Report of the Serious Case Review
March 2017
Child R

Contents

1.0 The Serious Case Review (SCR)

1.1 The Context to the SCR

1.1.1 This review was initiated because Child R experienced seriously harm whilst in the care of parents and this was considered by professionals to be non-accidental.

1.1.2 On the first of June 2016 Blackburn with Darwen Safeguarding Children Board (BwD LSCB) case review panel recommended that a serious case review in respect of Child R should be undertaken to consider how effectively agencies in Blackburn with Darwen had worked together to safeguard and meet the needs of Child R and to identify areas of learning. This decision was confirmed by the independent chair on the 7th of June.

1.1.3 Working Together 2015 is clear that professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children[1]

1.1.4 Serious Case Reviews and other case reviews should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;

[1] Working together to safeguard children 2015

- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed and
- makes use of relevant research and case evidence to inform the findings.

1.2 The Significant Incident Learning Process

1.2.1 The key principle of the Significant Incident Learning Process (SILP) is the engagement of frontline practitioners and first line managers, giving a much greater degree of ownership and a much greater commitment to learning and dissemination of lessons. SILP uses systems methodology, looking at how the actions of professionals are influenced by the organisations and systems in which they are working. The focus of this review was the effectiveness of professional systems to safeguard Child R and in understanding this, to consider events in the context of the child protection systems in Blackburn with Darwen at that time.

1.2.2 The chair of the review was Fiona Johnson, independent safeguarding consultant with significant experience of multi-agency working and practice and of facilitating serious case review; Fiona is an accredited SILP lead reviewer. The report author was Dallas Frank, an experienced strategic and safeguarding children board manager and accredited SILP lead reviewer. Neither Dallas nor Fiona had any previous knowledge or involvement in this case.

1.3. Introduction to the case and family background

1.3.1 Child R was the first child born to his mother and father who are both of white British heritage and had been in a relationship together for 13 months. Both parents were known individually to a range of services and there were child protection concerns about father when he was a child.

1.3.2 Child R was presented at the local accident and emergency department with a history of difficulty in breathing, vomiting and being unsettled. Subsequently Child R's condition deteriorated and a head computed tomography (CT) scan identified subdural haemorrhage, the injuries were unexplained and a non-accidental cause was considered. Further investigations at a tertiary hospital found Child R to have subdural haemorrhage, brain injury and retinal haemorrhages. The only possible explanation for this constellation of findings was a non-accidental injury due to shaking.

1.3.3 At the time of writing Child R resides back with local authority foster carers as a result of the breakdown of the extended family placement. Child R is the subject of a Care Order made to the local authority. After initially experiencing an unsettled period, Child R is described as contented with good interactions to both parents and carers, smiling and vocalising. Child R's prognosis remains unclear in respect of development of vision although professionals believe this to be more positive than initially anticipated. The local authority is currently undertaking assessments in regard to Child R's long term permanent future.

1.4 Scope of the review and terms of reference

The time period for the review is between January 2015, when mother was known to be pregnant, and April 2016, when the injuries occurred.

The specific terms of reference as agreed by the Blackburn with Darwen Safeguarding Children Board include;

- How well was the family history understood for the purpose of assessment? Where any specific tools used to analyse the history and if so, where they well used and shared within and across agencies?

- Please analyse the approach taken to the parents' historical missed appointment/non-compliance? How did the parents' continued poor engagement impact on service provision as the case progressed?
- Please critically evaluate the quality of assessments generally. Was the risk to Child R well understood?
- Multi-agency meetings were taking place in Child R's case. However, could communication and information sharing have been improved between agencies as part of this process? Were the correct agencies in attendance at meetings?
- How well did the professional network understand and respond to new developments within the case? Were services planned and prioritised appropriately? Were services effective in addressing need and reducing risk?
- Did action plans clearly reflect where professional responsibility lay for the delivery of the plan?
- Did the involvement of the Family Nurse Partnership lead other agencies to believe that Child R was adequately safeguarded?
- Did communication within services operate effectively, for instance during transitions between parts of a service or between practitioners? What role did record keeping play in this?
- Please identify examples of good practice, both single and multi-agency.

1.5 The Process and Contextual information

Decision to undertake SCR; 1st of June 2016
Scoping meeting; 8th of July 2016
Authors Briefing; 25th of July 2016
Agency reports completed; 23rd of September 2016
Learning Event; 10th of October 2016

Recall Day; 11th of January 2017
Presentation BDSCB; 4th April, 2017

1.5.1 Individual agency reports were received from the following sources:

- Children's Services.
- Homeless Charity.
- Community Health Trust providing adult mental health & psychology services and Family Nurse Partnership.
- Two Domestic Abuse Services.
- Hospital Trust.
- Two GP practices.
- Police.
- Probation Service.

1.5.2 2011 Census revealed that Blackburn with Darwen had approximately 57,453 households and 147,489 residents, and a younger than average age profile, with 28.8% of its population aged under 20, which is the fourth highest proportion in England. The borough's population is diverse, with 13.4% of residents having Indian heritage and 12.1% Pakistani. Deprivation scores continue to be based on the 2010 Index of Multiple Deprivation, which ranks Blackburn with Darwen as the 17th most deprived borough in England. The generally high levels of deprivation have consequences for the borough as a whole, and the contrast between neighbourhoods also leads to significant internal health and social care inequalities[2].

2.0 Key Practice Episodes

2.1 Background prior to the scoped period

[2] Blackburn with Darwen Joint Strategic Needs Analysis (JSNA), 2014/15

2.1.1 Child R's father has been described as 'a very 'bright young man who could rationalise well' and is very 'capable'. He and his siblings were known to children's social care (CSC) from 2004 and were the subject of a child protection plan between May 2007 and January 2008, in the category of neglect. During this period of intervention a sibling of Child R's father disclosed sexual abuse, and the family were supported on a 'child in need' basis until the case was closed in January 2012.

2.1.2 Following his sibling's disclosure Father experienced a turbulent adolescence when he displayed anti-social behaviour, undertook criminal damage and was a user of drugs and alcohol. In 2012 father became homeless and was signposted to a local homeless and housing chairty[3], where he received a significant level of intervention and support over nine months. Father was also known to the youth justice services prior to 2014 when his further offences led to the involvement of Probation Services[4] between June 2014 and June 2015. Child R's father was involved in substance misuse and had expressed concerns regarding his ability to manage his anger. In January 2014 father was again homeless and moved to new accommodation where over a period of sixteen months staff noted concerns relating to cannabis use and abusive language, rent arrears and handling stolen goods. Probation was involved during this period and improvements were noted between April and November 2014. Father made a planned move to new accommodation with a social landlord in April 2015 as part of a move on process.

2.1.3 Child R's mother has been described as a 'pleasant young woman' who spent a significant period of her childhood living with her own mother and sister in the home of her maternal grandparents. During

[3] A local homeless charity based in Blackburn providing holistic services to homeless young people aged 16 to 24 in Blackburn and Darwen.
[4] Probation services work with offenders to help them lead responsible and law abiding lives, to reduce reoffending and protect the public.

this time Child R's mother was exposed to a number of domestic violence incidents leading to referrals to CSC between 2007 and 2009, resulting in an assessment of her and her sibling's needs. The outcome of this assessment was 'no further action' as Child R's grandmother was perceived to have the 'capacity to protect'. Between November 2012 and January 2013, further referrals were received by CSC in relation to Child R's mother. The identifying concerns included; substance misuse, anger management, anti-social behaviour and putative pregnancies. She was reported missing on several occasions and was perceived to have been at risk of child sexual exploitation (CSE) as a result of her association with an adult male in 2013. As a result, mother had a warning marker on the police national computer record indicating that she may have been a victim of child sexual exploitation. Mother had poor school attendance at primary school and was excluded from her secondary school as a result of her bringing drugs into the school. Mother also had limited involvement with youth justice services and there was police involvement due to anti-social behaviour and substance misuse. In April 2014 mother presented at the homeless charity and in January 2015 presented to the Council's housing service as homeless; on both occasions it was ascertained that mother was residing at maternal grandmother's house.

2.1.4 Parents continued to regularly access day centre services at homeless charity throughout the time period covered in this serious case review and after the injury to Child R.

2.2 Key Practice Episode One: Early pregnancy

2.2.1 In February 2015 Child R's father was referred to the 'Evolve'[5] program by the probation service following his acknowledgement of continuing use of substances, an appointment he failed to attend. He was seeing

[5] Evolve – a service to support young people regarding drug and alcohol misuse.

his GP because of anxiety and stress and was being prescribed medication for his condition.

2.2.2 Information was received into the Multi Agency Safeguarding Hub (MASH) team from the police in mid May 2015 regarding an altercation between Child R's parents. Information received indicated that father alleged he had been assaulted by mother who was two months pregnant. Father accused mother of 'slapping him' and she countered with allegations that he had used abusive and sexually explicit language towards her. Neither party wished to pursue a complaint regarding this incident and a standard risk protecting vulnerable persons (PVP) referral was made. Prior to sharing the PVP with other agencies, police officers in the MASH upgraded the risk assessment from standard to medium due to the past intelligence on police records and checks undertaken with the police officers in the CSE team[6]. This referral was shared across agencies in the MASH and resulted in no further action from children's social care. Agencies involved with parents at the time of this incident include the Probation Service, GP and Homeless Charity. However, the parents respective GPs and Homeless Charity were not contacted by MASH following the PVP referral to assist in information collation. Domesitc Abuse Service 1 received the PVP and as there was no phone contact details, a letter was sent to mother to contact the service. Mother did not respond to the letter. Mother did not book her pregnancy with the hospital midwifery service until a few days after the incident. The midwifery service and Probation Service received the PVP referral and resulted in no further action.

