Nottinghamshire Safeguarding Children Board

A Serious Case Review

GN13

The Overview Report

June 2014

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1 Introduction and context of the review

1. This serious case review examines, for the purpose of professional learning and service improvement, the involvement of organisations with 22 month old GN13 who suffered a serious physical injury and abuse a few weeks after being transferred to Nottinghamshire from another local authority (County A).

2. An adult male (Adult 1) was convicted of sexually assaulting GN13 and is serving a substantial prison sentence. An adult female (Adult 2) was convicted of neglect and was made subject of a suspended prison sentence.

3. GN13 was the subject of a child protection plan (CPP) because of concern regarding a risk of neglect. The identified risk was not in relation to any information that Adult 1 posed a risk to GN13. Adult 1 had never been cautioned or convicted in regard to offences against a child or recorded on a local or national database as an adult who posed a risk to children.

4. The review is critical of some aspects of practice. These include a delay in conducting appropriate checks about Adult 1. However, even if those checks had been completed to the standard and timescale required, it is unlikely that they would have identified any information indicating a risk of harm to GN13 from Adult 1. The review has concluded that the specific abuse inflicted on GN13 by Adult 1 was not a predictable event and sets out the detailed reasoning for this in later chapters.

5. Legislation provides a duty to protect the identity of GN13 as a victim of a sexual offence and therefore on that basis the Nottinghamshire Safeguarding Children Board (NSCB) cannot publish any information that might compromise that protection for GN13. Section 1 (1) of the Sexual Offences (Amendment) Act 1992 provides: “Where an allegation has been made that an offence to which this Act applies has been committed against a person, no matter relating to that person shall during that person’s lifetime be included in any publication if it is likely to lead members of the public to identify that person as the person against whom the offence is alleged to have been committed.”

6. The serious case review overview report has therefore been written in such a way as to comply with the relevant legislation.

1.1 Summary of the circumstances for the serious case review

7. GN13 was brought to the local hospital emergency department by Adult 2. They had been driven to the hospital by Adult 1.

8. GN13 was diagnosed as having serious genital injuries as well as a bruise to the cheek and looked ‘generally unkempt’. Adult 2 provided an account for the injuries that described GN13 having fallen on a toy and also being struck by another child causing the bruising to the face.
9. Prior to this presentation at the hospital, GN13 had already been seen to have an injury on three previous occasions. A bruise had been seen by two different professionals; this is thought to have been one injury. GN13 had also received previous hospital treatment for a different injury to an eye that had allegedly been caused by a spoon.

10. The injury to GN13 that was presented to the hospital emergency department was referred to the NSCB standing serious case review (SSCR) sub group.

11. The SSCR initially decided that single agency reviews should be completed rather than recommending a SCR to the independent chair of the NSCB. Reviews were carried out by CSC and the Nottinghamshire Health Care Trust (NHCT) who then reported back to the SSCR.

12. A separate and routine quality review by the CSC Safeguarding and Independent Review Team identified issues about how the case had been handled.

13. Concurrent to these reviews there were other parallel processes. There was a criminal prosecution. Adult 1 was convicted of sexual assault and child cruelty and received a substantial custodial sentence. Adult 2 was convicted of neglect and received a suspended prison sentence.

14. There were legal proceedings in regard to GN13 that also involved the Court of Appeal. Formal complaints were also raised by Adult 3 with the local authority and through the Local Government Ombudsman Service.

15. As a result of new information that became available through these respective processes, together with the publication of revised national guidance set out in Working Together to Safeguard Children 2013 in regard to improvement and learning and the circumstances under which local safeguarding children boards should consider completing reviews, the independent chair of the NSCB commissioned this serious case review in August 2013.

1.2 The methodology and scope of this serious case review

16. The commissioning of the review coincided with the recent publication in March 2013 of the revised national guidance in Working Together to Safeguard Children 2013 that requires local areas in England to develop a learning and improvement framework (LIF).

17. The review methodology incorporates recognised best practice in regard to SCRs. In particular it explores underlying issues and moves away from prescriptive SMART recommendations that are increasingly understood to be

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1 The Local Government Ombudsman looks at complaints about councils and some other authorities and organisations, including education admissions appeal panels and adult social care providers (such as care homes and home care providers). It is a free service that is independent of the authorities and organisations and is used after the local complaint process has not resolved a complaint.
unhelpful in complex and interactive work such as safeguarding practice with troubled families and vulnerable children\(^2\).

18. As part of this approach, the analysis of the report uses an adaptation of SCIE's framework for grouping findings in the final chapter and provides a series of reflections and critical challenges for the NSCB to consider in respect of implementing learning and improvement.

19. The review gives an account of how and why the local safeguarding system of people and processes did not protect GN13 from abuse when the subject of a CPP. The findings set out how and why were people processing information in the way that they did, identifies the influences and critical factors in regard to decision making and action rather than just describing any missed opportunities.

20. A review panel chaired by the independent chair of the NSCB was convened and involved senior people from children’s services, the relevant local health organisations and police. At the initial meeting of the serious case review panel on the 3\(^{rd}\) September 2013 a number of potential areas or themes for improvement and learning had been identified as a result of the previous work.

21. An independent lead reviewer, Peter Maddocks, was commissioned to work with the NSCB and to have responsibility for providing this report for publication by the NSCB.

22. In addition to the chronology, the following information has been examined by the independent reviewer:

   a) Agency information provided to the original SSCR sub group;

   b) Information held by organisations including for example case recording, the minutes of the child protection conferences and agency reports;

   c) Information from the independent complaint investigation;

   d) Relevant local and national policies, procedures and practice guidance.

23. The independent reviewer also had a copy of the judgement arising from Adult 3’s appeal in respect of orders made in care proceedings concerning

\(^2\) A study of recommendations arising from serious case reviews 2009-2010, Brandon, M et al, Department of Education, September 2011 The study calls for a curbing of ‘self-perpetuating and proliferation’ of recommendations. Current debate about how the learning from serious case reviews can be most effectively achieved is encouraging a lighter touch on making recommendations for implementation through over complex action plans
GN13. The care proceedings are outside the scope and timeline for the SCR but the written judgment considers in detail the history of children’s services' involvement with the family.

24. The written judgment makes a number of important points about the manner in which information regarding Adult 3 was processed and the importance of securing factual and other evidential information upon which to make significant judgments.

25. Individual conversations were held between the lead reviewer and six professionals in October 2013. There were additional telephone conversations for example with the lead paediatrician for child sexual abuse (CSA) at Nottingham University Hospitals NHS Trust who is also the designated doctor for the county and the children’s services manager for the area that GN13 was living (although was not in post at the time of the events). There was also contact with the consultant paediatrician who diagnosed the abuse and initiated the safeguarding assessments and enquiries regarding GN13.

26. Information was also sought from the LSCB in County A who facilitated a telephone conversation between the independent reviewer and the social worker (CASW1) in County A.

27. An approach was made to the team manager who allocated and supervised social work involvement with GN13 in Nottinghamshire and had subsequently moved from the authority. The doctor who managed the initial admission to hospital had also moved to another position in a different area of the UK. Neither was available to provide information.

1.3 The scope of the review

28. The timeline of the review covers nine weeks from the first notification by County A about GN13 living in Nottinghamshire through to action being taken by the local authority through court proceedings.

29. The following organisations in Nottinghamshire had significant contact during the time frame for the review. The police were only involved following the diagnosis of abuse.

   a) Children’s social care
   b) County health partnership services that included health visiting, hospital emergency care, paediatric and orthoptist services
   c) Police
   d) Sure Start

30. GN13 never saw a GP during the time frame for the review.

31. GN13 remained on a CPP and on the caseloads of the professional core group members in County A until the initial child protection conference (ICPC) had made the decision in Nottinghamshire to make GN13 subject of a CPP. The
health visitor and early year’s worker were the professional core group members along with SW2 the social worker in Nottinghamshire.

32. In view of the short timeline to be examined by the review it was agreed that rather than selecting particular events or key episodes for closer analysis the review would use key lines of enquiry to frame the analysis of information:

a) The management of the transitions between services when GN13 and Adult 2 moved areas, including the exchange of information between County A and Nottinghamshire;

b) The assessment conducted by Nottinghamshire children’s social care, including a focus on the views of Adult 3, the presence of Adult 1, his relationship to Adult 2 and any potential risks and information sharing between the police and children’s social care;

c) The conduct and outcome of the Initial Child Protection Conference (ICPC);

d) The management and effectiveness of the core group;

e) The response to potential indicators of abuse including whether there were any indicators prior to the injuries which resulted in GN13 being taken to hospital.

1.4 The family and their participation in the SCR

33. GN13, Adult 3, Adult 1 and Adult 2 are all white British and speak English as their only language. There is no record of religious or other cultural affiliation. There is no record of learning or physical disability. Adult 3 is in employment.

34. Adult 3 and Adult 2 were notified about the SCR. Adult 2 had been convicted at the time that the SCR was commissioned and has not made any contribution to the SCR.

35. Adult 3 agreed to meet the independent lead reviewer and the NSCB development manager on one of his regular visits to Nottinghamshire for contact with GN13. GN13 now lives with Adult 3.

36. Information from that discussion has been included in relevant sections of the report. Significant themes from the discussion were:

a) the extent to which Adult 3’s contact and involvement with GN13 was not given sufficient attention at the point of transfer to Nottinghamshire or subsequently.

b) The manner in which reports of concerns about Adult 3’s behaviour to Adult 2 and to professionals in County A and how this influenced judgements but was not thoroughly inquired into or sufficiently understood. For example, Adult 3 acknowledged that he had been
controlling in the relationship with Adult 2; he described this as his reaction and response to the more chaotic lifestyle and caregiving that he reported seeing in regard to Adult 2.

37. The relatives of Adult 1 were not invited to participate in the SCR although reference is made to the disclosures that some of his relatives made when GN13 was abused and had been admitted to hospital.

1.5 The independent reviewer

38. Peter Maddocks has over thirty-five years experience of social care services the majority of which has been concerned with services for children and families. He has experience of working as a practitioner and senior manager in local and national government services and the voluntary sector. He has a professional social work qualification and MA and is registered with the Health and Care Professionals Council (HCPC). He undertakes work throughout the United Kingdom as an independent consultant and trainer and has led or contributed to several service reviews and inspections in relation to safeguarding children. He has undertaken agency reviews and provided overview reports to several LSCBs in England and Wales as well as work on domestic homicide reviews. He has not worked for any of the services contributing to this serious case review. He has undertaken training to work as an independent reviewer that has included participation and mentoring in the use of systems based learning and its application in serious case reviews.

1.6 Status and ownership of the overview report

39. The overview report is the property of the Nottinghamshire Safeguarding Children Board. Since June 2010, there has been a government expectation that all overview reports provided in England will be published in full. The overview report provides the detailed account of key events and the analysis of professional involvement and decision making. Its main purpose is to provide learning for the various services working with children and families in Nottinghamshire and to provide accountability.
2 Summary of events and professional contact

2.1 Initial referral to Nottinghamshire and information about the nature and longstanding concerns in County A

40. GN13 had been living in County A with Adult 2 but had regular contact with Adult 3. Those contact arrangements were characterised by increasing argument and conflict between the adults and led CSC to arrange for the transfer of GN13 for contact to occur in a neutral setting supervised by family members.

41. In the weeks before Adult 2 decided to leave County A there had been intensification in the assessment and support aimed at improving care for GN13. Both adults had considerable problems, although Adult 3 had shown significant improvements in regard to his health, lifestyle and care routines for GN13. Adult 2 had shown less engagement with the help being provided and managed negligible changes to her lifestyle and care routines.

