PLYMOUTH SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD A and CHILD B

PUBLISHED ON 20 NOVEMBER 2020

Independent Reviewer:
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INTRODUCTION

Events Leading to this Serious Case Review

1. In April 2017 a twenty-three month old child attended the local hospital Accident and Emergency Department (ED) with a swelling on his right arm. On examination he was found to have a fractured upper arm and healing fractures of his lower arm and lower leg. No explanation was given by his parents for these injuries. The child is known as Child A.

2. His twin brother, Child B, also had a skeletal survey and was found to have multiple injuries of different ages.

3. A Child Protection Investigation concluded the injuries were non-accidental. Care Proceedings were initiated and the children were placed with foster carers before going to live with a relative.

4. When abuse or neglect of a child is known or suspected and either the child has died or been seriously harmed and there is cause for concern as to the way in which services have worked together to safeguard the child, the Local Safeguarding Children Board (LSCB) has to consider whether a Serious Case Review (SCR) should be carried out. (Working Together 2015)

5. After discussion with the National Safeguarding Practice Review Panel, a SCR was initiated and an Independent Reviewer commissioned to undertake the task. The process was overseen by a Serious Case Review Group[1] (See Appendix for a list of SCR Group members.)

Method and Time Frame

6. A chronology of events was requested from the agencies who had worked with the family, and, because it was not advisable in light of the criminal investigation to hold meetings of practitioners, those who had worked with the family were invited to meet the Independent Reviewer individually or in single agency groups.

7. Because much of the work with this family had taken place three years ago, many of the practitioners had left the authority and findings are derived from records and descriptions of practice common at the time.

8. The SCR covers the period from May 2015, when the twins were born, to April 2017 when the injuries were diagnosed. The focus of the SCR is on whether, with the benefit of hindsight, any action could have been taken to protect the children sooner and if so, what can be learnt from this to strengthen safeguarding systems.

[1] A sub-group of the Local Safeguarding Board comprised of senior managers and clinicians none of whom had had direct involvement with the case.

9. The Review period does not cover the pregnancy but enquiries had identified that the maternity services did not consider there was anything unusual which suggested the family needed additional support at that time.

10. Although not included in the Terms of Reference, this case is about twins who were both injured. Reviewing the work done with the family prompts the question about the professional response to multiple births. The response of the practitioners who participated in the review (all of whom were involved after the twins' birth) indicated that, apart from the additional ante-natal care, they had not considered the increased risk/vulnerability of multiple births. (see comment in Consideration for the PSCB.)

Family Members

11. The children were born in May 2015; at the start of this review period they were living with their mother, putative father and a five year old sibling. In June 2016 the couple separated and in November 2016 a new partner moved in with the children's mother.

12. Family members are as follows:

• Child A and Child B	Subjects of the Review.
• Child S	Child A and Child B's older sibling.
• Ms MC	Mother of Children
• Mr PF	Child A and Child B's putative father, moved out when the subject children were about 12 months old.
• Mr NP	The children's mother new partner who moved in when Child A and Child B were 18 months old.

13. After the twins had been injured, a DNA test was carried out and the putative (presumed) father was found *not* to be the children's birth father. The children were subsequently placed with their birth father.

14. At the time of writing the cause of the children's injuries was being investigated. In order not to compromise any potential evidence, Ms MC and Mr NP were not invited to participate in the Review. This decision will be reconsidered when the outcome of the investigation is clear.

SUMMARY OF KEY EVENTS

AGE IN MONTHS	EVENT	COMMENT
2015	Child A and Child B born.	
Aged 12 months	First developmental review by Health Visitor.	Children showing developmental delay: cannot sit up. Ms MC has some mental health issues, Health Visiting suggest self-referral for counselling.
12 months	1st Referral from a relative to Children's Social Care alleging children are neglected and verbally abused, that they don't leave the house.	Children's Social Care and Health Visiting discuss the case. HV describes "slight delay." Social Worker observes good interaction with parents, no further action.
13 months	Ms MC tells Health Visiting she can't get out of the house, has no double buggy and mobility problems. Parents have separated, Mr PF has moved out.	
13 months	Common Assessment Framework (CAF) initiated by the sibling's school, meeting held at school.	Ms MC talks about domestic abuse from ex-partner, she is still considering self-referral for counselling.
14 months	Outreach visit from Children's Centre, worker observes children in high chair for whole of visit and raises concern with Health Visiting.	Health Visiting discuss need for stimulation with Ms MC.
14 months	CAF meeting.	
16 months	CAF meeting.	Health Visiting Support Worker to support Ms MC with children's development. Ms MC referred to domestic abuse programme.
17 months	2nd referral from a relative to Children's Social Care	