2.2.3 Also in May mother attended an ante-natal booking appointment regarding her pregnancy with Child R. The midwife undertook a social

[6] The CSE Team works to identify and support children and young people at risk of sexual exploitation and their families

needs assessment and mother disclosed previous substance use by herself and her partner and their previous history of social care intervention. A special circumstances form was completed and mother was referred to the children's centre and the local authority early help teenage pregnancy worker which resulted in the Family Nurse Partnership (FNP) nurse becoming involved in June.

2.2.4 In June the Homeless Charity received information regarding mother's pregnancy and father's house being used as a 'party house' and submitted a referral to MASH following discussion and assistance from the local authority teenage pregnancy worker. The referral included concerns regarding; the welfare of the unborn child due to domestic abuse, drug and alcohol mis-use, parents on benefits, disguised compliance, young inexperienced parents, father's chaotic past and criminal offending and mother being barred from Homeless Charity as a result of violent behaviour. This information was not considered in MASH until some days later and the reason for this is unclear. Two weeks later the MASH team including the local authority early help teenage pregnancy worker visited mother and following this the referral was passed to children's services social care for a child in need assessment and was allocated to a children's services social worker. By the end of July, the social worker had collated information for the assessment from the parent's historical social care records, respective GPs and family nurse. Probation and the Homeless Charity were not contacted to contribute to the assessment. Service provision at this stage was listed as: 'referral to the substance misuse midwife; engagement with the family nurse partnership and antenatal care; parents to undertake couple counselling and parents to work with a family support worker. The social worker to complete the assessment and escalate any non-engagement to a manager to review'.

2.2.5 In July father contacted his GP presenting with anxiety and stress symptoms. He was prescribed medication and advised regarding the process for self-referral for psychological treatment for anger management and stress control. Also in July mother attended the early pregnancy unit following a fall to her abdomen there is no record of how the fall occurred and there is no evidence that domestic abuse was explored with mother. In August mother attended the Homeless Charity daycentre briefly with a facial injury, possibly a cut lip. When asked if these injuries had been caused by father she nodded and left the building. The worker pursued this with mother and was later told that the injuries were not caused by father but were the result of 'fooling around' with her sister with a skipping rope. Around the same time mother was found to have covered up facial bruising with excessive make-up when visited at home by the social worker. The Homeless Charity workers discussed the bruising with the local authority teenage pregnancy worker who in turn shared it with the social worker. The social worker immediately made an appointment with mother and spoke to father on the phone. Mother minimised the incident but father admitted he had caused the bruising whilst removing mother from his flat. The social worker referred mother to Domrestic Abuse Service 1. Also during this period a substance misuse midwife was identified although experienced some difficulty in contacting mother.

2.3 Key Practice Episode Two: Later Pregnancy

2.3.1 At the end of August the social worker referred mother to Domestic Abuse Service 1 however, the service was not aware of the previous parental relationship or their individual social care histories. An Independent Domestic Abuse Advisor (IDVA) was allocated to the case and an appointment booked for early September, the IDVA completed safety planning with mother over the phone. However, mother failed to attend the first appointment and the IDVA tried to

contact mother and the social worker but without success. Mother did attend the IDVA's offices some weeks later to request a new appointment and further safety advice was given. She did not attend this appointment either and attempts to contact her by the IDVA were unsuccessful. Mother did attend an appointment with the IDVA in November when a risk assessment was completed which highlighted that mother was minimising her abuse. Safety planning was recommended for mother and she attended three sessions of the 'freedom program' in November before disengaging. [7]

2.3.2 In September police attended an incident following an anonymous call indicating that mother and father were arguing and that mother had sustained bruising caused by father. On attendance police colleagues were informed by mother that the bruising was caused as a result of her slipping in the bath. Mother also indicated that she had hit father as he had insulted her mother. Evidence suggests that mother had attacked father who had defended himself by blocking the attack causing injury to mother. The attending police officer completed a PVP referral assessing the risk as standard and a crime report for assault. Police officers in MASH upgraded the risk to medium (the report author for the police agency is of the opinion that the incident should have been upgraded to high risk). The sharing of information with children's social care and the new domestic abuse service 2, was completed nine days after the police home visit. The midwifery service received the PVP fourteen days after the home visit and the family nurse partnership received it after twenty two. Domestic Abuse Service 1 was no longer the local authority commissioned domestic abuse service and they did not receive the information. Domestic Abuse Service 2 contacted mother by phone on

[7] Domestic Abuse Awareness and Support Group for Women the **Freedom Programme** is a 12 week support group for women.

the second, fifth and sixth days after receiving the PVP but with no success. The service updated the police record to note that contact had been unsuccessful and closed their case record of the incident.

2.3.3 The social worker completed the child and family assessment in September and recommended that because of concerns about the parents' age and the concerns around domestic abuse there should be consideration of a multi-agency child protection plan. The social worker was of the opinion at this time that parents needed to live separately as the risk to baby would escalate if they were living together. A strategy discussion took place in October 2015 between police and children's social care which decided to progress to Initial child protection conference (ICPC). The conference was held within statutory timeframes and was attended by police, substance misuse midwife, family nurse and social worker. The Homeless Charity and Domestic Abuse Service 1 were not invited, although this is disputed by the local authority and nor was the father's GP. The meeting agreed that Child R should be the subject of a child protection plan because of concerns about emotional abuse. A core group attended by the family, social worker and family nurse was held in October and a further core group in November at which the social worker was the only professional present.

2.3.4 In October 2015 father referred himself to a the Adult Mental Health service[8] stating that he was 'feeling down' and had 'suffered bad things from the past'. He was offered trauma focussed cognitive behavioural therapy (CBT) and placed on a waiting list for the service.

2.3.5 During this period the family nurse completed five visits to the family to offer support. However, given that the schedule for (Family Nurse

[8] The service contacted offered talking therapies wellbeing service.

Partnership) FNP visits (weekly visits in first month and fortnightly thereafter), at least eight could have been undertaken during this time although a number of unsuccessful attempts were made to contact the parents and resulted in fewer visits being possible. Seven visits were arranged but then cancelled by either mother or father and one visit the parents did not attend. Rescheduled meetings were offered via telephone message and text message but no response was received. No home visits took place in September due to mother being away for a family bereavement and due to mother being ill, as a result the domestic abuse incidents in August and September were not discussed face to face. During one of the home visits in October the FNP nurse witnessed first-hand the parents arguing. Routine antenatal care continued and there was good engagement with the community substance misuse midwife.

2.4 Key Practice Episode Three: Birth and First Months

2.4.1 In December a family support worker was allocated and undertook a number of visits to the family. This work was undertaken alongside that offered by the FNP nurse who had visited the family and offered a significant level of support.

2.4.2 The third core group took place in this period. However, due to sickness the social worker was unable to attend and as a result there was no children's social work representation at the meeting, the FNP nurse chaired the core group.

2.4.3 In January a review child protection conference (RCPC) took place following the birth of Child R and agreed that the child protection plan should continue under the category of emotional abuse. Father was offered an appointment for cognitive behavioural therapy, but failed to attend and was discharged from the service in line with the Mindsmatter normal practice.

2.5 Key Practice Episode Four: Two Months Leading to Incident of Harm

2.5.1 During February and March the relationship between the parents deteriorated with escalating incidents of dispute. A further incident of domestic abuse was reported in February when mother contacted the police and alleged that father was refusing to let her out of the family home. The police visited and saw both parents who acknowledged there had been an argument but neither of them alleged any violence had occurred. The police shared this information with other agencies via a PVP referral and the incident was recorded as standard risk with a note made that this was the third incident of domestic abuse in the previous 12 months. Two weeks later there was a further altercation which was witnessed by the early help family support worker visiting the home who noted that Child R was present during the argument. The following day father contacted the police by telephone, and during the call mother was heard to say 'let me out'. Police attended as a grade 1 emergency and forced entry. Neither parent was in the property but, father returned soon after and mother was found nearby. The parents said they had been arguing about money and that father rang the police because mother was being verbally abusive. Mother confirmed to officers that she had snatched the telephone from Father who let her out of the house. Following this incident the police passed the information to other agencies via a PVP and classified the incident as medium risk.

2.5.2 In February father told the social worker that he was feeling low in mood but had not seen his GP for a month and had not commenced CBT, although he reported that he was still taking his medication.

2.5.3 In March police attended a further incident outside the family home when mother was found to be outside with her eleven week old baby. The maternal grandmother indicated that mother had just been

discharged from hospital and that father had been violent towards her, father had also been caring for Child R during mother's hospital stay. A standard risk PVP was submitted and information shared with children's social care, IDVA, health and probation. At a later home visit (6 days later) by the social worker, father disclosed that he was still taking drugs and had not been taking his medication. A week after the first police incdent in this month, police were called again because of a verbal argument between mother and father. The police officer who attended recorded that the couple need more support as they appeared to be struggling adjusting to a new baby. The officer submitted a PVP domestic abuse report assessed as standard risk. At the end of the month the social worker observed the parents were arguing and shouting during a visit and that Child R had remained content throughout the visit and did not react to parents arguing. Also at the end of March mother attended the Homeless Charity's day centre service alleging that father had thrown her out of the house. Nightsafe provided a place for mother to feed Child R and she used her mobile to call the social worker. However, whilst the staff member who overheard the call had believed mother was talking to a social worker, the social worker has stated that she did not receive the call.