42. There was increasing concern about the emotional distress to GN13 as a result of the acrimonious relationship between the adults and the continuing concerns about the lack of improvement in regard to Adult 2’s home circumstances and care. The local authority in County A had decided to invoke the procedure for commencing legal proceedings\(^3\). Adult 3 also began the process for applying for a residence order. However, before either of these processes had been started in any court Adult 2 had left County A without any prior notice or discussion with the local authority or Adult 3 and moved to Nottinghamshire.

43. Within 24 hours of the local authority social worker in County A being told that Adult 2 had left the county, action was being taken to locate Adult 2 and GN13. Adult 2 disclosed her location in Nottinghamshire through a phone conversation with the social worker at which point Nottinghamshire CSC were told of GN13 living in their area and the fact that GN13 was subject of a CPP. In parallel with this, the move was also notified by a health visitor in County A to a Nottinghamshire health visitor.

2.2 Summary of professional contact with GN13 in Nottinghamshire

44. In accordance with national and local procedures and standards, written information was provided by County A and an initial child protection conference (ICPC) was held in Nottinghamshire to transfer the case that was attended by the social worker (CASW1) from that area.

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\(^3\) The Public Law Outline (PLO) is a process to be followed by local authorities prior to issuing care proceedings in all but the most urgent of cases. After a meeting with legal services, to establish that the threshold for proceedings has been crossed, a decision is made whether to issue proceedings immediately or to meet with the family in order to set out the issues for them to try and work co-operatively to improve the situation and thereby avoid proceedings.
Nottinghamshire social worker (SW2) had already been allocated the case. Adult 3 was unable to get to the ICPC.

45. The ICPC was told of the previous history of involvement by statutory services in County A and the longstanding concerns about domestic abuse\(^4\) and neglect. The ICPC was told about the plan by County A to start the public law procedure for going to court. The ICPC was told about the intensive support that had been provided over several months in County A. The ICPC had less clear information about the extent and quality of contact that GN13 had with Adult 3 and does not appear to have appreciated the degree of progress that Adult 3 had achieved in making improvements to his lifestyle, home circumstances and care routines with GN13.

46. It also seems that the degree of disengagement by Adult 2 from any of the professionals in County A and her continued pursuit of a lifestyle and social networking that was not centred on GN13 was not properly understood by the ICPC in Nottinghamshire. A history of domestic abuse was mentioned in written information and discussion at the ICPC along with the acrimonious contact that the adults had with each other. Adult 2 had already begun telling professionals in Nottinghamshire that her main reason for leaving County A had been to escape the domestic abuse and to be near to family support. This became a key influence during the early weeks and coincided with the social worker becoming ill and being away from work for several weeks.

47. Information about Adult 1 had first been raised by Adult 3 just after Adult 2 left County A. He reported it to the social worker in County A. Coincidentally SW2 had met Adult 1 when the first home visit was made before the ICPC. Information had already been recorded by SW2 for the purpose of making a check on Adult 1 with other services including the police. He was introduced as a cousin who was helping Adult 2 and GN13 to settle in to their new home and was for example decorating bedrooms.

48. The ICPC was also attended by the health visitor and early years worker, who with SW2 would be the core group of professionals working with GN13 and Adult 2. It was agreed that there was risk of neglect because of the previous history in County A. GN13 was made the subject of a CPP, an outline plan was agreed and the first meeting of the core group was scheduled where a detailed plan was to be developed. All of this complied with local and national standards and timescales.

49. The health visitor was not available for the first core group meeting due to pre-booked annual leave and the requirement for the first core group meeting to take place within ten working days of the ICPC. Just before the first core group meeting the early years worker was told by a volunteer who lived close to GN13 that they thought Adult 1 was staying at the house. Adult 2 denied

\(^4\) There had been incidents between Adult 3 and Adult 2 but neither had a history of domestic abuse with any other party.
any relationship with Adult 1 when this was raised at the first core group meeting attended by SW2 and the early years worker.

50. Although further core group meetings were planned, none took place. The health visitor was not aware of the second meeting that had been scheduled and SW2 became ill and was away from work for the remaining weeks until GN13 was seen with an injury at the hospital emergency service.

51. A health assessment that was completed by the health visitor and early years worker found that GN13 was fit and healthy. Arrangements were made for follow up with the speech and language therapist but overall there were no concerns about GN13’s care. The interaction between GN13 and Adult 2 was observed to be good and Adult 2 appeared to be open to the contact with the professionals.

52. This generally positive picture in regard to how GN13 appeared to be appropriately cared for along with Adult 2’s assertions that she had fled the domestic violence was the context within which observation and communication about two bruises and an eye injury were processed. The bruises were explained by Adult 2 as being the product of usual childhood knocks while playing. The injury to the eye which was reported as occurring when GN13 had accidentally poked a spoon in the eye was examined and treated at the hospital ophthalmic service. The clinic was not aware of the CPP or history of neglect and did not consider the injury to be suspicious.

53. None of the injuries were examined or referred to a paediatric specialist and GN13 was never seen by the GP. Even if a paediatric specialist or the GP had seen the injuries this does not mean that they would have become sufficiently concerned as a result of any one single episode of injury as to have made a safeguarding referral to CSC. It was the emerging pattern of injuries that in retrospect invited further probing if the core group had been functioning as it should have.

54. As part of the CPP it had been agreed that checks would be made of Adult 1. This did not happen until the s47 enquiries began after GN13’s injuries were diagnosed as abuse by a consultant paediatrician. When the checks were made as a result of starting the s47 investigation into suspected abuse they were at an enhanced level that included the use of police national data and information systems. Those enhanced checks would probably not have been made when GN13 first came to Nottinghamshire. The reasons for this are dealt with in the final chapter.

55. Therefore, even if the agency checks had been made, it is highly unlikely that information to alert any professional to the threat that Adult 1 posed for a young child would have been revealed. However, a more rigorous approach would probably have revealed the true circumstances of Adult 2 moving to Nottinghamshire.
56. There was an initial delay by emergency department doctors and nurses in identifying potential abuse associated with the injuries when GN13 was admitted to hospital. The reason for that delay remains unclear; although clinicians were made aware of the CPP when the first phone call was made to the CSC emergency out of hours service, this did not lead the clinicians to make a referral either to CSC in order to start an investigation or to the duty paediatrician who could have assisted in making the diagnosis of abuse more quickly.

57. Although GN13 was kept safe because of being admitted to hospital, the delay meant that some forensic evidence was lost (through destruction in the hospital clinical waste system) and complicated the joint investigation by social workers and the police because of the opportunity given to Adult 2 and Adult 1 to continue having contact with each other.

58. Once the referral was made, the enquiries moved quickly and were generally consistent with procedures and expected practice. There was one discussion with Adult 2 by CSC that was undertaken without prior consultation with the police.

59. A significant issue arising from the case was the extent to which Adult 3 was kept at arm’s length. Despite making clear his wish to maintain contact with GN13, this was largely ignored. This occurred because Adult 2 was allowed to refuse contact and it was left to the adults to resort to private law if they had a dispute about contact arrangements. The significance of Adult 3’s contact and relationship with GN13 was not understood because nobody looked into it but rather relied on Adult 2’s views. When GN13 had been injured, Adult 3 came to Nottinghamshire but continued to be kept at arm’s length by the professionals.
3 Appraisal of professional practice; the significant points of learning and areas for improvement

60. Serious case reviews across the UK describe how men generally and fathers in particular can often be disregarded in the enquiries, assessment and ongoing contact with vulnerable children. Reviews also often comment on the degree to which work may not be sufficiently focussed on the needs and risk for the child or pay enough attention to their wishes and feelings, whether they can be heard for example in verbal children with language, or inferred in very young children or those with specific communication difficulties. Reviews also frequently describe the extent to which professionals’ judgments and decision making is influenced by adults wanting to disguise or misrepresent crucial information and to misdirect the attention of professionals away from sources of concern. These are significant themes in this case.

61. There was a concerted effort to misdirect professionals by Adult 2 about her reasons for moving to Nottinghamshire, to disguise the true relationship between Adult 2 and Adult 1 and this continued in regard to the four episodes of injuries that occurred to GN13 in less than two months.

62. The long term involvement by services in County A since the birth of GN13 had been about neglect and the impact of domestic violence.

63. CASW1, a social worker with several years’ experience of practice as well as case supervision, who had only been working with GN13 since February 2011, had felt that the case had required a more assertive approach and during the few months of involvement had been focussed on assessing and collating more detailed information about the extent of neglect and being more assertive with Adult 2 and Adult 3 in getting them to focus more clearly on how their lifestyle and behaviour was having an impact on GN13.

64. Intensive support was provided in County A through several services including Sure Start and FIP (family intervention programme) and family support workers had also worked with Adult 3. This level of intensive support and involvement did not continue in Nottinghamshire and may have contributed to the overly optimistic view of Adult 2.

65. By the time of the last CPC in County A it had become apparent that Adult 3 had made very considerable progress in using the support that had been provided. He had improved the living conditions in his home as well as to his personal health and had acted on advice in regard to adapting his home and style of interaction with GN13 to be more focussed on GN13’s needs. In contrast, Adult 2 had made very little progress and had been far less engaged with the support being provided to her.

66. This rather more nuanced understanding about what had been occurring over the most recent weeks before Adult 2 left County A was lost in the transfer and interpretation of information in Nottinghamshire where professionals
began to rely on the way in which Adult 2 interacted with them and presented information particularly about Adult 3.

67. Adult 2 was able to create a mind-set for the professionals that established her as a victim fleeing from domestic abuse. The next chapter that deals with findings explores the latent conditions for such mind-sets to develop. Factual information about the true nature of the violence was not enquired into until the s47 enquiries following the identification of abuse to GN13.

68. The concerns in County A about either adult having full time care of GN13 had centred on the inability of either to work constructively with each other and the emotional damage if GN13 continued to be exposed to their negative interaction. The decision to initiate the PLO (public law outline procedure) was delayed because of difficulties being able to schedule legal advice and input to the case in County A.

69. This level of detail about the CPP in County A was not apparent in the written information or the record of the ICPC that transferred the case to Nottinghamshire. The focus was much more on the history of domestic abuse and the concerns about GN13 being neglected. The domestic violence was turned into a local narrative in Nottinghamshire that portrayed Adult 3 as the threat and Adult 2 with GN13 as the victim by the time that a CPP had been agreed in Nottinghamshire.

70. The ICPC was not told, and did not ask clearly enough, about the level of contact that Adult 3 had been having with GN13 up until being taken away from County A or about the evidence of positive progress that Adult 3 had managed to achieve and did not understand the level of acrimony and joint responsibility for the ongoing conflict between both of the parents.

71. If there had been a greater focus on the needs of GN13 there would have been a more detailed discussion about the role and significance of each of the adults in regard to GN13 and the impact on GN13 of not having contact with Adult 3 with whom there appeared to be a good and caring relationship that was securely established.

72. Research evidence emphasises the importance of good emotional care and relationships for very young children to promote resilience in the child and create the conditions for long term healthy development. Giving attention to the quality of attachment is essential in assessment of children. Responsive relationships with consistent primary caregivers help build positive attachments that support healthy social and emotional development.