	expressing concern about children's developmental delay and Ms MC's new partner.	
18 months	New partner, Mr NP, moves in with family.	Family planning to move.
19 months	Development test shows children delayed in all areas, Ms MC "not taking children out very much."	Children's Centre to visit and offer intervention.
19 months	Family move house, CAF is closed. New Health Visitor allocated.	New Health Visitor tries repeatedly to make appointment for visit. Ms MC difficult to engage.
19 months	Child A is admitted to hospital with suspected meningitis, is found to be well and discharged.	No injuries observed.
22 months	Mr NP arrested by police following extreme mental health crisis. Police "very concerned for the children."	Referral to Children's Social Care who begin assessment.
22 months	New Health Visitor sees children and starts assessment, application made for nursery funding. Mr NP is at home but won't come downstairs.	
23 months	Child A and Child B seen in hospital, various injuries noted, no explanation given.	Strategy discussion, Section 47 investigation and Family Court. Children placed with foster carers.

AGENCY INVOLVEMENT WITH THE FAMILY

15. For the first year of the children's lives, apart from minimal contact with universal services, the family did not come to the attention of any children's services.

THE CAF PROCESS

16. In June 2016, when Child A and Child B were 12 months old, Mr PF moved out leaving Ms MC caring for the three children alone and with little family support. Ms MC alleged the relationship had been abusive both verbally and physically and she reported feeling anxious and isolated. A congenital health issue meant Ms MC had mobility problems and, because she lived in a property accessed by steps, she reported she was unable to leave the house with three young children and a double buggy.

17. The family first came to the attention of the older sibling's school because his attendance was deteriorating. When he was at school, staff noticed he wasn't school ready and needed additional help settling in. Child S's school initiated a CAF.[2]

18. Between June 2016 and November 2016 four CAF meetings were held, attended by Ms MC, Health Visiting, the local Children's Centre, Occupational Therapy and Plymouth Community Homes (housing.) The Lead Professional[3] was the school's Parent Support Advisor.

Focus of the CAF

19. Working Together to Safeguard Children 2018 states:

> *"Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life…"*
>
> *"Where a child and family would benefit from co-ordinated support from more than one organisation or agency (e.g. education, health, housing, police) there should be an inter-agency assessment."*

20. In this case there is no evidence of a written assessment of need and, it seems likely that at the time, it was not common practice to record an assessment. However the notes are clear that the focus of intervention was Child S's poor school attendance and the underlying reason, which was Ms MC's difficulty in leaving the house.

[2] Common Assessment Framework (CAF): this is a process for gathering and recording information about a child for whom a practitioner has concerns identifying the needs of the child and how the needs can be met. It is a shared assessment and planning framework for use across all children's services and all local areas in the UK. Sometimes referred as Early Help, it helps to identify in the early stages the child's additional needs and promote coordinated service provision to meet them.

[3] The Lead Professional is the professional nominated to convene meetings and ensure the process is carried out properly.

21. The plan included encouraging Ms MC to establish a support network of family and friends who could help get Child S to school and facilitating a move to an accessible property. In recognition of the domestic abuse, the Family Centre agreed to carry out a risk assessment and provide some one-to-one work in the family home as Ms MC indicated she was not able to attend the Family Centre to take part in group sessions.

22. For Child A and Child B the plan stated that Health Visiting would continue to provide "support."

Outcome of the CAF

23. The CAF achieved its goals of getting Child S to attend school regularly and re-housing for Ms MC and the children. The Family Centre offered additional help to Ms MC to address some of the issues which were identified during the process. Having expressed an interest in working with the Family Centre, Ms MC later concluded she didn't need any further help. The CAF was closed after four meetings when the family moved to another area.