2.5.4 At the beginning of April Child R was presented to hospital with injuries which were considered likely to have been as a result of non-accidental injury. Care proceedings were initiated by the local authority and an interim care order granted in respect of Child R who was placed in local authority care.

3.0 Analysis of Practice

3.1 Knowledge and understanding of the family history

3.1.1 Child R's mother received midwifery care from nine weeks' gestation when she attended ante-natal booking at the hospital. At this time

the midwifery staff undertook a 'social needs assessment' and shared information with the children's centre via an early notification form. The assessment identified the need for further communication with children's social care although this was not initiated and the rationale for this is not known. However it is possible that this was because staff believed that CSC would not accept a referral prior to sixteen weeks gestation. It could be argued that if this direct conversation had taken place and information pertaining to the parents own histories of complex family relationships, drug and alcohol misuse and possible child sexual exploitation (CSE) had been taken into consideration, an early assessment of mother's needs and those of her unborn child could have been considered more fully leading to earlier intervention and support additional to that provided by health services.

3.1.2 The assessment undertaken by midwives was in line with their procedures positively identifed the need for additional support for mother. This led to a referral to the children's centre for a common assessment framework (CAF) assessment. The Children's Centre panel considered the information and agreed a referral to the Family Nurse Partnership (FNP). However, the full range of family history and the implications of this were not well known by all professionals and the importance of this information as a tool to measure parental capacity to protect was not acknowledged. Most professionals relied solely on information provided by mother. Disguised compliance is a common factor in families living with domestic abuse and the maintenance of a healthy level of scepticism is a vital component of good practice. Triangulation of information should be a central element of assessment and the concept of 'respectful uncertainty' integral, in particular where there are additional indicators of concern for example teenage pregnancy, domestic abuse and current or historical substance misuse. It is the case nationally that 'almost 60% of children involved in serious case reviews were born to mothers under 21'.

3.1.3 Both of Child R's parents were known to have experienced volatile and chaotic environments as children and Child R's mother, to have been exposed to domestic abuse as a child. Both parents exhibited volatility during adolescence and their own relationship was pervaded by violence from its onset. Historical information regarding childhood experience and the parents own experience of being parented could have attracted more prevalence in respect of the first assessments undertaken in regard to the potential risk to their unborn child and the impact of these experiences on them as potential parents. Midwives undertook a social needs assessment and did identify the need for additional support however, as previously argued this relied on information provided solely by the mother herself.

3.1.4 Information was received into the MASH from the police in mid May 2015 regarding an altercation between Child R's parents. Children's Services in MASH considered this information and undertook initial enquiries but did not complete this until nine days later, as a result of difficulty in making contact with the mother. The Children's Services team in MASH did contact the maternal grandmother who gave assurances that although a previous history of complex relationships substance misuse, anger management, anti-social behaviour and putative pregnancies was correct, she also stated that since meeting Child R's father 12 months previously 'issues had reduced'. This information does not appear to have been triangulated with any additional information from health colleagues or information from Probation or the Homeless Charity who had a long history of intervention with Child R's father and mother. It is likely that the Children's Services workers in the MASH team would have had access to historical information pertaining to concerns regarding the mother and CSE and potentially could have linked this with previous concerns regarding CSE and mother's current pregnancy. It is possible that if additional information had been sought and additional professional

curiosity demonstrated, an initial assessment could have been undertaken and support offered to the family at an earlier stage. Systems which support the sharing of information within the MASH have undergone consideration and changes have been made to ensure that contact suggesting the need for further assessment is transferred in a timely way to the assessment team. Further work is being undertaken within the local authority to consider the front door arrangements and mitigate the impact on services, ensuring that contacts and referrals to the service receive a robust and timely response.

3.1.5 There are a number of examples evident within this review to suggest that professionals within the system need to look wider for sources of information regarding safeguarding children. MASH standard health checks are undertaken with the health visitor, school nurse records and where there is a known pregnancy, with the hospital safeguarding team. Other health services are only contacted if these enquiries reveal additional concerns. GP, accident and emergency department, or midwifery services are only contacted where there are queries from health visitor or school nurse records, thus limiting potential sources of information to augment assessment. The child and family assessment did not include contact with the Homeless Charity, who held significant information pertaining to the parents and indeed were the referring organisation. It also did not include a check with Probation where father was just completing his community supervision order.

3.1.6 The assessment undertaken by the social worker identifies; GP, family nurse and midwife as organisations having been consulted during the assessment. It is notable that contact was not made with father's GP, mental health services, Homeless Charity, and Probation Service which had significant involvement with father and it could be argued engendered a negative impact on the quality of the assessment and the subsequent analysis. The assessment includes a model of risk

assessment including 'BwD risk toolkit' based on work by Calder (2008). However there is little reference to parental history of drug use or considerations of current substance misuse and the potential impact of this on parenting.

3.2 Multi-agency communication and information sharing

3.2.1 An early referral was appropriately made by the Homeless Charity regarding concerns for unborn Child R relating to the perceived escalating violence between the parents, chaotic lifestyles and possible substance misuse. The Homeless Charity had worked with Child R's father for a significant period and were correctly concerned regarding the issues presenting within the couple's relationship and the potential impact of this on their unborn child. The service had also worked with mother and at the time of referral, mother was banned from the address due to threatening language and behaviour towards other residents and reports of violence towards father. It is concerning that this referral was not acknowledged by the MASH in that the Homeless Charity received no feedback and were not involved in further assessment work, planning and service delivery with the family.

3.2.2 This case review has identified that third sector involvement in child protection processes has been limited and arguably has resulted in significant information not being made available to multi-agency meetings and resultant plans. A view presented during the learning event suggested that the concerns of third sector organisations were not given an equal level of cogency as other sources of information and this view was compounded by the failure to invite the referring organisation to the strategy meeting and to share their significant levels of information within the assessment and in subsequent child protection conferences.

3.2.3 It was the view of practitioners contributing to the learning event that in the early stages of this case professionals did not have a common

understanding regarding the level of perceived risk to unborn R. The Homeless Charity expressed a view that the violence between the parents was escalating to a point which indicated a risk of significant harm but felt unable to translate this into intervention from Children's Services and indeed the decision to consider the risk of significant harm to unborn R was not made until some months later when a strategy discussion agreed that an ICPC should be convened. Furthermore, within the discussions some participants expressed the view that information from third sector organisations may be perceived as less valid than that of some statutory organisations. The referring agency was not invited to contribute additional information to the referral, was not invited to participate in the strategy discussion and was not invited to contribute to the initial child protection conference. Information provided by the Homeless Charity was not extensively shared in the strategy discussion and subsequent conferences. Opportunity to invite the Homeless Charity to the initial conference were missed and as a result information sharing in both directions will have been impaired. It is clear that Homeless Charity had a great deal of information pertaining to both historical information in relation to father and to current information regarding the couple's current relationship.

3.2.4 During the early pregnancy period there is evidence of good communication between agencies on an informal front line basis but this seemed to be dependent on individual knowledge of services and strong relationships between professionals. Whilst police information was appropriately shared with safeguarding colleagues following domestic abuse incidents throughout the case history some PVP risk assessments were disputed and defined the response undertaken from other agencies. It also appears that information was received by agencies at different times and that there were some delays in processing information within individual agencies. Health colleagues were not consistently aware of incidents of domestic abuse as a result

of various recording systems which do not automatically interrelate and GP's do not receive PVP reports.

3.2.5 A decision to convene an ICPC was made within supervision between the ASYE (assessed and supported year in employment)[9] social worker and the area team manager on completion of the assessment in September. Working Together (2015) anticipates that a decision to progress to ICPC is made as a result of S47[10] enquiries instigated as a result of a multi-agency strategy meeting. A strategy discussion was convened in early October 2015. There is a period of eight days following a discussion and agreement within supervision that Child R was at risk of harm. It is significant that a period of in excess of a week was allowed to pass when a judgement had been made by the social worker and the manager that Child R was potentially at risk of significant harm.

3.2.6 The strategy discussion was conducted by telephone with representatives from CSC and from the police with no representation from any other agency including the referring organisation and significantly health colleagues given that Child R's mother was in receipt of midwifery services and family nurse partnership and this telephone discussion was not followed up with a full multi-agency strategy meeting. Best practice, as outlined within Working Together (2015) identifies an expectation that; 'A local authority social worker and their manager, health professionals and a police representative should, as a minimum, be involved in the strategy discussion. Other relevant professionals will depend on the nature of the individual case but may include:

- the professional or agency which made the referral;

[9] The ASYE is a twelve month programme for assessing newly qualified social workers (NQSWs).
[10] Children Act 1989 section 47

• the child's school or nursery; and

• any health services the child or family members are receiving.