73. These relationships form the foundation of mental health for infants, toddlers and preschool children. There was clear concern in County A about the capacity of Adult 2 to meet these needs but this was not clearly enough understood in Nottinghamshire and was certainly not sufficiently reflected in the outline CPP.
74. The reasons that Adult 2 had given for choosing to move to Nottinghamshire was to be near to family who could provide support. This was never inquired into either in County A or by Nottinghamshire and in fact during the police interviews after GN13 had been seriously injured she acknowledged that she did not have close family living in the area. This should have been one of the tasks completed as part of opening s47 enquiries in Nottinghamshire; it was treated instead more as an administrative protocol with a great reliance on what County A provided as information which did not address the new circumstances in Nottinghamshire.

75. Adult 3 had almost immediately identified that Adult 2 was in a relationship, having seen information on a social networking site about Adult 2’s relationship status and passed that information on. The fact that this source of information was not checked when Adult 2 denied that she was in relationship with Adult 1 or after a neighbour had provided information suggesting that Adult 2 and Adult 1 were in a sexual relationship is discussed in the next chapter. The dissonance in the information and intelligence was never reconciled until the joint police and CSC enquiries after GN13 had been seriously injured.

76. The illness and absence for several weeks of SW2 as the lead professional for the case had a significant impact on coordinating and managing the case. SW2 had already felt overwhelmed by pressures and was away from work for several weeks at a critical stage in the case.

77. Whether the pressures were work related or were a combination of factors are not clear although SW2 described feeling unable to cope with an additional case at the time and says that they told their line manager. The manager no doubt had to manage complex workload pressures across a busy team and it would have been helpful to have had a greater level of information and insight about this if it had been possible to speak with them during the review.

78. It is a matter of fact that the workload for SW2 was not excessive as compared to the usual workload and level of responsibility given to equivalent social workers.

79. There were significant gaps in completing basic enquiries at the outset, ensuring the core group was functioning properly and developing a sufficiently detailed CPP after the ICPC. These gaps were not picked up through the routine line management supervision and oversight at the time. The workload of the supervisor or of the team as a whole at the time is not known.

80. EYW1 was the most persistent professional member of the core group to keep highlighting gaps in contact and the delays in carrying work forward. EYW1 did not escalate any concerns with their own manager; this should not be
interpreted as a criticism of the practitioner who showed the most effort and concern about the way the core group was not functioning and the follow up to information about Adult 1 and injuries. They were also relatively new into post although they brought experience from another related role.

81. The circumstances and motivation for Adult 2 coming to Nottinghamshire were not sufficiently scrutinised jointly by County A and Nottinghamshire from the outset. Resistance and opposition from parents and adults unwilling to accept the concerns about the welfare and safety of children are not uncommon for professionals working with vulnerable children and troubled families.

82. Flight, fight or disguised compliance are common strategies and it should be behaviour that professional core groups have the capacity to recognise and to engage with. In this case, the flight was not properly recognised and understood and the response in County A and in Nottinghamshire from the outset accepted the situation as a fait accompli or established fact. This does not reflect sufficiently child centred decision making.

83. Adult 2’s sudden arrival in Nottinghamshire just as County A were about to initiate the public law protocol with the express intention of pursuing care proceedings and the challenge of managing the case at a critical stage in professional intervention was complicated and impaired by the lead professional (SW2) becoming ill.

84. The case required continuity in respect of the plan that had been developed in County A. No advice or effort was sought in County A regarding an attempt to bring GN13 back to the area and to initiate care proceedings. With the benefit of hindsight this looks perverse given the greatest concerns in County A had centred on Adult 2’s poor caring and her inability to change her behaviour and was in contrast to the positive changes that Adult 3 had demonstrated.

85. Nottinghamshire were not in a position to initiate such proceedings given that at that time they had no evidence to support or justify a court application. They were being presented with a much more positive set of circumstances. These were accepted at face value rather than inviting more sceptical curiosity about why and where the neglectful care had disappeared.

86. The historical perspective became blurred when individual professionals in Nottinghamshire began to rely on their observations from relatively brief contact with Adult 2. They were reliant on working ‘in the moment’ and did not have opportunity to discuss the apparent dissonance about information.

87. The invisibility of Adult 3 and of Adult 1 within important aspects of assessment and enquiries are significant for different reasons and has implications for improving the focus on children in professional practice and decision making.
88. The implications for GN13 of the abrupt disruption of contact with Adult 3 were not considered at the ICPC or in the outline CPP. The extent and positive quality of contact was not fully known in Nottinghamshire until much later and then largely as a result of the complaint investigation and legal proceedings. There was insufficient attention to the implications of a new male being introduced or securing factual information about important aspects of both men’s histories.

89. Adult 3 was side-lined after Adult 2 left County A which abruptly ended all contact with GN13 although he sought contact and had made clear his wishes through CASW1 and followed that up in a phone call. Up until the point that GN13 was removed from County A, although there had been a high level of acrimony between Adult 3 and Adult 2, it seems clear that the contact for GN13 with Adult 3 had been of an improving and positive quality. This was never considered as part of the initial work of the CPP in Nottinghamshire.

90. A significant factor in the loss of contact and absence of Adult 3 from the life of GN13 is because of the attitude and decision making of Adult 2, who was not challenged in refusing requests for contact by Adult 3. He was uncertain of his rights in spite of retaining full and shared parental responsibility. When Adult 3 raised his concerns with CSC about the lack of contact the phone call was with a student social worker rather than with a qualified practitioner. The approach taken by CSC was that contact was a matter for Adult 3 and Adult 2 to resolve through private law applications if necessary and did not reflect a sufficiently child centred approach to the initial enquiries and assessment.

91. The reason that Adult 3 was regarded as peripheral to the new circumstances after the move to Nottinghamshire related to the local understanding about the history of domestic abuse and conflict. The detrimental impact on GN13 was recognised although there were crucial details that were not sufficiently understood through the transfer of information, both about the nature of the violence and the significance of contact for GN13. It was the inability of Adult 3 and Adult 2 to work together that had brought matters to a head in County A and for which both had been responsible. Adult 2 managed to make a significant change to this history by presenting herself as fleeing from domestic violence.

92. The information about conflict overshadowed the fact that there were significant differences in how Adult 3 and Adult 2 had used the respective support and the degree of improvements that each had achieved in County A.

93. The circumstances and facts about the domestic abuse were not clarified until the joint enquiries by the police and social workers after GN13 had been injured whilst in the care of Adult 2 and Adult 1.

94. There is consistent reference to domestic abuse in the records of meetings and in the information provided on transfer and a great deal of weight was given to this history it seems to the exclusion of other concerns in regard to
Adult 2’s pattern of care and to the exclusion of considering and enquiring into, for example the relationship, quality of care and degree of attachment between Adult 3 and GN13. These were not considered in the outline plan agreed at the ICPC or in any subsequent work up until Adult 3 had made a formal complaint and subsequent challenge of the local authority’s care plan.

95. There is further discussion in the next chapter regarding the definitions and understanding regarding domestic abuse that was the subject of judicial comment in the court judgment referred to in earlier sections of this report.

96. It was accepted from the start that GN13 was going to be adequately cared for by Adult 2 away from Adult 3. This should, even without the benefit of hindsight, have been challenged more strongly by County A who had worked with both adults and had direct knowledge about their contrasting circumstances and use of support.

97. Adult 2’s reluctance to engage with professionals in County A was not addressed in the CPP. In Nottinghamshire, apart from home visits and the one Stay and Play session at the Sure Start, Adult 2 was not required to make any other commitments or to be observed caring for GN13. Her ability to put on a positive front for the visits influenced how professionals interacted with her. Great reliance was placed on how GN13 interacted with Adult 2 during the home visits at a time when GN13 was still coming to terms with loss of contact with Adult 3, disruption to routine and social contacts and being introduced to several new people.

98. Adult 1 had never been cautioned or convicted in regard to offences against a child or recorded on a local or national database as an adult who posed a risk to children. However a significant issue in this case is information that has emerged relating to Adult 1’s previous contact with police and social workers in regard to concerns about injuries to the child of a previous partner in another part of the country.

99. The failure to invite the police to the ICPC or to request information is a significant area of learning. The reason for the checks on Adult 1 not being initiated remains unclear although it appears that SW2 was already subject to some emotional stress that was having an impact on their work. Monitoring the emotional and psychological health of professionals undertaking complex work such as safeguarding is essential in terms of obligations to employees as well as ensuring they have the capacity to function at the levels required. Emotional and psychological functioning is subject to change as a result of their work or other facets of people's lives.

100. The fact that SW2 showed appropriate curiosity about Adult 1 at the first home visit and secured information about him is evidence that SW2 knew what was required. It was in the follow through in that specific matter and in the general management of the case that their practice became problematic.
This was not picked up through the management oversight of the case. That combination of factors compromised the robustness of the CPP.

101. SW2’s explanation that they thought they had asked a colleague to process the check because of a change to SW2’s log in arrangements arising from a change in name has no correlation with established organisational arrangements. A change of name should not and is not an impediment to making a check. Although a significant oversight, as becomes clearer in later analysis in the next and final chapter of the report, it did not have a material bearing on what happened in this case.

102. It is probable that the information about Adult 1 would not have been revealed before the detailed search of police systems that were triggered when he and Adult 2 were suspected of causing or allowing the abuse of GN13. The information that was stored on the PND related to concerns that had been raised in another part of the country and had not been substantiated.

103. Such searches are time consuming and involve significant input from specialist personnel who have to sift and analyse the relevance and significance of a great deal of information that is often opaque and unclear. There are also intermittent IT issues such as those that occurred in this case that have an impact on searching information systems. It is not operationally viable for each and every background check requested by CSC to involve a PND check. It is therefore not a routine search and would not be undertaken without some justification and reasons relating to concerns about a child. An additional factor may have been an assumption that Adult 1 had always lived in Nottinghamshire.

104. The final chapter provides further detail on the framework used by the police for conducting background checks in relation to vulnerable children.

105. The drift in regard to meetings of the core group, beginning an assessment and completing enquiries had implications for the management of the joint enquiries in late August 2011 when GN13 was admitted to hospital. The enquiries had to deal with the absence of basic information and compensate for the absence of the lead professional who had already been away from work for several weeks. The team manager had to become more directly involved in the enquiries whilst managing a team and this led to several different professionals being delegated at different times to carry out aspects of the enquiries or case planning. This extended and complicated the lines of communication within CSC as well as with other organisations such as the police and health professionals.

106. The team manager was also simultaneously trying to address the gaps in regard to assessment and core group meetings, as well as comply with the requirements and protocols for conducting an investigation into the abuse of a child. There was a sense of trying to manage a crisis with very little capacity
to stand back and to adopt a more strategic approach to what needed to be done.

107. This should not be seen as criticising particular individuals who were managing a difficult and complex process under very difficult circumstances but it does highlight the implications when there has been inadequate planning and work at a much earlier stage. This is about organisational capacity as well as the way individuals perform and carry out their work. It had an impact on the general effectiveness of the CPP that had relied on meeting minimum visiting requirements using different professionals with very little substantial knowledge about GN13’s current circumstances.

108. It had consequences for example in important sharing of information about injuries to GN13 with Adult 2 before speaking with the police officers conducting enquiries. It also had profound implications for how Adult 3 was treated and the management of important decision making that subsequently fed into care planning processes that were the subject of complaint and challenge.