24. There is very little mention of Child A and Child B in the notes of the meetings indicating the focus was on their sibling and the family's practical problems.

25. In late June 2016 a safeguarding concern arose about the sibling during a CAF meeting. The notes indicate this was a "huge safety concern" (details are in the notes of the meeting) and that a safety plan should be put in place. A plan was set out which relied on Ms MC to implement and monitor, although there is no evidence her ability to do this was assessed. The information was not passed on to Children's Social Care.

26. Although the sibling is not the subject of this review, this information is relevant because:
    - It raises the question of whether it was common practice at the time for CAF meetings not to pass on to Children's Social Care information about children who might have been at risk;
    - It shows that Child S was vulnerable and potentially at risk of serious harm, this adds significantly to the vulnerability of the family;
    - If information about potential risk is not passed on to Children's Social Care, if and when further concerns arise, the chronology will be incomplete;
    - It highlights the need for an *assessment* as a basis for planning interventions, which can be updated as circumstances change and new information emerges.[4]

[4] In August 2016, Family Centre staff contacted the Children's Social Care following a home visit during which Ms MC expressed her worries about Child S. The outcome of the discussion was to reinforce the need for the parents to take responsibility for the safety of Child S.

HEALTH VISITING

27. The Health Visitor saw the children four times during 2015, four times during 2016, once in 2017 and attended the CAF meetings. A Health Visiting Support Worker also visited four times to advise Ms MC on how to stimulate the children's development.

28. The first signs of the children's developmental delay were noted in April 2016, just before their first birthday, when an assessment showed they could not yet sit up. The plan was to re-assess in three months and the Health Visiting Support Worker was asked to visit and provide some advice. However, there is no evidence of a follow-up assessment until December 2016, when there were further signs of developmental delay, this was just before the family moved and a new Health Visitor was allocated to the case.

29. It would appear that Health Visiting were pro-active in getting practical help, for example financial help, food parcels, an application for nursery funding and in supporting a house move.

30. Health Visiting were asked to comment on the children's health and development by the Family Centre when staff observed the children spending long periods sitting in high chairs. They were also asked for their views by Children's Social Care on two occasions following referrals expressing concern about the possibility of neglect.

31. On each occasion the agencies were reassured by Health Visiting that there were no particular concerns about the children.

32. Partly the reason for this was the vague and subjective language used by Health Visiting to describe the children's needs and experiences, for example, saying Ms MC doesn't take the children out "very often" and describing their development as "slight delay."

33. For Health Visiting their own analysis of practice highlights that the complexities of this case were not recognised. Ms MC had multiple vulnerabilities, she experienced:
    - caring for three children under three years old, including the twins;
    - the developmental delay of the twins;
    - mental health issues, anxiety and an eating disorder;
    - physical problems affecting her strength and mobility ;
    - isolation;
    - past domestic abuse;
    - relationship breakdown and becoming a single parent;
    - two "referrals" to Children's Social Care from a family member alleging neglect.

34. Health Visiting's own appraisal of practice states that child centred assessments and care plans should have been more robust.

FAMILY CENTRE

35. In June 2016 the Family Centre were asked to attend the CAF meetings with a view to offering family support. Following the first meeting, workers visited Ms MC to encourage her to attend the Family Centre with a view to attending groups, to increase the children's socialisation and help with their development. The family centre was also able to offer services for women who had experienced domestic abuse.

36. In July 2016, on the first home visit, Family Centre staff noticed that the children spent the whole visit, lasting an hour, sat in their high chairs; their demeanour (quietly compliant) suggested this was normal for them. The practitioners contacted the Health Visitor to discuss this.

37. The Health Visitor responded saying she too had observed this practice but had also seen the children playing on the floor. The Health Visitor had noted some developmental delay and the outcome of the discussion was that a Health Visiting Support Worker would be asked to visit and provide advice.

38. Family Centre staff made four more visits to the family home during the summer of 2016 aimed at trying to engage Ms MC in some ongoing work. In August staff observed the children were still spending significant time in their high chairs. Ms MC was asked to complete a Family Star Assessment.[5] This is a self-assessment and Ms MC scored herself highly indicating that she did not see the need for any further help. Despite further encouragement and drawing attention to her situation, Ms MC was not persuaded and cancelled appointments until the Family Centre finally withdrew in October 2016.