All attendees should be sufficiently senior to make decisions on behalf of their agencies'.[11]

3.2.7 It is described as 'not unusual' in Blackburn and Darwen for telephone strategy discussions to be held which include phone calls to all relevant agencies. However, this arrangement does not allow for a full discussion between organisations potentially missing vital information pertaining to the assessment of risk. This strategy meeting should have constituted the first opportunity in this case for a full multi-agency discussion regarding risk to unborn R to have been undertaken and the inclusion of health and other agency practitioners in this discussion would have added to the richness of information and would have ensured that all agencies involved with the family were aware of the escalating concerns and able to contribute effectively to the management of risk. The lack of opportunity for full multi-agency discussion of issues in this case has compounded professional ability to assess the 'cumulative and interacting risk of harm'[12] including potentially pervasive patterns of intergenerational abuse and neglect. Lead reviewers have been advised that current practice utilises conference calling facilities to ensure that all agencies are involved and able to collectively consider concerns regarding safeguarding children. It is significant that the allocated social worker for the case was not invited to contribute to the discussions and have input into the development of the resultant strategy, this is despite working from the same open plan office as the manager who undertook the telephone discussion with police. Whilst best practice dictates that a strategy meeting be chaired by an appropriately senior and experienced CSC manager it is easy to speculate that connotation and nuance could

[11] Working together to safeguard children 2015

[12] Sidebotham et al 2016

be lost as a result of information being delivered by a third party, having the potential for limiting decision making in context.

3.2.8 Within the period between allocation of this case to the ASYE social worker and the conference some three months later, there were no opportunities for the multi-agency professionals to meet to discuss the case, develop an intervention plan and to eliminate the opportunity for the parents to divert workers from the needs of the child to their own significant unmet needs. As the case was allocated to a social worker at child in need level it would be anticipated that child in need planning meetings would have taken place. The Pan-Lancashire Multi-agency pre-birth protocol (2012) indicates its purpose is to 'ensure that a clear system is in place to develop robust plans which address the need for early support and services'. It is clear from the CSC report that no opportunities were afforded to the other agencies involved with Child R's parents to come together to identify a plan and to develop a full picture of the scope of concerns prior to the ICPC. It could be argued that a valuable opportunity was missed to enable a clear plan to be developed and to allow services to work together to provide the significant level of support which would have been required in this case and to work in partnership with the parents and avoid opportunities for their non-cooperation or miscommunication between services. Studies of evidence regarding multi-agency working provide consistent findings in regard to the benefit of such working including; clear aims, roles and responsibilities and timetables that are agreed between partners.

3.2.9 The ICPC took place in October and agreed that unborn Child R should be made subject to child protection plan in the category of emotional abuse. Invitations to ICPC are developed by the social worker and then passed to independent reviewing officer

administrators to be sent out. It is significant that Homeless Charity as the referring organisation and one with extensive knowledge and information regarding the parental relationship was not included in the invitations and as a result not able to contribute to the analysis of risk and need. Information from the father's GP was also not made available to the conference as there had been no invitation to attend or to submit a report. Mother's GP was invited to attend and to provide a report, neither of which was undertaken. It could be argued that this led to a lack of opportunity to consider father's mental health in line with any potential impact of this on Child R both prior to and following the birth and that this was augmented by the apparent lack of challenge regarding the invitation list. The Police were also not in attendance at the RCPC. It is the case that police colleagues nationally face an on-going challenge around capacity to participate routinely in multi-agency child protection processes, such as conferences and strategy meetings and it is of concern that although the issues raised within this review pertain to a specific timeframe, similar capacity issues are inevitable for organisations at different times, including GP's who often are unable to attend at short notice as a result of responsibilities in regard to pre-arranged clinics and this arguably will become more so as resources become more limited.

3.2.10 It is not clear from the information submitted to this review what level of discussion was had at core groups which were appropriately held in February and March, regarding the escalation of violence between the couple and their lack of attendance at appointments with IDVA and father's CBT appointments. There is no evidence of a clear contingency plan relating to Child R including the potential to call an early conference to discuss increasing concerns in a multi-agency environment and to ascertain clear legal advice in respect of threshold for care proceedings and as such it would not have been clear to the

parents or to professionals what actions should be undertaken if a failure to adhere to and advance the plan was perceived. It could also be argued that the clarity and indeed legal advice provided to the parents as a result of instigation of the Public Law Outline process could have crystallised concerns and encouraged parents to work more openly with professionals.

3.2.11 The attendance of appropriate professionals and family members at core groups impacts on the effectiveness of this mechanism to monitor and develop the child protection plan. Child R's maternal grandmother and aunt were present at core groups in the period between ICPC and RCPC and after this juncture did not attend. It is of note that the perceived support offered from the extended family appears to have diminished at this point and consideration of the impact of this on risk to Child R should have been considered within core group discussions. Practitioners involved in this review indicated that minutes of the core group were taken to the subsequent core group for consideration and presented an opportunity for the core group to develop and manage the child protection plan and progress against the objectives benchmarked against previous meetings. However, the core group attendance does not appear to have included the range of agency professionals working with the family and who could have offered additional insight and management of the plan including the substance misuse midwife and Homeless Charity, who were working with the couple to improve life skills and to secure tenancies and Domestic Abuse Service 1 who whilst in receipt of the outcomes letter from the conference were not invited to core groups. Positively the core group did include the FNP nurse who did have extensive knowledge of the family and was continuing to work with them.

3.2.12 Systems for inviting professionals to multi-agency planning meetings including strategy meetings, ICPC, RCPC and core groups appear to lack systematic consideration. A prerequisite for attendance at conference is a robust system which ensures invitations are disseminated efficiently to all those who are required to attend, ensuring that they have sufficient notice. It is acknowledged that this can be particularly difficult in the context of ICPCs, where the nationally prescribed timeframes make the notice period inevitable. Current arrangements cite responsibility for development of invitation lists with the social worker and independent reviewing officer (IRO) responsible for the case. However IRO responsibility for the process also suggests that they should undertake increased levels of constructive challenge to ensure that all appropriate professionals are included in invite lists and as a result enhance safeguarding discussions in Blackburn with Darwen. An invitation was sent regarding the ICPC to the independent domestic violence advisor (IDVA). However, this invitation was sent directly to the practitioner and not through the agency and as a result was not received by the IDVA. It is likely that the social worker would not have been aware of the agency arrangements for invitations but could be argued that this should have been known by the IRO administration team who processed the invitation. BwD LSCB may wish to consider additional scrutiny regarding attendance and invitation to safeguarding meetings, including core groups, in order to ensure that there is robust challenge in regard to processes which, if not attended effectively have the potential to limit professional ability to safeguard children and young people.

3.2.13 Information pertaining to the date and time of review child protection conferences is included in a letter to professionals but is not followed up with additional reminders closer to the time of the conference. This has resulted in the child's GP in this case not attending or sending a

report to the RCPC which impacted on the breadth of information and on inclusion of the GP in the management and joint responsibility for the plan. GPs are not routinely informed of information pertaining to domestic abuse concerns regarding pregnant mothers and MASH do not routinely share protecting vulnerable person reports (PVP) except in high risk cases and those which indicate the potential to be considered at a multi-agency risk assessment conference (MARAC). This has resulted in mother's GP not being aware of concerns regarding domestic abuse and of referrals to other services and as such was unable to make a contribution to the assessment of risk.

3.2.14 Child R was discharged from inpatient midwifery care, following birth, without a pre-discharge planning meeting. As the child was subject to CP plan best practice considerations should include the facilitation of a pre-discharge meeting to ensure that the range of professionals responsible for the care of mother and child are fully cognisant of the plan for the child and for ensuring the child protection plan following discharge home, is clarified. Lord Laming indicated that 'verbal handovers and referrals, either face-to-face or on the telephone, carry with them a high risk of ambiguous transfer of information and the creation of false confidence that actions have been understood and will be carried out. Such verbal exchanges alone, unsupported by clear documentation, undermine high-quality care'.[13] The decision not to convene a discharge meeting was made by the social worker and was because it was felt that the regular core groups had already provided opportunity for planning. However core groups in this case did not always offer an opportunity for a full multi-agency discussion regarding the child protection plan and as a result of the substance misuse midwife not attending core groups she would not have had opportunity to engage in discharge planning.

[13] Laming 2003 Climbie Inquiry report.

3.2.15 Although core groups took place within appropriate timeframes, they did not routinely include the full range of professionals and records indicate that on at least one occasion only the social worker was present. Clearly this impacted on the level of information available to be shared at meetings in particular in relation to domestic abuse and the ability of the core group to develop and manage the child protection plan effectively.

3.2.16 National and local procedures/guidance around the operation of core groups allow for different interpretations of multi-agency ownership and the leadership role of social workers. If the core group function is to be consistently effective, BwD LSCB needs to clarify its position in relation to this and reinforce implications across the multi-agency workforce to reflect the importance of core group meetings to the child protection process and consideration given to core groups being supported administratively in a similar manner to conferences. Where this is not possible a wider ownership of responsibility is likely to impact positively on the quality of meetings, as long as expectations are clearly defined. The attendance of parents and extended family members at core groups is essential to ensure that they are aware of progress against the plan and more importantly of any deterioration or drift which might lead to an earlier conference or indeed public law outline (PLO) procedures.

