about a number of services and was more able to speak about the things that she was worried about now rather than reflect on her past involvement.
- 5.3 Ms A stated that Child L's wheelchair was currently not fit for purpose and she described it as a 'safety hazard'. Wheelchair services have not been forthcoming in sorting the problem. At the time of the meeting she had deactivated the chair as she felt it was not safe for Child L to use and so it had effectively become a static chair. She has the same issue with the current bed and doesn't feel that it is safe – it is unplugged all the time.
- 5.4 Ms A felt that Child L should have had an allocated social worker from birth and that she should have been allocated in the Disabled Children's and Young People's Service. She was unclear as to why this service was not available but thought that the extent of Child L's needs was not recognised. On reflection Ms. A acknowledged that she was not always easy to work with and that she was angry and could have done things differently. Her anger was about the lack of recognition of Child L's needs. She learnt to deal with multi agency meetings by keeping her 'mouth shut' and 'keeping (her) cool' so she didn't 'lose it'. Ms A recalled feeling 'picked on' and thought that they (social workers) 'had it in' for her. She now admits she didn't always understand what was going on and found that difficult. If she saw some papers before meetings she felt she couldn't change what it said once it was on paper and therefore couldn't add her side. She did not feel her children trusted social workers.
- 5.5 Ms A was positive about the Family Group Conference process and gets a great deal of support from her family now especially since child L has returned home. Members of her family take the older girls out and do shopping when it is needed.

5.6 Ms A was also pleased about the progress that physio had enabled Child L to make – she is able to pull herself up and generally becoming more independent. School have also been good at helping Child L improve.

5.7 Due to there being so many services involved, one of her biggest frustrations was not knowing who to contact to help her with the various things.

The Children's lived experience - Child L

5.8 The three children in this family had many contacts with professionals over the review period and their voice does not stand out strongly in the information provided. They were not consulted directly about the review but a number of observations about their contact with services are recorded here.

5.9 Child L's cognitive ability would have made it difficult to consult her directly but the expectation would be that any assessment undertaken would have the child at its centre. Assessments and plans should include the child's voice and information about the impact of the parents' lifestyles e.g. the child's lived experience. Most of the information from agencies provided to this review is silent on this issue suggesting it was not heavily present in the records.

5.10 Ensuring that the voice of the child when children are not verbal, professionals have to rely on other cues such as observations, eye contact, physical contact between parent and child and the level of care given.

5.11 One important way that children with disabilities can have their voice heard is through an advocate. It would appear however that this was not considered and that practitioners were unaware if this is provided by any service within Newham. It has been established though the review that advocacy services are available so it is concerning that workers were unaware of the service available.

5.12 Child L's medical and developmental needs were neglected throughout the period under review. Ms. A failed to take Child L to a significant proportion of routine appointments though she did respond appropriately when Child L presented as ill. Missed appointments were not challenged sufficiently by the professional network and meant that Child L's health needs were not always met. Practitioners were able to reflect that this may have been because they appreciated all too strongly how difficult life was for Ms. A and getting to appointments was a challenge for her.

Child's lived experience – Children M and N

5.13 In relation to the older children in the family it appears to be a similar story, though the review has been furnished with less information in relation to their needs.

- 5.14 The family live in a diverse community and their make-up reflects this. Child L's older siblings' (M and N) father is Black British and the children are of dual heritage. In consultation with practitioners many of them were unaware of their ethnicity. This may be because the focus of their work was Child L and her siblings went to different schools, perhaps limiting the opportunities for them to meet.
- 5.15 Ethnicity is an important factor in assessing the holistic needs of a child especially in regards to a child's identity. An opportunity was missed in 2015, when Ms A was convicted of a racially motivated assault, to assess the impact of this act on the day to day experiences of these children. Despite management guidance, it was not possible to find any individual direct work with the children to ascertain whether issues around their identity had been explored.
- 5.16 A question has arisen from the Serious Case Review in how much of the care Child L's older siblings. A disclosure in 2015 about carrying out tasks beyond their expectations did not result in a Carers Assessment and the issues do not seem to have been explored in any depth. We are also now aware that at the time of the incident both Child L's siblings were alone in the house with her and it is unlikely that this was an isolated occasion. This is a huge responsibility to place on such young shoulders.

6 Recommendations

- 6.1 Newham Safeguarding Children Board should review its Neglect Strategy to ensure that there is clear guidance on thresholds for intervention for children with complex needs.
- 6.2 To ensure holistic and co-ordinated care for children with complex needs, Newham Safeguarding Children Board to be assured that a system for identifying a Key Worker/Lead Professional for all Children with Complex Needs is in place i.e. this should be the case for all children not just those with an allocated social worker.
- 6.3 Newham Safeguarding Children Board should be assured that advocacy services are available for disabled children, young people and their parents. Further, those services available are widely advertised and accessible.
- 6.4 Newham Safeguarding Children Board to receive regular reports on the progress and timeliness of Education, Health and Care Plans provided to children with complex needs. The Board needs to be satisfied that plans are in place to ensure that each child entitled to an Education, Health and Care Plan has one.
- 6.5 Newham Safeguarding Children Board to seek assurances that the commissioning arrangements for specialist equipment for children with complex needs are;

- fit for purpose,
- transparent to families and practitioners and;
- have due regard for safeguarding of children.

6.6 Newham Safeguarding Children Board to ensure that practitioners in the children's workforce are equipped with the appropriate tools to be able to assess risk to children from violent adults.

6.7 Newham Safeguarding Children Board to ensure that there is a robust system in place to identify and assess those children who are consistently not taken to health appointments and particularly how these are managed by GP practices. The Board should also lead and embed a change in terminology for children who consistently miss health appointments from 'Did Not Attend' to 'Was not Brought'.

6.8 Newham Safeguarding Children Board to ensure that the new policy document *Disabled Children and Young People's Team 0-25 Eligibility and Functions 2018* is widely publicised and circulated to all relevant parties.

6.9 The Independent Chair of Newham Safeguarding Children Board to write formally to the bed manufacturer. The purpose of this is to make them aware of this incident and request that they explore the possibility of adding safety features such as a sensor to help prevent further accidents.

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