CHILDREN'S SOCIAL CARE

39. In May 2016, just after the children's first birthday, Children's Social Care received a referral from a family member alleging the children were being left unsupervised for long periods, were verbally abused, constantly crying and one had allegedly "been dropped on his head previously."

40. Children's Social Care contacted the Health Visitor who gave a positive report and referred to a "slight delay" in the children's development. Children's Social Care made a visit and observed "good interaction" between Ms MC and the children. Ms MC was "signposted" to a counselling service and the case was closed. There is no evidence that the specific allegations of lack of supervision, verbal abuse, crying and a child being dropped were addressed.

41. The CAF had not yet started and Children's Social Care could have considered accessing Early Help through this process. Signposting to a service was unlikely to help as Ms MC had consistently indicated she was unable to access any services away from her home.

[5] This is a recognised method to support and measure change when working with families. It is recommended for use where parents are receiving one-to-one support in brief or relatively light touch interventions. ww.outcomesstar.org.uk/wp-content/uploads/Family-Star-Early-Years-Worker-Guide-Preview.pdf

42. In October 2016 information was passed to Children's Social Care, from the same family member, alleging the children were being neglected and left in their high chairs for long periods. The information also raised concerns about Ms MC's new partner.

43. The outcome of this second "referral" is noted as "no further action." There is no recording on the file about agency checks although the Health Visiting record shows they were asked if they had any concerns. The workers who managed this referral are no longer in post, enquiries for this Review indicate that it is likely that, as the CAF was in place at this time, it was left to the practitioners at the CAF meeting to discuss these concerns with Ms MC.

44. A CAF meeting was held three weeks after the referral, there is nothing in the notes of the meeting to indicate participants knew about it or discussed the content; Health Visiting had not seen the family since June.

45. In March 2017 Ms MC's partner, Mr NP, came to the attention of the police because of his bizarre behaviour in a public place. He was taken into custody and seen by a doctor who assessed his mental health. The outcome was that he was regarded as fit to return home. A notification was sent to Children' Social Care who initiated an assessment within the Child in Need Framework. There is no recording to indicate whether a Section 47 Strategy Meeting should be convened and an investigation conducted within the Child Protection procedures.

THE IMPORTANCE OF BACKGROUND HISTORY

46. During this review consideration of the response to referrals has reinforced the importance of background checks and re-consideration of any previous referrals which inform a chronology.

47. When information was received about Child A and Child B expressing concerns about their care, the records indicate that Children's Services own case files were not checked.

48. Ms MC has an extensive history of involvement with Children's Social Care as a child and young person. This information could indicate potential vulnerabilities which should have prompted the need for further assessment of her parenting capacity.

HIDDEN MEN

49. When Mr NP joined the family and further information was received from a family member about the possible risk he posed to the children, there is no record of any checks being considered on his background or that of previous partners.

50. In 2015 the NSPCC published a report called Hidden Men which states:

> *"Men play a very important role in children's lives and have a great influence on the children they care for. Despite this, they can be ignored by professionals who*

sometimes focus almost exclusively on the quality of care children receive from their mothers / female carers."[6]

51. Mr NP is well known to adult mental health services and was already a father to two older children. Information about his background was not sought or shared until he came to attention of the police five months later, following a dramatic and very public mental health crisis.

HOSPITAL ADMISSION

52. In December 2016 Child A was admitted to hospital with suspected meningitis, he was examined and was found not to be seriously ill, he was discharged the next day. During the medical examination no external injuries were observed.

53. At their presentation in April 2017 multiple fractures were found on both children, the nature of which indicates these had been sustained on different occasions over the past few days to several weeks.

54. During this time there was very little professional involvement with the family, just one visit from the new Health Visitor in March 2017.

PHYSICAL ABUSE

55. The new Health Visitor saw the children one week before they were admitted to hospital with multiple fractures; this was her first contact with the family who had moved to the area three months earlier. Despite persistent efforts to make an appointment for an introductory visit, none of the offered appointments had been convenient for Ms MC.