3.3 Recognition of domestic abuse

3.3.1 In July 2015 Child R's mother attended the early pregnancy unit following a fall onto her abdomen, this was a gynaecology unit and staff there had no access to records kept by midwifery except the hand held notes. There is no evidence that the risk of domestic abuse was considered by staff at this presentation and no history of how the fall occurred is recorded in the notes. At a subsequent maternity

appointment mother presented with a black eye which was questioned by the midwife who documented that Child R's mother reported that she 'felt safe at home'. One explanation for this limited recording is that generally information is recorded in the hand held notes which are held by the mother. This creates a dilemma for health staff who need to be cautious in their record keeping to avoid creating additional risk to a potential victim of domestic abuse. The hospital midwifery team undertook routine enquiries regarding domestic abuse on two occasions with mother who maintained her position of denial. Without access to information regarding the PVP's and with only the level of detail held within the hand held notes there was no opportunity for the midwives to assess ongoing or additional risk. Information regarding incidents of domestic abuse were emailed to the midwife but were not acted upon and as a result were not included in the maternity notes or on the special circumstances form and as such, were not immediately available to the hospital midwives or the community substance misuse midwife that were providing services to mother and Child R.

3.3.2 Generally information received from the police PVP's regarding incidents of domestic abuse is graded by police colleagues as; standard, medium and high. Assessment is undertaken as a result of the information obtained at the time of the incident and concerns regarding whether a child is present. Assessments using the current DASH[14] tool focus primarily on the risk to the adult victim and the potential for risk and harm to children is considered subsequently. This is of particular note when the child is unborn and not considered to be 'present' despite research which clearly identifies risk to unborn children and also of the potential for escalating violence during pregnancy. Some incidents in this case were recorded as standard

[14] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model March 2009.

and as a result were not prioritised for information sharing by MASH. It could be argued that in this case this practice has adversely affected the Children's Service's response to the family, limited at least one opportunity to review the case at MARAC and engendered delay in undertaking a full assessment. Assessment of risk based on whether a child is present at the actual altercation is in some respects fallacious and research is clear that children are adversely impacted by violence and aggression within the parental relationship regardless of their direct involvement in the event. 'Because babies have little sense of self, they are very dependent on their parents or key carers for their psychological well-being.[15] Consideration in this case could also have been afforded to the number of events and the short timeframe in which they had taken place and a higher assessment of risk correlated. Some of the reported incidents of domestic abuse state that 'the incident was not witnessed by Child R' who was described as 'not having been present'. However, given the fact that the child was subject to a child protection plan and the significant previous history of domestic abuse, coupled with both parent's individual vulnerabilities, it is of note that many incidents were identified as standard. Additionally the 'flag' relating to unborn Child R's being subject to a child protection plan as a result of the ICPC was not then automatically translated to police records following the birth and acquisition of a name. As a result a 'flag' did not appear on the child's records following birth and as such this information was not available to officers attending the four domestic incidents following the RCPC.

3.3.3 In line with other police forces local police officers often attend domestic abuse incidents without prior knowledge of previous history of abuse or verbal assault. It also appears to be the case that attending officers have failed to cross-check the history in the case when

completing paperwork following incidents. However, this is likely to have been affected by the fact that the domestic abuse flag was not transferred to the most current police file following the RCPC. Assessments of risk are made pertaining to the level of impact on the adults and include a raised level of concern only if a child is present which appears to make limited consideration of the impact of domestic abuse on the unborn child. The quality assurance processes which ensure a common understanding of risk appear inconsistent and police colleagues acknowledge that three of the six assessments were considered risk to be low or standard when in fact this should have identified as medium and in one incident high risk.

3.3.4 Domestic Abuse Service 2 was commissioned by the local authority in 2015 to provide services to individuals and families experiencing domestic violence. The service was aware that the putative victim was 'heavily pregnant'. Three telephone calls were made to Child R's mother in September 2015, none of which resulted in contact. In line with standard practice, a letter was then sent including an offer of support and the case was closed. At this point this new sevice did not have an information sharing process agreed with Domestic Abuse Service 1, the previous local authority commissioned service, and so were not aware that mother was open to Service 1 following the referral the social worker had made in August 2015. It is of note that the service was aware of the pregnancy but did not appear to prioritise this as a potential/additional risk factor regarding the domestic abuse and importantly as 'a trigger for the onset of domestic violence in a relationship'. NSPCC research in 2016 suggests that any domestic violence incidents during pregnancy should be viewed as posing a high risk to the mother and the unborn child.'[16] Additional persistence in attempting contact with young women in these circumstances may

[16] NSPCC 2016

increase the chances that victims of domestic abuse engage with support over time, although in this specific case it is unlikely to have impacted on the outcome for Child R.

3.3.5 By the time of the February 2016 domestic abuse incidents reported to the police, both domestic abuse services had an information sharing protocol in place and both incidents in the month were passed to Service 1 by Service 2 to follow up with mother. The two incidents reported through police in March 2016 had different name spellings and a different address; Service 2's recording system did not link the four incidents across the two months resulting in the March 2016 incidents not being shared with Service 1. Service 2 has now amended their recording system to ensure such issues do not re-occur.

3.3.6 The social worker had referred mother to Service 2 following mother being observed with bruising on her arm in August 2015. Mother's risk assessment was completed in November following a number of missed appointments; the IDVA undertaking the risk assessment noted mother's minimisation of the risks. Mother then attended for three sessions of the Freedom Programme before disengaging around the time Child R was born. Prior to the RCPC the social worker contacted the service to discuss the IDVA's recommendation for continuing the CP plan; the IDVA recommended the plan to continue as progress had yet to be evidenced due to mother not attending Service 1 since the birth of Child R. The IDVA contacted mother after the first incident in February 2016 and was told that the incident was over reaction on her part, but agreed to attend the Freedom Programme that month. The IDVA recorded that she felt mother was minimising the incident. Mother did attend Service 1 offices on the day of the Freedom Programme and reported being under pressure due to the family's house move; she did not stay to attend the session. The IDVA contacted mother

twice without success after the second police reported incident in the month. Up to this period, Service had received three of the four police reported incidents. They had also received the referral from the social worker in August 2015 though the meaning of the referral appears to have been lost, with Service 1 reporting that the referral was for a relationship that was abusive and volatile, and the social worker referring due to observed bruising that mother was attempting to conceal. At the end of February 2016, due to mother's lack of engagement, the IDVA allocated the case to a manager to review for closure. The case was closed eight days later. Service 1 has reflected on their practice and have now changed procedures to ensure case closure processes also involve contacting relevant services involved with a family to inform their decision making.

3.3.7 Had multi-agency meetings at Child in Need level taken place or meetings at CP level (Core Groups) been effective (all relevant agencies invited and regular attendance by agencies), the various allocated workers involved with the family could have known that in addition to the six reported police incidents of domestic abuse there were also a further nine incidents reported by the parents or witnessed by professionals. At least two (August 2015 & September 2015) could have been considered as high risk incidents due to mother's bruising on arm and then face.

3.4 Understanding of the nature of domestic abuse

3.4.1 Consideration of domestic abuse in this case appears to have been framed within a stereotypical view of a female victim. A growing body of empirical research has demonstrated that domestic abuse is not a single phenomenon and that types of domestic violence can be differentiated with respect to partner dynamics, context, and consequences. Four patterns of violence can be identified:

- Coercive controlling violence where one person is violent and controlling (generally perpetrated by men against women);
- Violent resistance, usually a form of self-defence (often conducted by women against men);
- Separation instigated violence, which occurs in the context of relationships ending (usually perpetrated by men on women); and
- Situational couple violence, the most common form of domestic abuse, which is conducted by individuals of both genders nearly equally and is likelier to occur among younger couples, such as adolescents. [17]

3.4.2 However, it could be argued that services locally and nationally are not developed on this premise constituting a systemic issue as opposed to individual understanding and interpretation. Discussions within the practitioner event evidenced that practitioners involved with the family were aware of mother's potential for aggression and inability to manage her emotions but there is little evidence to support that this was a factor which was identified within the protection plan for the child or in the interventions provided to the family. Research into violence in young people's relationships[18] identifies that there are a number of forms of interpersonal violence and stresses the need to acknowledge that young people should be protected by legislation in respect of violence against them and should be considered in respect of the risk posed to them individually. Multi-agency safeguarding practitioners need opportunity to develop an understanding of forms of domestic abuse including situational couple violence and interpersonal violence in young people's relationships and develop knowledge and understanding in order to achieve realistic and

[17] Johnson, M.P. (2008) A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence. The Northeastern series on gender, crime, and law. Lebanon, New Hampshire, US: UPNE

[18] Research in practice (2016) violence in young people's relationships.

effective interventions to address this. Practitioners were aware of the potential for mother to have been an equal if not substantive perpetrator of the violence and that father was not perceived and assessed as a potential victim may have led to interventions which lacked focus and indeed failed to recognise mother as a source of risk to the child.

3.4.3 It is probable that the majority of the violence in this case was of a situational nature and there is a growing recognition that situational couple violence may respond to a different style of intervention. In many of the calls to police it was father who instigated the intervention as opposed to mother who was often identified as the victim. The fact that father sought the intervention of the police is unusual, in particular if he were the perpetrator of the violence and accounts from both parents needs to be sought to avoid a focus on women as victims as is often the case. Practitioners in this case did not question why father was contacting the police or consider whether this indicated that the nature of the violence between the couple was outside of normal parameters of coercive control types of domestic abuse. The services offered to the couple in this case focussed on father's management of anger and were separated into victim/perpetrator interventions. Intervention was offered to mother but as part of a victim programme whilst consideration was given by the social worker and IDVA, although subsequently felt not to be appropriate, for a referral for father to 'making the change[19]' which seeks to engage with perpetrators to support them to become aware of the consequences of the abuse.