109. GN13 was injured on at least three occasions in the period examined by this review and had lost weight. Young children suffer minor injuries such as bruises and their weight can also fluctuate. It is not necessarily the case that an injury is evidence of abuse but it is important, especially for children who are known to be at risk of neglect, that they are the subject of even more careful checks and examination. Health professionals should take account of the histories that parents and carers provide as well as using their own observations of the injury and their understanding about what may or may not be an unusual or suspicious injury within the context of a particular child’s circumstances. In this case there had been very visible and persistent neglect up to the point that GN13 was brought to Nottinghamshire and such persistent neglect does not suddenly cease without reason.

110. Adult 2 had an established history of minimising concerns and trying to misdirect attention away from evidence of neglect in County A that was either not considered by professional members of the core group or were not reported to other health professionals or clinicians, such as at the eye clinic at the time that an eye injury was examined. No referral was made to the GP or to a paediatrician for the bruising, eye injury or weight loss. That history of minimisation was not factored into the mental calibrations of professionals querying bruising, injury and weight loss.

111. The most curious response to an injury was in regard to the presentation at hospital and the initial delay in having a paediatrician examine GN13 and review the history.

112. The admission to the hospital emergency department with the type of injury that GN13 had sustained should have aroused a greater level of concern from the outset. The delay in arranging a consultant paediatric examination had
implications for planning and starting the joint investigation by the police and CSC. It allowed opportunity for forensic evidence to be lost (the destruction of the nappy and clothing from arrival at the hospital) and gave opportunity for Adult 2 and Adult 1 to interfere with other forensic evidence and exchange information with each other.

113. The initial assessment and treatment of GN13 was by a doctor who was not a paediatric specialist. Although all doctors and nursing staff should undergo training and development to allow them to identify indicators of child abuse, it seems that on this occasion the doctor (and the non paediatric consultant who was consulted) was unable to contemplate the possibility of sexual abuse in such a young child. They may also have taken reassurance from the fact that GN13 was going to be admitted as an inpatient and that a paediatric specialist would be involved the following morning without appreciating the implications for conducting forensic and other enquiries.

114. Children attending the hospital paediatric emergency department with serious or suspected non accidental injuries should be discussed with the consultant paediatrician on call. It did not happen in this case and the reason remains unknown given the doctor no longer works in any of the local health organisations. The consultant who was called was not a paediatrician but was in a specialism that was seen as relevant to the main injury which was viewed only through a clinical and surgical perspective. The use of a non-paediatric consultant meant that there was no immediate access to specialist expertise and advice about potential abuse.

115. There was confusion about the purpose of contact with CSC just after the initial presentation. A referral should have been made and if it had been it would have triggered an earlier joint enquiry by CSC and the police.

116. There was also confusion about which of the paediatricians was the lead doctor. Although this did not hamper diagnosis or treatment it did add to complexity in communication between health, CSC and the police.

117. The significant themes in appraising professional practice were:

a) The circumstances and motivation for Adult 2 leaving County A apparently after being told of the local authority’s intention to start legal proceedings was not subjected to rigorous discussion between County A and Nottinghamshire at the outset;

b) Interaction and information was heavily influenced by how Adult 2 behaved and communicated with professionals after arriving in Nottinghamshire. The absence of a sufficiently rigorous enquiry and assessment of the new circumstances meant that professionals were unable to counterbalance that influence;
c) The fact that Adult 2 had begun a relationship was missed during the initial weeks despite information being provided by Adult 3 and the suspicion of the early years worker;

d) The clarity of communication between professionals and organisations was a recurring issue; it began in the transfer of information at the outset in regard to achieving enough clarity about recent events and developments in County A; it reoccurred when contradictory information was being processed about the relationship between Adult 1 and Adult 2; the initial consultation between the hospital and CSC when GN13 was presented at hospital was unclear;

e) The written and verbal information about the concerns that had been the subject of a child protection plan in County A were quickly seen as a historical concern in Nottinghamshire with an emphasis on the threat of domestic abuse from Adult 3 as presented by Adult 2, who presented as a woman who had fled domestic abuse and was making a new start;

f) Because Adult 3 was viewed as a source of abuse and violence, this had implications for how contact arrangements were agreed as well as the processing of information and concerns from him. Adult 3 remained peripheral until the outcome of the investigation of his complaint to the local authority and to the ombudsman service several months later (and outside the scope and timeline of this review). Nobody ever explained to Adult 3 what legal status he had; the use of the formal complaints procedure was effective in Adult 3 being recognised as a party to the care planning as well as legal proceedings;

g) Contact was managed as a dispute between antagonistic adults rather than an issue to be addressed in regard to GN13’s emotional health and developmental needs and was not addressed in the CPP;

h) Relying on outline plans of protection and the personal recording of core groups; the CPP which was not developed into a detailed plan, did not sufficiently address any detail about people who would have contact with GN13 and made no demands on Adult 2 in regard to participation at Sure Start sessions beyond an introductory session. The plan became preoccupied with process such as frequency of visits and the overall contact and supervision was at a lower level than had been taking place in County A;

i) Injuries and loss of weight were recorded and managed as separate episodes rather than seeing a pattern; this created the latent conditions for a general tendency to treat incidents as
accidental in spite of the CPP and history which was not routinely known in emergency treatment centres. There is not a consistent practice for enquiries and checks to be made by clinical or nursing staff in hospital emergency services to establish if a child is on a CPP;

j) Contradictory evidence and perception was not reconciled for example from the neighbour regarding Adult 1 being at the house overnight;

k) Leadership of the CPP was compromised by the illness and absence of the allocated social worker; this was not communicated to other professionals in the core group;

l) The only structured assessment that was completed was the family health needs assessment by the health visitor and early years worker; the positive evidence from this and other observations were not counterbalanced by other more holistic collation of evidence and history;

m) Adult 2 and Adult 1 were both very self-confident and skilled in misdirecting and misleading professionals, some of whom had several years of professional practice. This proved successful until faced with the compelling evidence of injury to GN13 and a more forensically driven approach to checking information than was achieved previously;

n) Implementation of child protection plan actions were delayed in County A and in Nottinghamshire; in County A there were delays in seeking legal action; in Nottinghamshire the focus of the plan was on complying with visiting schedules;

o) Gaps and delay in checking of information in regard to Adult 1 within CSC was not picked up by the supervising manager or by other professional members of the core group. The lack of a consistent social worker meant that no individual had enough single oversight of the case and information and observations that were being reported;

p) Judgements about the injuries to GN13 were made without full knowledge of history in regard to neglect and without the benefit of paediatrician input until the admission to hospital and that input was subject of further delay;

q) Restrictions on contact with GN13 occurred before any legal advice had been sought and legal action had been taken. There was an initial reliance on the police being willing to exercise their powers of protection and the restrictions on contact imposed by
the police bail only applied to Adult 2; Adult 3 was not and has never been subject to bail conditions restricting contact with GN13;

r) Getting bogged down in process; the conduct and management of the s47 investigation was hindered by the delays in starting assessments and collating information; the involvement of several professionals created more complicated communication within CSC and with other services.

118. Further analysis from this review and how it relates to significant themes for learning is discussed in the next chapter.
4 Analysis of key themes from the case and description of findings for learning and improvement

119. Meaningful analysis of the complex human interactions and decision making processes that are involved in multi-agency work with vulnerable children and troubled families needs to understand why things happen and the extent to which the local systems (people, work processes, organisational arrangements) help or hinder effective work locally within ‘the tunnel’.

120. This chapter sets out key findings that are designed to offer challenge and reflection for the NSCB and partners. The emphasis is not on the more traditional formulation of SMART recommendations that tend to call for ever more procedure or protocol with the consequences of introducing more bureaucratic and mechanistic responses that do not help promote effective practice and decision making.

121. The key findings are framed using an adaptation of the systems based typology developed by SCIE to identify some of the underlying patterns that appear to be significant for local practice in Nottinghamshire:

   a) Cognitive influence and human bias in processing information and observation;
   b) Responses to significant incidents and information;
   c) Family and professional contact and interaction;
   d) Tools and frameworks to support professional judgment and practice;
   e) Management and agency to agency systems.

122. The remainder of this report aims to use this particular case to reflect on what this reveals about gaps or areas for further development in the local child protection system.

123. In providing the reflections and challenges to the NSCB there is an expectation that there will be a response to the key findings in regard to the following:

   a) An indication as to whether the NSCB accepts the findings;
   b) Information as to how the NSCB will take any particular findings forward;
   c) Information about who is best placed to lead on any particular activity;
   d) An indication of the timescales for responding to the findings;
   e) Information about how and when it will be reported.

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5 View in the Tunnel is explained by Dekker (2002) as reconstructing how different professionals saw the case as it unfolded; understanding other people’s assessments and actions, the review team try to attain the perspective of the people who were there at the time, their decisions were based on what they saw on the inside of the tunnel; not on what happens to be known today through the benefit of hindsight.
124. The NSCB will determine how this information is managed and communicated to relevant stakeholders including the LSCB in County A. The formal response should form part of the publication of the SCR.

4.1 Cognitive influence and human bias in processing information and observation

Recognising and dealing with the latent conditions in which the rule of optimism can develop; the influence and dangers of first impressions; creating and sustaining appropriate mind-sets based on sufficient reflection and analysis;

125. This part of the analysis explores how people working with GN13 processed information and attributed meaning or interpreted aspects of behaviour and what it represents in terms of work with vulnerable children at risk.

126. The way that people think about the behaviour of another person and how they interact has an influence on how information is processed and their judgments are formed. Professionals undertake training and development, and are often very experienced as they were in this case, although they can be subconsciously susceptible to these cognitive influences.

127. People who abuse children often have an absence of the usual socialised emotions such as love, shame, guilt, empathy or remorse. With a clear facility to deceive and to manipulate other people they can become very dangerous to vulnerable children, especially when the child has limited language or contact outside the home as in this case.

128. The people, as exemplified in this case who are required to spot the threat, could hardly be more different by virtue of their personal values and vocation to work with and to help vulnerable children and adults and often in the face of great economic and social disadvantage. They are by contrast natural carers and nurturers, people who easily empathise with others. Therein lies the risk that their belief in the decency of human nature can interfere in how information is processed.

129. A recurring theme in reviews and research is the extent to which the rule of optimism dominates important judgments about the adults caring for vulnerable children\(^6\). The rule of optimism influenced how Adult 2’s explanations and accounts were heard and dealt with.

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\(^6\) In 1983, Dingwall, Eekelaar Dingwall and Murray, (The Protection of Children: State Intervention and Family Life, Blackwell, Oxford) investigated professional decision making in an English child protection system. They developed the 'rule of optimism' to explain how health and social workers were screening or filtering out many of the cases with which they were involved. These researchers asserted that under the 'rule of optimism' workers applied a heuristic or routine method of practice which was used to reduce, minimise, or remove the concerns for the child's welfare or safety. This was done via the workers applying overly positive interpretations to the cases that they were
130. Daniel Kahneman’s book *Thinking, Fast and Slow* describes how we all generally rely on fast or automatic thinking to process information. It is an attribute that skilled professionals will use to quickly retrieve stored experience to make complex decisions and often under pressure.

131. It is the sort of processing that workers in emergency services will use along with other practitioners who work with volatile and unpredictable situations such as alcohol, drug, mental health and social care settings. This type of cognitive processing makes low demands and is therefore a default position that is called ‘system 1 thinking’ by Kahneman.

132. In contrast, there is slower and more reflective thinking that allocates attention to the mental activities that demand effort, such as complex computations and conscious, reasoned choices about what to think and what to do. This is Kahneman’s ‘system 2 thinking’.