56. The new Health Visitor reviewed the notes before the visit and there was nothing recorded which made this case stand out, no concerns about the children or anything which suggested the family needed additional attention. The visit lasted for about an hour, the children were in their high chairs when the Health Visitor arrived but were quickly taken out.

57. The Heath Visitor noticed that there was a delay in the development of the children's gross motor skills[7] and Ms MC said that Child B was pulling out his hair[8]. Ms MC also talked about her history of domestic abuse in a previous relationship.

58. The Health Visitor asked Ms MC about her current relationship and discovered Mr NP was in the home, but upstairs, and did not want to meet her.

[6] Hidden Men: Learning from Serious Case Reviews, NSPCC 2015, updated 2018.
[7] A motor skill is simply an action that involves a baby using his muscles. Gross motor skills are larger movements a baby makes with his arms, legs, feet, or his entire body. So crawling, running, and jumping are gross motor skills. Fine motor skills are smaller actions.
[8] This act of self harm may be an indication of stress and anxiety and/or an indication of emotional abuse/ distress.

59. Ms MC said she felt safe with him, that Mr NP was her carer. The Health Visitor did not hear about Mr NP's earlier mental health crisis until the following day.

60. During the visit the children were playing on the floor, there was no indication of any injuries or that they were in pain.[9] The Health Visitor planned to carry out further assessment of the children's development but they were admitted to hospital before this could take place.

[9] At this time the fractures were healing, the acute fracture occurred later.

FINDINGS AND LEARNING

Early Help

61. If Early Help is to be effective it is essential that any interventions are based on an assessment of need. The assessment should be updated as new information emerges, for example if there is a safeguarding concern or if a new adult moves into the family.

62. It is essential that consideration is given to the needs of the children, the purpose of the plan, how the intervention will promote the welfare of the children and how outcomes will be evaluated.

63. If safeguarding concerns arise during Early Help Intervention, a referral should be made to the MASH without delay.

Response to Referrals

64. When a referral is received alleging children are at risk of harm, agency checks must include Children's Social Care's own records. The GP may have useful health information and, if the referral indicates an adult has mental health problems, consideration should be given to checking with adult services.

65. In this case the response to information provided about the children was inadequate. There was a heavy reliance on information from Health Visiting which was vague and potentially misleading. There was a false assumption, that the CAF meeting would provide some follow up, which was not followed up.

66. When a referral provides specific information, for example in this case that a child has been dropped on its head, each allegation should be discussed with the parent and a judgement reached about risk.

67. Sidebotham et al in *Pathways to Harm, Pathways to Protection* [10] points out that "*mental illness is not in itself harmful to children*" but that parental mental health issues were prevalent in the Serious Case Reviews analysed and that "*it is crucially important that professionals consider the risks and implications of any mental health problems for children in the family."*

68. In March 2017, when the police notified Children's Social Care that Mr NP had had a mental health crisis, consideration should have been given to initiating Child Protection enquiries.

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf

Developmental Delay and Indicators of Neglect

69. In this case there were repeated concerns that the children were spending extended periods of time in high-chairs and were not being taken out; both children had been identified as having developmental delay which can be an indicator of neglect.

70. The definition of neglect[11] reminds practitioners that well-meaning parents can still neglect their children's basic needs. In order to recognise neglect and respond appropriately all practitioners need to focus on the detail of a child's experience and consider what life is like for that child in that family.

71. All agencies should be aware of the need to use specific language and avoid subjective terms such as "slight delay" and "doesn't take the children out very often." Using tools to measure parenting behaviour, its impact on children and expected improvements will ensure a more objective assessment and more effective inter-agency communication.

72. When seeking information or feedback from colleagues, all practitioners should ensure they are receiving up-to-date and sufficiently detailed information and should be encouraged to ask questions to find out how well their colleague knows a child or when they were last seen.

73. If assessment tools are based on self-reporting, for example the ASQ Child Development questionnaire and the Family Star Assessment, professional judgement must be recorded alongside a parents own views when analysing information and planning intervention.

74. In this case there is little evidence that the children were seen as individuals.

Hidden Men

75. There was little curiosity evident in this case about the men with whom the children lived. Assumptions were made about the nature of the relationship and when, for example, Mr PF moved out of the family home but had no contact with Child A and Child B, this did not raise any questions. (It later transpired he was not their birth father.) Similarly, little was known about Mr NP when he moved in. An opportunity to make background checks was missed.