3.4.4 The ICPC recommended that father attend anger management sessions, a service which he was positive to attend. However, it

[19] Making the change is It is a behavioural change programme, as opposed to anger management, for men who recognise that they are or have been using power and control to abuse their female partner or ex partner, and want to address this behaviour.

appears that no consideration was given to the potential for mother to have benefitted from similar sessions in that she had displayed significant evidence of her lack of emotional control and verbal aggression. It is likely that there was a stereotypical focus on the father as perpetrator and mother as potential victim, with little consideration regarding the potential for this to have been contrary. There appears to have been a prevailing understanding that the violence within the relationship identified the mother as the primary victim and that this has led to interventions which fail to acknowledge the situational nature of the violence[20] and to undertake full assessment of the interpersonal dynamics of the parental relationship. It is likely that if full information regarding mother's violence had been more widely known to services, referral to more relevent services could have been undertaken. Information within the Children's Services' report suggests that a discussion took place with the mother in respect of her moving into mother and baby accommodation. This discussion does not appear to have considered information pertaining to the likelihood that the mother was also a perpetrator of abuse within the relationship and at least was potentially an equal aggressor.

3.5 Recognition of the risk of physical harm to the child as a result of domestic abuse

3.5.1 It was the unanimous decision of the ICPC that a child protection plan be put in place in respect of Child R as a result of continuing risk of significant harm. Once the decision was made that a plan was required it was the responsibility of the IRO to determine (following discussion with conference members) which category or categories of abuse or neglect the child was experiencing or was at risk of suffering. In this case a decision was made to categorise the harm as emotional. Working together to safeguard children (2015) defines emotional abuse

[20] Situational couple violence; TCCP 2016(1)

as; 'the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development', which, it could be argued does not best describe the potential risk in this case. The definition goes on to describe emotional abuse as 'seeing or hearing the ill-treatment of another' and as such could apply in the context of the parental relationship. Given that agencies and professionals working with the family had a significantly high level of concern and information pertaining to parental volatility and a number of violent altercations between them it is notable that this does not appear to have influenced consideration of the category of physical abuse in recognition of the potential for Child R to have been exposed to physical risk within the context of parental volatility.

3.5.2 It is clear from practitioners that discussions took place within the conference regarding the potential for physical injury to the child as a result of parental volatility and domestic abuse. However, a policy of no dual registration was understood to be in place and it was the view of the conference that emotional abuse was the most appropriate category. In fact this is not the case and the BwD LSCB policy allows for dual registration in appropriate cases. It is interesting to consider the potential impact of this category of registration on the development of the plan and on interpretation of the risk to the child, specifically that which ensues from exposure to angry and violent episodes between the parents. It is possible that the focus of intervention was predicated on the potential for emotional abuse and that the risk of physical injury to Child R was not well recognised and was not specifically addressed within the resultant plan.

3.5.3 Research regarding children experiencing domestic abuse indicates an increased risk of physical harm to children, particularly babies or other non-mobile children, when they are living/in close contact with

violent adults. There is clear research evidence of the increased risk of physical harm to children from men who are violent to their female partners. UK: In 40-70% of cases where women are being abused, the children are being directly physically abused themselves (Stark and Flitcraft, 1996; Bowker et al, 1998)[21]. Domestic violence is also a key indicator for child abuse and neglect – with children experiencing domestic violence being three to four times more likely to experience physical violence and neglect. [22]

3.5.4 The child protection plan developed as a result of the RCPC includes a number of recommendations regarding parental behaviours and their seeking support in regard to their management of anger and in regard to domestic abuse, albeit separately as putative victim and perpetrator. Recommendations developed to ensure the physical protection of Child R are not explicit and the inclusion of an overview of heath and development is not included. A clear recommendation that the child should not be 'subjected to further incidents of domestic abuse' is supported by the outcome 'parents will understand the dynamics and cycles of domestic abuse to ensure this does not negatively impact on their baby's safety and welfare' but does not acknowledge the propensity for harm as a result of being present during volatile episodes, work with the couple to augment their understanding of these issues is also not explicit. It is also likely that the language used within the child protection plan will have had little meaning to the parents making it difficult for them to understand and work towards the outcomes outlined.

[21] Stark, E., and Flitcraft, A., *Women at risk: domestic violence & women's health*, Sage Publications, 1996 Bowker, L. H., Arbitell, M., McFerron, J. R., 'On the relationship between wife beating and child abuse', in K. Yllo & M. Bograd (Eds.), *Feminist perspectives on wife abuse* (pp.90-113), Sage Publications, 1988.

[22] Stanley, N. (2011) *Children Experiencing Domestic Violence: A Research Review,* Dartington: research in practice

3.6 Assessment of risk of parental substance misuse and impact on Child R

3.6.1 When the midwifery services completed their social needs assessment early in the pregnancy mother acknowledged previous use of substances but stated that she had not used any substances in the previous twelve months, although she later stated that she had and this conflicting information does not appear to have featured in assessments. Although the midwifery service did share this information with the specialist community midwife for substance misuse a referral was not made at this stage. However when the teenage pregnancy worker became involved she discussed a referral with the family nurse who made the referral and involved the specialist community midwife. Information contained within the referral from Homeless Charity in June 2015 indicated concerns regarding the father's accommodation being the 'party house' and reported both parents as being involved in substance misuse. The CSC assessment in respect of Child R includes reference to historical substance misuse in regard to both parents but does not translate this into analysis regarding the potential for the use of substances to remain a feature of the relationship. A specialist community substance misuse midwife was allocated and worked with the family. The referral to this service was completed in July 2015, but the initial visit was not completed until the end of September as a result of difficulty in arranging the initial visit and of subsequent visits being cancelled by parents. At the initial visit, mother indicated that she had not taken drugs since knowing she was pregnant. This pertains to the differences in information and the lack of healthy scepticism in relation to conflicting information and over reliance on self reporting. Between September 2015 and January 2016 eight home visits were conducted by the specialist community midwife. The records for these visits has been limited as parents had lost hand-held postnatal records and the ante-natal hospital record had not been updated regularly by the specialist community midwife specialist substance misuse midwife.

3.6.2 The ICPC did not discuss substance misuse as a significant issue pertaining to risk and represents a missed opportunity to triangulate the parent's assertion that they were no longer using substances. Issues of substance misuse were not included in the child protection plan despite illicit drug use being a significant feature of father's history. Following the RCPC a subsequent conference was planned for six months later. It could be argued that given the complexity of the case and the relative length of time six months represented in relation to the child's age that an earlier conference would have been more proportionate in this case.

3.6.3 During a home visit prior to the injury to Child R, father informed the social worker that he was no longer taking his mental health medication and was self-medicating with cannabis, this information did not result in a referral to substance misuse services for father as the social worker prioritised a referral into mental health services.

3.7 Supervision and support to newly qualified workers

3.7.1 Supervision and appropriate caseloads for safeguarding staff in all organisations needs to reflect the complexity and risk integral to the work. Social work staff, in particular, should have appropriate levels of support and challenge from senior managers. A newly qualified social worker, if allocated child protection work, should benefit from a protected caseload and should be afforded additional mentoring and reflective supervisory opportunities to ensure best practice.

3.7.2 This case was allocated in July 2015 to a social worker who was in the first year of her qualification and subject to an 'assisted and supported

year in employment[23]. Given the complexity of this case it is surprising that the local authority chose to allocate a worker with such limited experience. It could be argued that a more suitably experienced worker should have been allocated as a minimum, to oversee the work and to mentor the social worker in the management of the case.

3.7.3 When workers are inexperienced it is very important that there should be close and supportive supervision provided. ASYE social workers should expect to receive additional case supervision during this first year of practice to ensure that they are supported in the development of their social work ability. In this case the manager has reported that she provided extra support and management oversight however supervision records show only two formally recorded supervision sessions between allocation, July 2015, and March 2016, eight months later. Learning from serious case reviews identifies effective supervision as a vital element of professional good practice and states that a 'lack of staff, high staff turnover, over use of unqualified staff, inadequate supervision, a lack of professional curiosity and a sense of helplessness and low morale were often identified as reasons for a lack of timely and holistic assessments and appropriate planning, these were often issues for all professional groups.[24]

3.7.4 At this time, following a reorganisation of service delivery, Children's Services had difficulty in allocating work because of staff vacancies, significant levels of newly qualified social work staff, a high number of referrals and increasing complexity of cases. This meant that caseloads for social workers within the team were at times over 30 children. ASYE social workers should expect during their protected year to have a protected case load, usually under 20 cases. It is

[23] The ASYE is a twelve month programme for assessing newly qualified social workers (NQSWs).
[24] Sidebotham et al 2016

unacceptable that the ASYE holding this case had up to 30 cases on her case load at the time she was working with the family, a number which would be considered excessive for a more experienced worker. Research undertaken by community care in 2016[25] identified 'Patchy implementation of the ASYE leaves newly qualified social workers facing unprotected caseloads'. The research found significant variation in caseload numbers across the country with some social workers taking on cases not appropriate for their experience. Lead reviewers have been informed that a new supervision policy has been developed by children's services outside of the scope of this review which was implemented in July 2016. The new policy ensures that all social work staff receive case supervision on a monthly basis, reflective supervision six weekly and a personal supervision on a quarterly basis.