133. In this case slower thinking could have included really exploring the circumstances and motivations for GN13 to have been brought to Nottinghamshire, dealing with the conflicting accounts about Adult 1, making better sense of why there appeared to be such a contrast in the observations from home visits in Nottinghamshire compared to County A and dealing with the accounts of injury to GN13.

134. Achieving the slower reflective thinking requires emotional and mental discipline that professional supervision should be assisting with. It will be susceptible to issues such as the emotional, mental and physical capacity of any given professional and their organisational pressures such as workload. SW2 was already feeling overwhelmed when allocated the case despite the workload being within the organisation’s calibration of what should reasonably be expected of a qualified and experienced social worker.

135. Within Kahneman’s model there are a number of phenomena that have relevance to complex work such as safeguarding. It is System 1 that will initially make an active effort to assign meaning to events and information, and to make judgments about people and events. Because System 1 does this very quickly, and often in very busy and stressful circumstances, it relies on short-cuts and educated guesses. The required response to this is not to create more procedures and checklists (which can help as aide memoirs or prompts) but rather focus on the mental processes and discipline that should be brought to bear.

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assessing. The same research suggested that the ‘rule of optimism’ was only discounted when parents refused to cooperate with workers and rejected help (a ‘failure to cooperate’), or when there was a ‘failure of containment’ where a number of workers became involved with the case and the pressure for protective action became too great. Child death inquiries and serious case reviews have continued to comment on the phenomenon.
136. In making sense out of unfolding events or disclosure of information, System 1 is involved in judging and evaluating the people and behaviours as it is experienced and because System 1 resorts to shortcuts and educated guesses to process its impressions as quickly as possible, it jumps to conclusions based on what limited information it has ready access to. Therefore information, which given that it lives very much ‘in the moment’, is confined to what is directly in front of it, and/or is readily coming to mind rather than what might be in a computer record or report to a child protection conference.

137. System 1’s tendency to consider only the information that is directly at hand is so pervasive and Kahneman refers to it so often, that he uses an abbreviation to represent it. WYSIATI: what you see is all there is. In this case, what people saw was someone who was escaping domestic abuse from a controlling ex-partner and saying that she wanted to do the best for GN13 and she presented herself as being motivated and friendly and disinterested in any sexual relationship and with the apparent support of family members, including a ‘cousin’ ready to help her set up a new home and make a new start.

138. This became the prism through which subsequent information was processed in the absence of any structured and analytical discussion within the core group or with lead safeguarding professionals.

139. In addition to WYSIATI, System 1 also jumps to judgments and evaluations in several other ways. For example, when presented with a question that we do not know the answer to, System 1 will get to work and answer a related but much easier question, and then offer up this answer to System 2 as the solution to the more difficult question. In a case such as this, a question might be whether a parent has changed or is able to care effectively for their child. This will be much more difficult than the question ‘is the parent someone I find likeable (and by implication can trust and want to help)?’

140. System 1 is very susceptible to first impressions. System 1 also takes a third short-cut in evaluating people, and this short-cut is known as the ‘halo effect’. As Kahneman explains, the halo effect is “the tendency to like (or dislike) everything about a person including things you have not observed”. Essentially, System 1 tends to evaluate someone on one or a handful of traits, and then simply extends this evaluation to other characteristics. Kahneman gives an example; “you meet a woman named Joan at a party and find her personable and easy to talk to. Now her name comes up as someone who could be asked to contribute to a charity. What do you know about Joan’s generosity? The correct answer is that you know virtually nothing... But you like Joan and you will retrieve the feeling of liking her when you think of her. You also like generosity and generous people. By association, you are now predisposed to believe that Joan is generous. And now that you believe she is generous, you probably like Joan even better than you did earlier, because you have added generosity to her pleasant attributes”.
141. In this case, when the first injuries were observed on GN13, the overriding influence was what Adult 2 was saying and this continued through to the first time that a consultant paediatrician examined GN13 who had not met Adult 2 or Adult 1 and arguably also had the collated evidence for the first time of a pattern of injuries over several weeks as well as having training and professional knowledge to query the evidence.

142. *Thinking, Fast and Slow* provides an accessible vocabulary to discuss the processes of human cognition which are the interactions between System 1 and System 2 thinking and are critical to work with vulnerable children. It does not, however, provide solutions or reliable approaches to bias mitigation.

143. According to Kahneman, the best we can hope to do is learn to recognise the situations in which mistakes are likely, and try harder to avoid specific errors when the stakes are high; for example when making enquiries and completing assessments where there is evidence of vulnerability.

144. The effort to combat such influences has contributed to the creation of procedures and checklists that do little to help create the level of cognitive awareness and discipline required. If core groups are operating effectively and are being led by a sufficiently experienced and supported professional this creates the opportunity for more focussed and thoughtful processing of information as long as information is not taken at face value. Other factors such as the degree of stress or workload will also be powerful influences and are discussed in a later section of this analysis.

145. Research and evidence from reviews also often highlight the influence of confirmation bias; the human instinct to find only the information that is consistent with an expectation that has already begun developing in the mind of those responsible for the checks or enquiries into information. Adult 2 set out to deceive from the outset and created a narrative of being a woman making a fresh start for her child.

146. The curiosity in this case is that given the extensive history of agency involvement and concerns in County A and the agreement that GN13 was at risk of harm after arriving in Nottinghamshire, the human instinct that became influential was more of watchful waiting rather than the more sceptical and curious query as to where had the neglectful behaviour gone? It shifted the focus from identifying and managing risk of neglect to one of providing support. Some of this can be attributed to the fact that the only discernibly structured observation and assessment was in regard to health and development which at that stage did not show evidence to cause concern. Neglect is not a single or one off event but a pattern over longer time periods. There is further discussion in later sections about the tools and frameworks that can help.

147. The early years worker who had begun working at the Sure Start centre relatively recently was alert to information that was provided about Adult 2
being heard at night apparently with a sexual partner who it was believed could be Adult 1.

148. The information was reported to SW2 and it was discussed at the first (and only) core group meeting but was met with denials from Adult 2, who provided an alternative account of the sounds being heard. In spite of that dissonance in information, it did little to disturb the initial impression that Adult 2 was no longer neglecting GN13’s needs despite a long previous history in County A.

149. The relative professional status of the social worker and early year’s worker was also probably a factor; a tendency to defer to the more qualified and more experienced practitioner, although in this case the more experienced professional’s functioning was impaired (SW2).

150. Developing the capacity for achieving and maintaining a healthy sceptism and respectful uncertainty to collating and processing information and observation are recurring themes in SCRs; in this case it is not certain that either practitioner believed the account by Adult 2 but found it impossible to prove or disprove and it was not discussed again and did not appear to be revisited when subsequent information about injuries began to accumulate.

151. One of the professionals who has several years experience described how they had felt that they had been taken in by Adult 2; evidence of the ‘halo effect’ at work. The account that Adult 2 provided of fleeing violence appeared plausible and the professional had not observed any behaviour from GN13 or Adult 2 to cause concern about their relationship. When the bruise was seen on GN13 the history of it being accidental was felt to be plausible, as was the eye injury when examined at hospital.

152. SW2 showed initial rigour in her questioning of Adult 1 although did not follow through with completing the required checks in spite of this being discussed at the ICPC and being a specific action in the CPP.

153. It was Adult 2’s ability to misdirect attention that probably contributed to the lack of urgency in regard to making checks and the absence of any detailed assessment or planning. This lack of urgency occurred in County A as well as in Nottinghamshire.

**Issues for the NSCB to consider in regard to learning and improvement**

1. Is local professional training and development providing sufficient attention to the cognitive discipline required for combating inadvertent optimism in work with vulnerable children and troubled families?
4.2 Responses to incidents or information

Keeping the child as the focus for enquiring into incidents, injuries and information; checking and triangulating information about adults (and men in particular) not biologically related to the child;

154. ABC is a mantra familiar to many criminal and forensic investigators. Assume/Accept nothing (about information being given or observed), Believe nobody (be sceptical and curious) and Check information (veracity and source).

155. The point has already been made that the starting point for both County A and for Nottinghamshire should have been achieving a clearer focus on what the removal of GN13 from County A meant to the child rather than responding to Adult 2’s actions and decisions which can now be seen to have been self-centred and intent on meeting her own needs and not those of GN13.

156. A child protection conference in County A had made it clear to Adult 2 that there were multi agency concerns about her persistent neglectful care and that the local authority intended to go to court. Adult 2 also knew that Adult 3 was waiting for a decision regarding legal aid funding to support a residence order application with the intention of having GN13 live with him. Adult 3 and Adult 2 had been locked into an acrimonious battle with each other for several months and it was apparent that GN13 was being harmed in regard to missing developmental milestones and suffering the emotional and psychological distress of two parents unable to work together.

157. Instead of understanding Adult 2’s sudden departure from County A as flight from an increasingly concerned group of professionals which occurred as the local authority were escalating their intervention it was quickly traduced into the very different scenario that has already been described.

158. Adult 3 had very quickly raised concerns that Adult 2 had formed a relationship with an unknown male and that this needed checking. This case reinforces the importance of being vigilant and curious about relationships and those people who have contact with a vulnerable child; this was initially recognised by the social worker who had intended to carry out relevant checks. A later section of this chapter deals with agency to agency processes and the learning for example in regard to processing of checks with the police.

Reliance on the parent’s explanation of injuries; use of paediatric expertise to assess loss of weight and physical injuries; ensuring that clinicians have relevant social information and background when considering diagnostic options in regard to injury and evidence of neglect; inference and interpretation of information as it is communicated between professionals;

159. Given the reason for the CPP was because of neglect there should have been anticipation and an explicit understanding in the core group about how
information about injuries and evidence of neglect was recorded and reported to other professional core group members and not to view information in isolation from previous history. It was probable that neglect would emerge given the long and consistent pattern of Adult 2’s behaviour before moving to Nottinghamshire.

160. The long term absence of SW2 due to illness meant that no single individual was in a position to oversee information about individual incidents of bruising.

161. The role of the GP along with other primary health care professionals is crucial to monitoring for signs and symptoms such as fluctuations in weight, diet, language and social development. The GP never saw GN13. The first evidence of weight loss and the first bruise was observed after the first and only core group took place and after SW2 had become ill and was not at work. Work on language development had not started in Nottinghamshire although referrals had been made to the speech and language therapy service.

162. The weight loss and bruises were never discussed collectively by the core group because it did not meet and none of the information was referred on to paediatric specialists because the individual episodes were not regarded as significant. It was left to individual professionals to make their own judgments and they were predisposed to believe Adult 2, in spite of a longstanding record of minimising concerns.

163. Although the health visitor advised Adult 2 to take GN13 to the GP to talk about the weight loss, GN13 was never taken and the health visitor never had a discussion with the GP. If there had been a check on whether an appointment had been made it would have been one tangible test of Adult 2’s motivation and focus on GN13’s welfare.

164. When GN13 was taken to the local hospital with an injury to the eye, the specialist clinic examining the eye injury was unaware of any other history including the fact that GN13 was subject of a CPP. The eye injury was never discussed by the core group and although it was reported to CSC, it was almost a week after the visit to the hospital and the injury was not the subject of any discussion with a paediatric specialist. Reliance was placed on the history provided by Adult 2 being consistent with the injury. The history of minimising concerns whilst living in County A was never considered.

165. When Adult 2 was asked about the bruise, it appears that she sought to deflect the enquiry by, for example, talking about going out a lot with GN13 including trips to a cousin’s home in a nearby town. This was a strategy that had also been used in County A of trying to change the subject, divert attention or to close down discussion when concerns were being raised.

166. The loss of hair and weight and the bruising do not appear to have been reported or discussed with any social workers or the manager; SW2 had become ill and was away from work.
167. Weight loss is one of the factors that can provide tangible evidence about the care being given to a child although there may be other factors causing the fluctuation and this is the reason why it needs checking with appropriately qualified and experienced doctors.

168. If the evidence about weight loss and the bruise had been given equal inference in regard to potential evidence of neglect along with the other more positive information about how GN13 and Adult 2 behaved with each other, it would have created the potential for a more assertive approach to checking for evidence.

169. The absence of core group meetings meant that individual professionals were overly reliant on their personal impressions and personal processing of information, reducing the opportunity for devil’s advocacy. For example, nobody ever observed what GN13 was actually eating other than crisps.

170. At this stage HV1 and EYW1 were the only professionals in regular contact with GN13. Although this may sound like hindsight, it is a recurring theme in reviews such as this that a human bias looks first for an optimistic interpretation and can overlook or give lower inference to harder factual data such as weight loss and physical injury.

171. The initial presentation in August 2011 after GN13 had sustained the most significant injuries was to the emergency hospital service that had no information about GN13’s status as a child on a CPP. The checks with other organisations such as CSC are discussed in respect of management and agency to agency systems in a later set of findings in this chapter.

172. Medical staff were very concerned about GN13’s significant injuries, which appeared to divert immediate attention in dealing with GN13’s physical safety.

173. The level of information and concern in the hospital record is significantly higher than was recorded from the contact between the staff nurse and the out of hour’s social work service the previous evening or in regard to the subsequent communication with the police officers conducting the S47 enquiries with CSC.

174. It was some ten hours after the initial admission when the consultant paediatrician examined GN13 and further injuries were diagnosed; the previous injuries were also diagnosed as evidence of abuse.

The significance of opening and managing enquiries regarding the changed circumstances for a child, for example when moving to a new area;

175. The purpose of the Section 47 enquiry is to determine whether any further action is required to safeguard and promote the welfare of the child or
children who is or are the subject of the enquiry. It is a discrete and important professional task that can either be completed as a single agency or more commonly will be a joint enquiry involving the police as well as CSC.

176. It is not an administrative function but rather describes what should be a sufficiently curious and proactive approach to seeking and collating relevant information about the current circumstances of a child. In this case the circumstances were the sudden move from County A and the implications for GN13. The focus in this case remained on the historical accounts from County A rather than the significance for GN13 of being in Nottinghamshire.

177. The opening and closing of the s47 enquiries in the preparation for the ICPC in Nottinghamshire was treated as a formality required by the protocols of the electronic recording system as well as being a discrete aspect of managing safeguarding processes; in effect it was opening electronic access to the part of the electronic system for inputting information about the ICPC.

178. This appears to be an example of where a core safeguarding task can become enmeshed into information protocols that require a sequence of tasks to be completed that do not carry sufficient significance or relevance. The recording of the enquiries were, it seems, being done to unlock gateways to further parts of the system rather than describing actual enquiries into current and local circumstances.

179. The absence of a more thorough investigation about why Adult 2 had moved to Nottinghamshire, establishing the exact nature of the claimed family support and the status of different relationships all point to an over reliance on the historical information from County A rather than recognising the need to explore the radically changed and new circumstances for GN13.

180. Whether this reflects an insufficient understanding about discrete stages in the safeguarding process or is the adapted response of people to computer controlled gateways to recording and processing information is not clear on the basis of this one particular case.

Giving enough detail and precision when communicating and describing injuries and historical information such as domestic abuse;

181. Several examples are provided in the summary of the key events in regard to how important sharing of information was beset by apparently different inference and emphasis between the person giving information and the person recording and reporting it onwards.

182. An example was the various descriptions of the injury to GN13’s eye. The understanding about what the nature of the neglect that GN13 was at risk from was also loosely defined and for various reasons began to be treated as a historical concern.
183. This in turn allowed a subtle but important shift in focus away from using public law frameworks to seek alternative care arrangements for GN13 to encouraging Adult 3 and Adult 2 to resolve their conflict over contact through private law proceedings.

184. There is much reference to the history of domestic abuse and yet very little factual information actually recorded. Information was not sought in Nottinghamshire until the S47 enquiries after the serious injuries to GN13.

185. The high court judgement draws attention to the imprecision of the terms "domestic violence" and “domestic abuse”, and how it is routinely used, often interchangeably, to cover many things ranging from actual physical violence to arguing with a partner/ex-partner or seeking to control their behaviour.

186. More care is therefore required to describe what is meant in a particular case because it may make a difference to the weight and inference that should be given to the behaviour and the most appropriate decisions. None of this infers that different forms of domestic abuse are more or less harmful to a young child in particular but rather has implications for assessment and intervention strategies.

187. For example, in this case, there is evidence that Adult 3 participated and benefitted from participation in a course of anger management that helped him develop better strategies to deal with conflict although this did not occur until after care proceedings had been started after the abuse and injury of GN13.

**Issues for the NSCB to consider in regard to learning and improvement**

1) Is the NSCB satisfied with arrangements for vulnerable children being registered as new patients with a GP and that sufficient attention is being given to linking between the GP and health visitor?

2) Are the NSCB satisfied with the functioning of core groups and robustness of detailed child protection plans?

3) Are there implications for training and awareness raising in regard to domestic abuse and assessment and developing appropriate help and intervention?

**4.3 Family and professional contact and interactions**

The role and relationship of fathers with children where they do not live in the same household;

188. Adult 3 had very significant levels of contact with GN13 until GN13’s abrupt removal to Nottinghamshire by Adult 2. Adult 2’s abrupt departure to a
completely different part of the country deserved more significant enquiry than was achieved before or after transfer. Until the ICPC in Nottinghamshire the responsibility for decision making was with the professionals in County A.

189. The implications of that loss of contact for GN13 were not assessed or discussed at the ICPC, a core group or in any other setting. Adult 2 remained highly influential with all the professionals in discouraging any contact with Adult 3. There appeared to be a professional predisposition that the issue of contact was a private legal matter for the parents rather than an important area of enquiry within the context of GN13’s emotional and developmental wellbeing and longer term security and identity.

190. The first section of this chapter described how bias and cognitive processing of information can influence professional judgment and decision making and how it had an impact in this case. The continued exclusion of Adult 3 had consequences for GN13 and also diminished the range of information available to the professionals in Nottinghamshire. Nobody clarified what information Adult 3 had or consulted him about arrangements, despite him having parental responsibility for GN13.

191. Nobody in Nottinghamshire spoke to Adult 3 about the information he provided regarding evidence of Adult 2 having moved to Nottinghamshire to pursue a relationship before or after the reports of Adult 2 and Adult 1 being in a sexual relationship.

**Detecting and counteracting manipulation and misdirection of professionals;**

192. Parents or adults whose behaviour and lifestyle is a source of risk to a child are often resistant to professional contact and involvement. This leads to behaviour designed to divert or impede professional intervention. It can take the form of dependency, closure, flight or disguised compliance.

193. People who abuse children can often be very convincing. In this case, Adult 2 created the impression that she was motivated to co-operate with professionals to protect her child when, behind closed doors, she was colluding in hiding any evidence of abuse or harm to GN13. She had made expressions of wanting to co-operate in County A and had more than once asserted that she had had a ‘wake up call’ to improve but shown no ability to do this. This was a strategy in County A that had recently been recognised when a fresh pair of eyes in respect of a new and experienced social worker (CASW1) had taken responsibility for the case.

194. Disguised compliance occurs when parents want to draw the professional’s attention away from allegations of harm. It is often highlighted as a theme in
Serious Case Reviews. A biennial analysis of serious case reviews 2003-2005 identifies disguised compliance as a theme\(^7\).

195. Guidance from the Centre for Excellence and Outcomes in Children and Young People's Services (C4EO)\(^8\) emphasises the need for professionals to constantly question all assumptions by playing the devil's advocate or bringing in a fresh pair of eyes. This can be supported through the provision of high quality supervision. Individual professionals were working in their own silos and had little facility to challenge assumptions; there is evidence that EYW1 was the most sceptical but was also the person most recently appointed to their post.

196. Adult 2 and Adult 1 were both very convincing in their presentation with experienced professionals including the police, although it is notable that the police interviews identified inconsistencies and secured statements. The accounts in regard to their relationship which they attempted to try to disguise even as the criminal investigation was beginning had reflected the approach taken in their contact with every other professional. They were never hostile and never displayed any obvious lack of co-operation although GN13 was kept away from professionals during the first and only core group meeting, and from the statements made during the criminal investigation, there were other occasions when Adult 2 avoided professionals having contact with GN13 to disguise other injuries such as a scald. This is evidence of disguising further evidence of neglect or injury.

**Issues for the NSCB to consider in regard to learning and improvement**

1. How the NSCB can, with partner agencies, improve professional’s recognition of the role of fathers and other significant adults in the life of a child especially following separation?

2. Do the professional members of core groups have opportunity to discuss their contact and interaction with families and explore what degree of misdirection may be an influence through the use of strategies such as devil’s advocate?

**4.4 Tools and frameworks to support professional judgment and decision making**

**Triangulating evidence in any assessment or enquiry;**

197. Relying on only one dimension of information is not sufficient when making judgements about potential risk or harm to children. Relying on observation is susceptible to the cognitive and other influences discussed in earlier sections.

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\(^8\) C4EO (2010). Effective practice to protect children living in ‘highly resistant’ families. London: Centre for Excellence and Outcomes in Children and Young People’s Services (C4EO)
Information has to be triangulated using direct observation and structured enquiry, checks with third party information and use of relevant individual and family social history.

198. The health visitor and early years worker completed a health assessment with GN13. This was the only evidence of any assessment work between the ICPC and the genital injury to GN13.

199. A preschool child such as GN13 rapidly develops complex social and neurobehavioral capabilities, and the purpose of the assessment is to differentiate normal variations from abnormal behaviour. It is an opportunity to observe normal and abnormal growth and development in preschool children and how they interact with their parent.

200. The recorded evidence and the discussion with the practitioners confirmed that the assessment did not highlight any concerns and appeared consistent with the behaviour that had been observed on other occasions.

201. The fact that the only assessment that was completed with GN13 had provided positive data no doubt contributed to a generally positive view about Adult 2’s care of GN13. The outcome of the assessment contrasts with the information from County A that had noted that developmental milestones had been missed. It is therefore probable that an inference was made that the care routines for GN13 were of an improved quality.

202. When injuries were observed there was reliance on one dimension of relying on what Adult 2 gave as an explanation. Presentation to the eye clinic concentrated on immediate history. A similar approach prevailed in August until the paediatric examination.

203. If core groups rely on the outline CPP agreed at the child protection conference rather than developing a more detailed plan and discussion there will be less likelihood of giving enough attention to recognising emerging patterns for example in relation to relatively minor injuries which in isolation are not viewed as a cause for concern.

**Assessment of neglect and the use of tools and frameworks;**

204. Assessment and intervention in respect of neglect is a problematic area of professional practice. Part of this reflects the inherent difficulties when trying to arrive at a consensus in a core group or other multi-agency setting as to whether the parenting and care being given to a child is of a good enough standard.

205. It becomes complicated by issues such as poverty and quality of housing and environment and is also susceptible to some of the cognitive influence and mind-set that has been discussed at the start of this chapter.
206. If the mind-set is that a parent is trying to improve their circumstances, it creates an optimistic mind-set that seeks to encourage rather than to challenge which creates conditions for colluding when a pattern of relatively minor incidents such as a bruise occur.