3.7.5 Supervision of a relatively inexperienced member of staff in this case was insufficient given the complexity of the case and in particular child protection status. Child protection work, however has an additional level of scrutiny as it is independently monitored by an independent reviewing officer (IRO) who chairs the conferences and provides an oversight of the work. The IRO quality assurance function has a responsibility for; 'appointing a lead statutory body and a lead social worker, who should be a qualified, experienced social worker and an employee of the lead statutory body'. It appears that the IRO failed to recognise the opportunity to challenge the appropriateness of the allocation of an ASYE in such a complex case or to advocate for additional support in respect of management of the complexities inherent in this case.

3.7.6 The independent reviewing service has a remit to ensure that the child protection plan is being progressed and if not to trigger a different

[25] By Rachel Schraer on January 27, 2016 in Caseloads, NQSWs, Workforce

intervention with the family usually by recommending initiation of a legal process. Liaison by the IRO with the social work team would have established that this was not the case, indeed in a supervision session on the 1st of March between the social worker and her manager, this possibility was discussed but agreed that it would be initiated following a further event, this was not pursued following the three incidents in March, when mother was allegedly 'thrown out' of the couple's home and the one occasion where the social worker witnessed first-hand arguments between the couple. Within the months following the RCPC there were a number of opportunities for the core group to acknowledge the increasing violence and to avoid drift in case planning and which could have led to additional clarity regarding increasing levels of concern and brought the parents to seek independent legal advice.

3.7.7 The child protection plan produced as an outcome of the RCPC includes information pertaining to the seeking of legal advice pending further deterioration of the parental relationship and further reported violence. However, despite increasing concerns and incidents of violence, legal advice was not sought by the local authority. Mechanisms to consider these issues including supervision of workers, core groups, liaison and challenge from the independent reviewing officer were not utilised to best effect in this case. There has been a lack of robust challenge from the IRO service with regard to attendance at conferences, in particular, predicated by an apparent acceptance that GP's will not attend conferences nor send a report.

3.8 Cross-Agency understanding of services

3.8.1 It is apparent that a significant number of services were offered to Child R's parents throughout the scope of this review and in the years preceding. However, it is difficult to make sense of each separate

service and the different opportunities they offered to the parents. Indeed the social worker when referring father to an assessment and treatment team perceived this to be a crisis mental health support immediate service when in fact this was not the case. It is a considered view therefore that a clear understanding of the responsibilities and service offered by the many professionals involved in the life of this family will not have been well understood by them.

3.8.2 It appears within Blackburn with Darwen there exists a general acceptance that GP's will not attend conferences and no challenge to this assumption appears to have been established. Given the nature of the concerns in this case pertaining to both parents reported turbulent and complex childhood experiences, drug and alcohol misuse, mental ill health and lack of emotional regulation, it could be assumed that information which would have been available to the conference from GP services would have benefitted the discussion and the resultant child protection planning. The RCPC minutes suggest that there were 'no concerns over their (the parent's) ability to care for a baby', despite clear information to suggest that they had exposed the unborn child to the volatility within their relationship and although they had undertaken some work to develop their understanding of the potential impact of this on Child R's emotional development, there was limited evidence that they had understood this.

3.8.3 The outline plan developed as a result of the ICPC was sent to all professionals invited to the conference; although without follow up from a professional in attendance at conference, the list of outcomes and actions appear not to be related to the social worker's assessment and are hard to interpret. The plan includes a recommendation that father will 'continue to manage his medication successfully', but as his GP was not invited and therefore not present at the conference and

would not have been in receipt of minutes, it is not clear how this recommendation was to be managed or indeed assessed in line with the plan. The ICPC minutes evidence a discrepancy between involvement from Domestic Abuse Service 1 and Service 2 and confusion regarding which agency was involved to provide services to mother and father and which led to neither service being invited to the core group. It is possible that this was as a result of a recent transition in the commissioning arrangements from Service 1 to Service 2 and that this engendered a level of professional confusion. The date of the next conference is included in the letter to professionals sent following the ICPC. However, this is not followed up with a reminder nearer the time. In this case this has prevented the mother's GP surgery from identifying the date (from the letter) and then from attending the subsequent RCPC. Clearly it is the responsibility of the organisation in receipt of the correspondence to register and record the date of the next conference, additionally that the cost of postal invitations as a means of information may be preclusive. However, an email or phone call prior to the review conference to reiterate the date and importance of attendance would have significantly enhanced the depth of discussion in this case and allowed the GP to have had a full involvement and develop a level of ownership in relation to the on-going child protection plan.

3.8.4 Despite information being provided by the community safety partnership regarding the changes in commissioned services in Blackburn with Darwen in respect of domestic abuse there appears to have been a lack of professional understanding of information, leading to confusion regarding appropriate services. It has been reported to lead reviewers that more recent audit activity by the board suggests that this is now significantly clearer.

3.8.5 Within the safeguarding partnerships there appears to have been a number of common understandings including that referrals to MASH could not be made regarding unborn children prior to sixteen weeks gestation. This is in fact not the case and this is made clear in the Pan-Lancashire joint multi-agency pre-birth protocol[26] which identifies the circumstances in which early referral should be undertaken.

3.8.6 A further common understanding pertains to the attendance of GPs at safeguarding meetings. The lack of attendance and reporting from GPs in this case was not appropriately challenged by the IRO and has resulted in limited information pertaining to father's mental health in particular being available to conference and to be included in safety planning for the child. Additionally practitioners present at the initial child protection conference understood there to be a preclusion of dual registration which is also not the case and circumstances in which this is appropriate are included in BwD LSCB procedures.

4.0 Good practice

A SILP review seeks to learn from good practice as much as from shortcomings. The following areas of good practice are identified:

4.01 The Homeless Charity correctly expressed concerns regarding the parental relationship, volatility and aggression and made a correlation between these issues and potential risk to their unborn child and made appropriate referrals. Professionals within this service anticipated a response within three working days from MASH following their referral but did not receive one, although a joint visit was arranged. Restructure at the Homeless Charity, new CEO, and refreshed policies and procedures including a review of staffing levels has been undertaken and additional staff employed to respond to increasing levels in demand. Formal recording processes have been introduced

[26] Pan-Lancashire joint multi-agency protocol 2012

and Charity now routinely follow up MASH referrals within three working days where they do not know the outcome.

4.02 Midwives undertook assessment in respect of Child R's mother and she was identified as in need of support and early intervention. Midwives referred mother to the children's centre for a child and family (CAF) assessment. The resulting consideration for the CAF included the local authority teenage pregnancy worker and as a result a referral was made to the FNP nurse who acknowledged the need for additional support for mother. The FNP nurse in turn identified the need for the specialist substance misuse midwife service. The FNP nurse provided an excellent level of provision in regular ante-natal and post-natal home visits and a high level of commitment and sustained intervention was evident on a range of risk and protection issues including; domestic abuse, child development, anger management, low moods/mental health, bonding/attachment, coping strategies when babies cry and safe handling of babies. Despite the lack of evidence of substance misuse at that time it was good practice that a service from the specialist substance misuse midwife was provided that involved regular ante-natal and post-natal home visits before discharge to the FNP nurse.

4.03 A high level of resources was offered to this family by a variety of organisations throughout the period of involvement and there is evidence of close working relationships between professionals working on this case. There is evidence of a significant level of persistence of front line professionals in attempting to engage the parents in work to address the issues in their relationship despite a level of resistance. Organisations have worked well individually with the parents although this work would have benefitted from being more 'joined up' in its nature.

4.04 Despite the family's lack of willingness to engage, professionals persisted in the child protection processes to protect the child. Workers recognised the progress made by the parents in respect of contact with agencies following the ICPC but did not allow this apparent engagement to be perceived as a long term safety factor and ensured that Child R remained subject to a child protection plan.

4.05 The relationship between professionals at the practitioner event and within BwD LSCB are positive and strong with evidence of constructive and supportive challenge. Reports received for the purpose of this review were considered and contained a good level of analysis and evidence of learning. Professionals in this case have offered a good level of support and challenge to very young, damaged parents who appeared to struggle with the responsibilities of being parents and in managing their relationship with limited support from extended family. Parents were difficult to engage and displayed a level of defensiveness regarding services and limited engagement. It is notable that despite parents attempts to minimise and deny concerns professionals persevered and continued to engage safeguarding processes in respect of Child R.

5.0 Lessons learned

5.01 Much information has been considered within this report which pertains to the importance of historical information being sought from a variety of sources, triangulated and used to assess current levels of risk and need. It is the case that the quality and effectiveness of assessment is predicated by the analysis of information both current and that which pertains to parents own experience of being parented, of adolescence and of young adulthood. Information offered to professionals by parents should be subject to professional curiosity and additional sources of information sought to support or discount information.

5.02 The process for inviting participants to key meetings does not consistently ensure that the right people will be in attendance and able to contribute to the assessment of risk and development of subsequent child protection plan. The original referrer was not invited to the strategy meeting or ICPC despite having a high level of information and it is of note that this lack of information could have adversely affected the planning in this case. Opportunity for multi-agency meeting and decision making should form an integral element of all work with young people and their families including that which sits outside the child protection frameworks. The lack of multi-agency coordination and planning opportunities prior to the ICPC in this case has meant that safeguarding professionals had limited opportunity to establish a common understanding of levels of risk and to develop a multi-agency approach to supporting the family.

5.03 Community midwives do not have routine access to the maternity records as these are stored at the hospital and as a result may not be fully informed regarding domestic abuse. Information sharing between all professionals is a vital element of protecting children in particular the timely sharing of information between health professionals who are in significant direct contact with the family.