207. This is a difficult balance of wanting to help adults change behaviours whilst keeping an appropriately sceptical mental framework and is why structured discussion between professionals helps. Empathy without reflection and challenge will create the latent conditions in which dangerous collusion can develop especially in regard to neglect of very young children.

208. The way questions are framed and developing a strategy for interviews or conversations are important to being able to provide an appropriate level of sceptical curiosity and challenge.

209. Indicators of neglect are many and varied and each on their own are unlikely to provide definitive evidence. This is why it is important for professionals to have recognisable frameworks within which to collate and analyse the significance of information and observation.

210. Neglect can be indicated by the physical appearance of a child; in County A this had been a regular problem particularly when GN13 was in Adult 2’s care. In Nottinghamshire there is no report of poor physical appearance although crucially there was less frequent contact than had been in place in County A. Adult 1 may also have been responsible for cleaning GN13 and therefore contributed to a misleading view about Adult 2’s actual care and also provided him with opportunity for abuse.

211. There may be indicators in the child’s behaviour. There was nothing observed in GN13’s behaviour that attracted concern in County A or in Nottinghamshire. Considerable inference was given to the quality of apparent attachment shown by GN13 in Nottinghamshire although this was not specifically assessed. Given the history of poor and neglectful care it would have been advisable to have considered tools such as the attachment style interview and graded care profiling that would have helped provide a more informed view about Adult 2’s motivation and insight regarding GN13’s needs.

212. The third group of indicators in regard to neglect is the behaviour of adults. It is this third category of indicators that have greatest relevance in this case. It was Adult 2’s behaviour and inability to prioritise GN13’s needs that had escalated the intervention in County A. At no stage was there a concerted effort to enquire, assess and reconcile the stark contrast in the behaviour that had been observed in County A compared to Nottinghamshire. In reality, not much had changed in Adult 2’s behaviour other than there was less contact and therefore observation and supervision than had been provided in County A and there was another adult regularly in the house.
213. Adult 1 was in the house and was motivated to keep professionals at bay and therefore may have been doing some if not most of the household management tasks that had been so poorly attended to by Adult 2 in County A. It invites further scepticism as to how much the apparently improved conditions were attributable to Adult 2 or to a male who had been given unchallenged access to a young child and opportunity to commit abuse.

214. There was evidence, certainly with hindsight, of GN13’s neglect in regard to a pattern of injuries and loss of weight that were not subjected to sufficiently rigorous checking along with checking properly on the circumstances and motivation for Adult 2’s sudden arrival in Nottinghamshire. The absence of an assessment or detailed plan or any meetings of the core group were all significant factors in this case. There was no reference to how the issue of neglect was to be assessed or the sort of factors that were of most concern.

215. There was no contact with the GP throughout the time period examined by the SCR. GP’s should be an important source of advice in cases involving neglect. In order to be effective it is important to ensure that the GP practice is fully informed about the circumstances and status of a child subject to a CPP to provide the context for direct examination of the child and processing information from other sources such as emergency treatment centres. The only reference to the use of the GP was when Adult 2 was advised to take GN13 to the GP; she never did and no check was made.

216. The GP practice did not apparently make any attempt to make an appointment to see GN13 as a child and new patient who had recently moved into the area. This meant that there was no benchmark information for the GP to use in any future consultations.

Developing an understanding about the use and value of social media to support enquiry and assessment;

217. Social media had been used by Adult 2 to make contact with and to meet other men and was it seems the avenue through which she had first made contact with Adult 1. Her use of social media to make these contacts was known about in County A but was never apparently checked in Nottinghamshire. It was social media that allowed Adult 3 to first identify Adult 1 and also give an indication of location and of relationship status.

218. The development of the internet and social media provides additional sources of information and intelligence that may have relevance to making enquiries in relation to children at risk of harm. Accessing such information has to be subject of clear guidance that sets out the circumstances of considering what sources of information need to be checked and the legal and ethical implications.
Issues for the NSCB to consider in regard to learning and improvement

1. Is any further guidance required in regard to the circumstances, scope and conduct of information checks to be conducted in regard to adults who have contact with or care of children at risk of abuse or other harm including the recording of a history of addresses?

2. Is there a sufficient understanding across local professional disciplines as to what tools and frameworks are available to guide the collation and analysis about the neglect of children?

3. Does the NSCB consider any further information is required in regard to new patient checks for children who are subject of a child protection plan moving to a GP practice?

4. Does the NSCB consider any further guidance is required in regard to professionals’ use of social media and other information sources to check or make enquiries relating to the safety or circumstances of children?

4.5 Management and agency to agency systems

Managing transfers of children subject to CPP that indicate flight from statutory help and intervention;

219. It is not uncommon for children who are subject of a CPP to move from one area to another. There may be any number of reasons why a family need to move some of which may be legitimate; for example employment. There are clear procedures in place for local authorities to manage transfers of children subject of a CPP. Those procedures were used in this case and were complied with by both of the areas. As has been illustrated, simply complying with a procedure does not guarantee proper outcomes for vulnerable children. It is more how people approach their tasks.

220. A particular aspect of this case was the extent to which the motive and reasons for such a sudden move from County A was not subject of more scrutiny in either County A or in Nottinghamshire. The local authority in County A had already made a decision to begin legal proceedings with the intention of removing GN13 from the care of Adult 2 and the only reason that had not happened by the time that GN13 was taken to Nottinghamshire was the delay in getting access to a local authority solicitor.

221. If the decision making had been more focussed on GN13 there should have been an urgent consideration of what legal action was required in response to the change in circumstances that should have been led more clearly by County A who continued to have responsibility for GN13 up to the point at which the ICPC had formally transferred the CPP.
222. Although the local authority could not have compelled Adult 2 to return to County A there was an arguable case for GN13 to be returned pending further enquiries and for this to have been put before a court; the local authority in County A had already committed itself to removing GN13. This was not done by either local authority and was not discussed with legal advisors as part of the initial transfer in information or at the ICPC in Nottinghamshire. Nottinghamshire did not have evidence from their contact with GN13 that would have justified going to court at the point of transfer in to their area.

223. The learning from this case is to ensure there is a clearer focus on the circumstances, motivation and reasons for a child being moved from one area to another and for any decision regarding the transfer to be focussed on what is in the best interest of the child.

224. In this case the removal to Nottinghamshire disrupted the positive and extensive contact that existed between GN13 and Adult 3 and disguised the fact that Adult 2 was in flight from an escalation of intervention by the local authority in County A.

Access to information to inform differential diagnosis; guarding against false reassurance;

225. The detection of abuse, especially in very young children, is highly reliant upon the expertise and input from medically qualified professionals. Abuse that arises because of neglect is almost always reliant on seeing individual incidents or observations within the context of longer term patterns. For example, what is known about the quality of the total care and parenting being provided; what history is there in respect of a particular child; the context within which an injury occurs?

226. The bruising, eye injury and loss of weight that occurred over a few weeks were interpreted as being the routine sort of episodes that can and do happen to children who are not being abused. The incidents on their own did not cause concern for either the professionals who were members of the core group (and therefore knew about the CPP and history) or for the professionals who did not have that information.

227. It is a fact that the consultant paediatrician diagnosed the injuries as evidence of abuse; it is acknowledged that the paediatrician was doing this with the hindsight of examining a child who had been admitted to hospital with very serious and suspicious injuries.

228. It is left to the discretion and judgment of clinicians to make the enquiries they judge appropriate and necessary to help inform their diagnosis. There are dangers if clinicians rely on information such as whether a child is already on a CPP to decide whether a particular injury or condition is evidence of abuse or not. A false reassurance can be inferred if the child is not a child already identified as being at risk of significant harm and this can prevent
seeing an injury for what it is. Equally, in this case there were occasions when knowing about the history did not apparently lead to differential diagnosis that neither ruled in nor ruled out the possibility of abuse.

229. These issues are not about hard and fast rules but rather rely on the judgment of professionals who are vigilant and open to exploring possibilities. Having access to information, for example about the status of being subject of a CPP, may be appropriate and essential and requires a busy clinician to be able to access relevant information relatively quickly and efficiently.

230. GP practices are the recipients of a great deal of information about patients who will include children subject of CPP. Unless information is flagged as potentially important to any patient contact consultations or contact, it is likely to remain simply archived and therefore limit the opportunity for the GP to have input into the ongoing assessment and monitoring of a child.

231. Information about children subject of a CPP being presented at hospital emergency departments had been the subject of an SCR completed by Nottingham City LSCB that had recommended that details of children subject of CPP in Nottingham are available in the paediatric emergency department.

232. This led to a paper file being kept in the department but only applies to children living in or subject of a CPP under the Nottingham safeguarding arrangements and does not apply to other treatment centres. Being a paper based system there is no log of how often the information is checked. In any event, the system apparently does not currently apply to children such as GN13 who live in the county.

233. GN13 was presented at hospital on two occasions while subject to a CPP. On the first occasion, the eye clinic apparently made no recorded inquiry about history. The information about the clinic examination was routinely reported to the GP who was aware of the CPP (although had not been invited to the ICPC). There was no other contact between the GP and any other professionals. GPs will not generally be made aware of all correspondence relating to individual child patients unless specific arrangements have been agreed with the practice manager and staff managing receipt and filing of information.

Clarity about information sharing and referral; contingency planning when key professionals are absent from work; managing joint agency enquiries;

234. On the second presentation to hospital when GN13 had sustained significant injuries, a phone call was made to EDT less than an hour after the initial admission. The purpose of the phone call was not clarified in regard to either seeking information, to inform the initial diagnosis of injuries or to make a referral to initiate enquiries by CSC and the police. The duty social worker asked whether the injury was regarded as evidence of abuse but was advised that this was not a diagnosis at that time or even that there was a differential
diagnosis. There was no clarification as to whether a paediatrician had been consulted about the injury given the unusual nature of the injuries and the fact that it involved a child subject to a CPP.

235. The consultant paediatrician examined GN13 some ten hours later and at that stage made the diagnosis that GN13 had been abused on more than one occasion and made the referral to CSC which initiated the s47 enquiries.

236. There is access to a paediatrician on a 24/7 basis although in this case the admission of GN13 was not referred because the injuries were not initially viewed as indicative of abuse. The consultant paediatrician diagnosed the previous injuries as being indicative of abuse. This was the first occasion a paediatrician had been consulted about any of those previous injuries.

237. The delay in making the referral provided opportunity for Adult 2 and Adult 1 to develop their accounts and also created opportunity for interference or loss of material that could assist with forensic evidence. For example, nappies and other items that GN13 had been wearing when brought to hospital had already been placed in the hospital medical waste system for destruction rather than being preserved as evidence for the police criminal investigation. In the event, the police were able to assemble sufficient evidence to support a prosecution.

238. The significance and extent of the injury to GN13 was not made clear to the police and to CSC at the outset. Although there was reference to the significant loss of blood, the extent and severity of the injuries were not made sufficiently explicit at the early stage of the enquiries. This may have reflected medical professionals making assumptions about the inference that other non-medical professionals could give to evidence and information for example about blood loss. Although this does not suggest that any delay occurred to the investigation, it would none the less have helped the police and CSC to understand the extent and significance of the injury at the outset.

239. The conduct of enquiries were complicated by the absence of the allocated social worker. Although it may have been anticipated at the onset of the illness that they would only be away from work for a matter of days when the illness became more long term, information about their absence was not communicated to other core group members and the case was managed through duty arrangements which meant different people having contact at different times; not helpful in cases of neglect where it is looking for and recognising the relatively minor issues that help build a picture about underlying patterns of care and lifestyle.

240. There is no evidence of the team manager making other more substantial contingency arrangements in regard to implementing even the outline of a CPP beyond maintaining a pattern of minimum visits and this inevitably meant that when the s47 referral was made there was already a backlog of tasks that were outstanding. This had the effect of diverting attention and complicating
the analysis of information and the making of decisions during a three day period.

241. It is not known what other factors the team manager was managing at the time such as availability of staff allocation of other cases also demanding urgent support at the time.

242. People were trying to catch up and to get on top of several different tasks. The most significant aspect was the absence of prior contact and therefore knowledge of Adult 3’s circumstances and relationship with GN13. This had implications for how he was treated during the enquiries and had continuing implications for subsequent care proceedings which took a formal complaint to resolve. It was a task that was given least attention.

243. There were up to six people in CSC handling different aspects of information and although it is clear that there was a great deal of contact particularly with the team manager through the use of mobile phones for example, this was the subject of some delay and restrictions because of much of the enquiry taking place in a hospital setting where mobiles had to be restricted. The team manager was attempting to remain updated, for example by accessing the electronic recording system although this was often not being updated for several hours and therefore only partial information was available.

244. Particular moments in the enquiries when the logistics became very stretched included information about the fractured finger; this was initially reported to CSC who had already spoken to Adult 2 about the injury before the police officers involved in the enquiries had been informed and agreed an interview strategy.

245. There was also information coming in from relatives which included highlighting historical concerns as well as more recent information regarding recent injury by scalding that had been hidden from professionals. The sharing and discussion of the information was the subject of some delay.

246. The communication was further complicated by the lack of clarity about which of the doctors was the lead. This resulted in the police and CSC speaking to different doctors and nursing staff which added to the complexity of communication and processing of information.

247. This summary is not intended to criticise or simply apply hindsight reflection to the events. It is intended to draw attention to the considerable complexity of managing joint agency enquiries and having lead professionals in both services that have sufficient capacity and knowledge to deal with the work and to deal with issues such as the unexpected or unplanned absence of a key professional.

248. The team manager had to cover during SW2’s illness and leave, manage the consequences of no assessment having been started and not having a detailed
plan or information. This had implications for managing the contact with Adult 3 when he became aware of GN13 being injured as well as for managing the ongoing enquiry and collation of evidence.

249. The earlier sections of this report have described the delays in conducting checks on information in regard to Adult 1 and made clear that even if those delays had not occurred it is more likely that a PND check would not have been routinely completed and therefore the checks would not have produced grounds for concern about any history.

250. The circumstance under which the police will complete a PND check include;

   a) Strategy discussions;
   b) MASH (multi agency safeguarding hub) enquiries when there are adults of concern where there is information or intelligence to suggest that the adult(s) have lived outside Nottinghamshire;
   c) Urgent checks on placement of children where the adult is not an approved carer if there is information from PNC or other sources that suggest an adult has lived outside the county;
   d) Child deaths.

251. In making a request to the police for an information check it is important that relevant information has been sought about the social history of an adult including whether they have lived outside of the county. It is not evident that this is routinely understood or clarified for CSC requesting the checks. Under the local protocol, the first occasion when the police were likely to have made a PND check was when the strategy discussion and joint enquiries began in August and these were carried out.

252. There were several opportunities to check agency information including with the police; the first opportunity was in County A after GN13 had been taken from the county; the second opportunity was when SW2 was first given Adult 1’s information but did not initiate the CRIMS system (criminal record information management system); the third opportunity would have been available if the police had been invited to attend or submit information to the ICPC in July 2011; the fourth opportunity would have been the development of the CPP which should have been the subject of collective oversight by the core group and in terms of the social worker, the team manager had responsibility for checking on what work required following up when SW2 became ill and was absent from work.

253. Earlier sections of the report describe SW2’s account about a perceived inability to personally access the system to do the check; although this should not have been an impediment to initiating the check, it seems to be SW2’s belief that because a name change was taking place the outcome of the CRIMS would not have arrived in their new electronic mail ‘inbox’.
254. This belief was not based on any discussion with the IT service and in reality was probably the behaviour of a professional whose performance was already being adversely affected by emotional and psychological stress at the time. It would have been helpful to have discussed with the line manager whether this was evident at the time.

255. In the event the task was not carried forward. SW2 says that they felt overwhelmed although managers feel that the workload should have been manageable at the time. It has not been possible to speak to the team manager in post at the time about any of these issues.

256. SW2 indicated that the significant stress at the time related to other cases that they were responsible for. The emotional and psychological demands on professionals undertaking safeguarding work are significant and have implications for how they are supported.

257. SW2 has described feeling unable to take on this or any other additional cases. Managers have provided evidence that the workload was not excessive compared to other colleagues, taking account of numbers and type of work. SW2 talked about an especially difficult few weeks preceding the allocation that had involved complex legal proceedings and personal threats against SW2.

258. The independent reviewer is not in a position to comment on the information that has been provided other than to invite further reflection by CSC regarding how the overall capacity of staff is monitored. The local authority have made significant investment in recruitment and increasing the workforce and they clearly monitor and take account of how workload is allocated. It is also known that complex work such as this does not lend itself to a formulaic workload measurement matrix. What looks like a manageable workload can change quickly if, for example, complex or disputed legal proceedings are required.

259. Work with troubled families and vulnerable children remains one of the most difficult and challenging of professional roles and can have an impact on the emotional and psychological capacity of any individual practitioners, whether newly qualified or more experienced. Again, it would have been helpful to have had a discussion with TM1 about this aspect of the case but they were not available to provide information and had moved on from the local authority.

260. The plan to encourage the police to use their (police) powers of protection (PPOP) was in anticipation of either Adult 2 or Adult 3 removing GN13 from the hospital. The PPOP is intended to allow the police to keep a child safe in unforeseen or unanticipated circumstances. The independent reviewer discussed this issue with a manager to check if there were any barriers to social workers seeking court orders in emergencies. The manager reports that
there are no barriers and that PPOP are not used instead of applying for a court order.

**Issues for the NSCB to consider in regard to learning and improvement**

1. How will the NSCB ensure that the transfer in of cases of children subject to a child protection plan have an assessment that includes information and implications about their new circumstances rather than a reliance on historical information from a previous local authority?

2. How will the NSCB ensure that issues for learning and improvement are shared with the LSCB in County A and in particular draw attention to the delay in accessing legal advice and the implications that had in this particular case before and during the transfer arrangements?

4.6 **Issues for national policy**

261. The value as well as complexity of accessing national police databases is highlighted by this case. There was nothing in local systems that would have alerted any of the organisations to prior concerns about Adult 1. Accessing the various systems at local and national level varies between local areas and there are differences in the information and detail that is inputted across different police areas. This has implications for the speed and quality of accessing intelligence.

262. The NSCB will provide information to the Association of Chief Police Officers (ACPO) to consider what further work could and should be considered in developing clearer national guidance and standards.

_Peter Maddocks, CQSW, MA._
**Independent author**
_May 2014_
Appendix 1 - Procedures and guidance relevant to this serious case review

Legislation

The Children Act 1989

Section 2 defines parental responsibility

Section 11 of the Children Act 2004 places a duty on the key people and bodies described in the Act\(^9\) to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. The application of this duty varies according to the nature of each agency and its particular functions. The Section 11 duty means that these key people and bodies must make arrangements to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children and this includes any services that they contract out to others.

Section 17 imposes a duty upon local authorities to safeguard and promote the welfare of children in need.

Section 20 describes the circumstances under which the local authority can provide accommodation to a child in agreement with a parent or person with parental responsibility and without a care order; under this provision the local authority does not share parental responsibility which is retained entirely by the parent or person with parental responsibility.

Section 31 describes the circumstances under which a court can make a care order and defines ‘significant harm’; if an order is granted the local authority shares parental responsibility with the parent or person with parental responsibility.

Section 31 (9) defines harm which was extended via section 120 Adoption and Children Act 2002 implemented in January 2005 that now includes ‘impairment suffered from seeing or hearing the ill-treatment of another’ recognising that children who witness or hear abuse suffer, or are likely to suffer, significant harm as a result.

Section 46 provides the police with powers of removal and accommodation of children in cases of emergency to take children into police protection where a police officer has reasonable cause to believe that a child would otherwise be likely to suffer significant harm. These are police powers of protection.

Section 47 requires a local authority to make enquiries they consider necessary to decide whether they need to take action to safeguard a child or promote their welfare when they have reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm. These enquiries should start within 48 hours. The local authority is required to consider whether legal action is required and this includes exercising any powers including those in section 11 of the Crime and Disorder Act 1998 (Child Safety Orders) or when a child has contravened a ban

\(^9\) Local Authorities, including District Councils, the Police, National Offender Management Service, NHS bodies, Youth Offending Teams, Governors/Directors of Prisons and Young Offenders Institution, Directors of Secure Training
imposed by a Curfew Notice within the meaning of chapter I of Part I of the Crime and Disorder Act 1998.

Safeguarding and other local procedures relevant to the review

The Nottinghamshire Safeguarding Children Procedures

The procedures provide advice and guidance on the recognition and referral arrangements for children suffering abuse. This includes emotional abuse that involves causing children to feel frightened or in danger. The procedures also cover physical abuse of children. The procedures also describe abuse involving the neglect of children that includes failing to protect children from physical harm or danger or the failure to ensure access to appropriate medical care or treatment. This includes describing distinct action to be taken when professionals have concerns about a child, arrangements for making a referral, and the action to be taken. The procedures cover arrangements for the LSCB to ensure there are effective arrangements that promote good interagency working and sharing of information and training. The procedures describe specific responsibilities for all organisations contributing to this serious case review.

National guidance

Working Together to Safeguard Children (2013)

The national guidance to inter-agency working to protect children is set out in Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. The guidance includes safeguarding and promoting the welfare of children who may be particularly vulnerable. The guidance that applied at the time of events examined in this SCR was the previous version of guidance that was published in 2010.

Framework for the Assessment of Children in Need and their Families 2001

The guidance in respect of the Framework for the Assessment of Children in Need and their Families was issued under section 7 of the Local Authority Social Services Act 1970 and was therefore mandatory until it was withdrawn with the publication of the revised guidance in Working Together 2013.

It set out the framework for ensuring a timely response and effective provision of services to children in need. It made clear the importance of achieving improved outcomes for children through effective collaboration between practitioners and organisations. The framework set out clear timescales for key activities. This included making decisions on referrals within one working day, completing initial assessments within seven working days and core assessments within 35 working days. As part of an initial assessment children should be seen and spoken with to ensure their feelings and wishes contribute to understanding how they are affected. If concerns regarding significant harm are identified they must be subject of a strategy discussion to co-ordinate information and plan enquiries. Child protection procedures must be followed.

Assessments should be centred on the child rooted in child development; this requires children to be assessed within the context of their environment and surroundings. It should be a
continuing process and not a single or administrative event or task. They should involve other relevant professionals. The outcome of the assessment should be a clear analysis of the needs of the child and their parents’ or carers’ capacity to meet their needs and keep them safe. The assessment should identify whether intervention is required to secure the wellbeing of the child. Such intervention should be described in clear plans that include the services being provided, the people responsible for specific action and describe a process for review.