5.04 MASH standard enquiries following a contact do not routinely include liaison with extended health services which pertain to the parents. It is likely that this will impact detrimentally on decision making. Information was appropriately shared with partner organisations although this was received and processed by them in varying timeframes.

5.05 There appears to be a perception by professionals that it is CSC policy to not accept referrals for pre-birth assessment prior to sixteen weeks

gestation. This common misunderstanding means that the opportunity to offer early help and support and to undertake a comprehensive assessment of need is not afforded in some cases.

5.06 There has been a lack of robust challenge from the IRO service with regard to attendance at conferences, in particular, predicated by an apparent acceptance that GP's will not attend conferences nor send a report. Furthermore opportunity to challenge regarding allocation of appropriately experienced worker and progress of the plan appears to have ben missed.

5.07 Limited supervision for ASYE in management of this case is likely to have impacted negatively on interventions. Opportunity for supervision and case reflection have limited the development of effective intervention in this case further exacerbated by an unrealistically high caseload of significantly complex cases.

5.08 In line with other police forces local police officers often attend domestic abuse incidents without prior knowledge of previous history of abuse or verbal assault. It also appears to be the case that attending officers have failed to cross-check the history in the case when completing paperwork following incidents. However, this is likely to have been affected by the fact that the domestic abuse flag was not transferred to Child R's new police file following the birth of the child and RCPC. Assessments of risk are made pertaining to the level of impact on the adults and include a raised level of concern only if a child is present which appears to make limited consideration of the impact of domestic abuse on the unborn child. The quality assurance processes which ensure a common understanding of risk are inconsistent and police colleagues acknowledge that three of the six

assessments considered risk to be low or standard when in fact this should have identified as medium in two incidents and high in another.

5.09 Throughout this report it has been argued that stereotypical attitudes and understanding to domestic abuse have been prevalent and that this may have affected the focus of interventions in this case. Safeguarding professionals need to understand and consider a variety of forms of domestic abuse in order to effectively assess risk and manage appropriate interventions.

5.10 Discussions throughout this review have identified a lack of contingency planning within this case which could have clearly articulated both to parents and to professionals the identified plan which would be put in place should progress not be made against the child protection plan within prescribed timescales for the child. It is possible that failure to obtain legal advice and to respond significantly to increasing levels of violence have impacted on the outcome in this case.

5.11 It is apparent that a high level of services were offered to the family in this case. However there also appears to have been a lack of coordination of services which potentially could have led to a shared understanding of risk and clarity regarding concerns for Child R and the risks posed.

6.0 Conclusions

6.01 It is clear from the work undertaken to arrange and contribute to this review that the Blackburn with Darwen Safeguarding Children Board and its partners are committed to the safety and welfare of children in the area and to learning from outcomes for children. The scrutiny of and reflection on practice in this case has resulted in a number of

lessons learned for individual organisations and for the safeguarding partnership as a whole and offers opportunities to develop practice across Blackburn with Darwen and to contribute to wider national learning.

6.02 The importance of clarity of information regarding parental and family history and the consideration of information from all agencies with knowledge pertaining to and providing services to families is clear within this report. It is vital that the full range of information is included in assessment and in safeguarding meetings and that all appropriate agencies are included in the development and implementation of safeguarding plans for children. The importance of triangulation of information obtained from parents is highlighted and professionals need to ensure that assessment and intervention does not solely rely on information sourced from them. Contingency planning regarding children subject to child protection plans should be clear and jargon free to ensure that parents and professionals are clear regarding actions to be initiated should the plan fail to progress within the identified timeframe. Information regarding missed appointments and perceived poor engagement needs to be fully shared to ensure that all agencies share a clear analysis of risk and understand their individual responsibilities regarding child protection plans.

6.03 It is clear that the quality of assessments is predicated by the quality of the information which underpins them and consideration has been given within this report to opportunities for information to be sought from a wider range of sources and for this to be considered with reference to historical information and also to include opportunity to update assessments in light of information pertaining to cumulative risk. Professionals working in the safeguarding arena need to have a clear understanding of the concept of professional curiosity and have

organisational 'permission' to read between the lines. It could be argued that opportunities to undertake this were missed in this case as a result of the lack of multi-agency meetings and the range of professionals in attendance at those meetings. Furthermore that this lack of full multi-agency consideration of risk and of a shared understanding of increasing concerns in this case has meant that the safeguarding network functioned less well in regard to reducing and managing the risk to Child R and to the delivery of the subsequent child protection plan.

6.04 There is no evidence within this review to suggest that the involvement of the FNP nurse led other agencies to believe that their responsibility to safeguard Child R was in any way reduced. Children's Services staff appear to have have the perception that the parents were fully engaged with the FNP nurse service and that direct work to address safeguarding concerns was being undertaken when in fact this was not the case. This view is also disputed by the FNP nurse who recalls sharing informaiton regarding the lack of engagement, cancelled and missed appointments. However, there is also no information to suggest that this perception impacted in any way on the service provided to the family by CSC, or on the outcome in this case.

6.05 Professionals involved in this review have identified a good level of learning and identified impact on indivudal and agency practice as a result. Professionals involved in this process have stated that they would "challenge and would contact other agencies with less concern regarding data protection" as a result of learning generated. They have also 'enjoyed the process' and have felt able to use the opportunity to learn from their own practice and that of other organisations. They have clearly identified learning and significantly perceived gaps in service and improvements in safeguarding practice.

7.0 Recommendations

7.01 Lead reviewers have been advised that Blackburn with Darwen Safeguarding Children Board is currently undertaking a piece of work to consider 'demand management and response' regarding services and recognise that this presents an opportunity for the board to consider the recommendations and learning from this case within this wider piece of work. Blackburn with Darwen Safeguarding Children Board may also wish to give consideration to the potential to form a single point of access regarding service delivery as part of the wider work currently being undertaken.

7.02 Blackburn with Darwen Safeguarding Children Board may wish to consider revisiting/re-launching the multi-agency pre-birth assessment pathway to ensure that partners are aware of and follow the pathway and that mis-conceptions regarding the timing of referrals for concerns regarding unborn children are addressed. The board may also wish to consider seeking assurance that agencies have mechanisms in place to ensure that concerns regarding unborn children are translated into current records pertaining to the child following birth and should consider a challenge to police colleagues in particular in regard to the potential development of their IT record systems to incorporate a change of name (following the birth of a child) to ensure that CP concerns and 'flags' on the system are automatically transferred.

7.03 Blackburn with Darwen Safeguarding Children Board should consider how agencies can best enable the family history to be incorporated into safeguarding assessment processes, including agency safeguarding enquiries. The board may also wish to seek assurance that partner organsations have robust strategies in place to ensure that internal processes are not overly reliant on self-reporting.

7.04 Lead reviewers have been informed that Blackburn with Darwen Safeguarding Children Board is currently undertakeing a piece of work to consider the role of the IRO and are assured that learning from this review will be considered within this. Inherent within this work should be assurance sought by the board that the full range of safeguarding meetings are appropriately convened and attended, that they identify clear actions and ensure that these actions are regularly reviewed. This should include assurance that the IRO quality assurance function is robustly and consistently applied appropriately in the management of cases, throughout the range of safeguarding meetings and within the development and implementation of plans. Consideration could also be given by the IRO service to the dissemination of the full CP plan to all agencies to ensure that they are aware of and responsible for the management and progress of the plan and have a clear understanding of contingency planning.

7.05 Blackburn with Darwen Safeguarding Children Board should be assured that the provision of domestic abuse services is not predicated on a stereotypical perspective in the context of; recognition of abuse, understanding of the nature of abuse and recognition of the potential for physical harm to adults, unborn and living children.

7.06 Blackburn with Darwen Safeguarding Children Board should be assured that the supervision of multi-agency safeguarding staff is prioritised within agencies and that opportunity for reflective supervision in child protection cases is embedded. This should include renewed consideration of multi-agency supervision standards within the safeguarding partnership and consideration regarding work with partners to develop and support opportunities for joint multi-disciplinary supervision in CP cases.

7.07 Blackburn with Darwen Safeguarding Children Board may wish to consider revisiting/updating the domestic abuse policy, to include situational couple violence and interpersonal violence in young people's relationships and to be assured that all professionals are made aware of, have access to and utilise this document. Information pertaining to emerging forms of domestic abuse should be considered in the development of the multi-agency training needs analysis and included as information in the safeguarding policy.

7.08 The recommendations developed as a result of this learning do not include specific reference regarding substance misuse. However it is important to identify that learning pertaining to this issue is inherent within the framework of recommendations (and in the development of clarity regarding the commissioning and delivery of services) and consideration should be given by Blackburn with Darwen Safeguarding Children Board to issues of substance misuse in the development of action planning as a result of this review.

8.0 Appendix

8.01 Glossary

ASYE	Assessed first year in employment
BDDWA	Blackburn and Darwen District without abuse
BwD LSCB	Blackburn with Darwen Local Safeguarding Children Board
CAF	Child and family assessment
CBT	Cognitive behaviour therapy
CRC	Community rehabilitation company
CSC	Children's social care
ICPC	Initial chid protection conference
IDVA	Independent domestic abuse advisor
IRO	Independent reviewing officer

JSNA	Blackburn with Darwen Joint strategic needs analysis
AMH	adult mental health
FNP	family nurse partnership
MASH	Multi-agency safeguarding hub
NQSW	Newly qualified social worker
RCPC	Review child protection conference
WT 2015	Working together to safeguard children 2015

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