76. Marion Brandon et al in Missed opportunities: indicators of neglect what is ignored, why and what can be done states:

> "*Men are frequently overlooked in practice as well as in research, both as a source or risk and as a resource to children they are raising… social workers often perceive men*

[11] Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to provide adequate food, clothing and shelter (including exclusion from home or abandonment) protect a child from physical and emotional harm or danger ensure adequate supervision (including the use of inadequate care-givers) ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

in vulnerable families as a threat, not just to their children and partners but also to practitioners who may in turn feel relieved when men absent themselves."[12]

77. All practitioners should be reminded of the need to consider the role and relationships of men and children in families and record relevant information.

[12] https://www.gov.uk/government/publications/indicators-of-neglect-missed-opportunities

RECENT DEVELOPMENTS

78. Since 2017, when these children were found to have injuries and were removed from home, areas of practice requiring improvement have been identified by the Safeguarding Board and work is in hand to improve outcomes for children.

Neglect Strategy

79. In June 2018 the Safeguarding Board launched a Multi-Agency Neglect Strategy and Neglect Framework and Practice Guidance. The production of these documents reflected the priority given by the Safeguarding Board to improving the early recognition of neglect and the quality of response. At the time of writing implementation was in the early stages.

Early Help

80. In November 2017, after a trial period, Early Help was formally launched to replace the Common Assessment Framework. (CAF) Four documents are available for practitioners:
    - *Early Help Assessment Tool:* Can be used by services in order to gather a holistic picture of need for the whole family where there is a concern;
    - *Early Help Outcomes Based Plan:* Once the level of need has been established, the Outcomes Based Plan will help professionals create a family plan that addresses these needs;
    - *Early Help Plan Review:* A form to facilitate the timely review of the Outcomes Based Plan ensuring actions are on track and outcomes are achieved for the child/young person and their family;
    - *Early Help Exit/Closure:* A form to capture the closure of the Early Help process due to achievement of outcomes, escalation or a change of circumstances for the child/young person and their family.

81. Advice, information and support with the process is available from “The Gateway,” the authority’s access to services team.

82. A Review of the effectiveness of the Early Help process is underway.

CONSIDERATIONS FOR THE PLYMOUTH SAFEGUARDING CHILDREN BOARD

83. At the time of writing this Review the criminal investigation into how the twins were injured and who might be responsible had not been concluded. The outcome of the investigation and from a Finding of Fact[13] Hearing in the Family Court is likely to shed further light on the learning from this case.

84. Whilst acknowledging there have been a number of significant practice developments since the events described in this report, this case draws attention to the need for the PSCB to satisfy itself that:

- The dissemination of the new guidance and policy has been effective and that each agency's response to the initiatives is evaluated;
- There is clarity regarding which practitioners the practice developments are aimed at and how tools are to be integrated into practice;
- Priority is given to the promotion of child focus and outcomes for children;
- Basic practice in responding to referrals is satisfactory and that all agencies understand the purpose and limitations of Early Help;
- The potential impact of adult mental ill-health on families and parenting capacity is well understood, that links with adult mental health services are well established and any implications for children and families are made explicit in risk assessments;
- That the findings from this, and other Serious Case Reviews, about "hidden men" are given consideration and the Board is satisfied that lessons are being learnt and practice is improving.

85. During the past five years SCRs about cases involving twins indicate common themes.[14] Research is limited but some studies suggest there is an enhanced risk of harm when there is a multiple birth.[15] Common themes among the published SCRs[16] are the high incidence of prematurity in multiple births leading to babies spending time in special care, with a potential impact on attachment, the babies extra health needs, additional parent vulnerabilities and lack of discharge planning.

[13] A Finding of Fact Hearing is a type of court hearing that considers evidence surrounding allegations of child abuse. It can be used in the family court to determine whether the alleged incidents happened and who might have been responsible. The family Court is not a criminal court and cannot prosecute parents, findings are based the balance of probability and reported by a family Court Judge. The findings can be used by other agencies to inform planning for children.
[14] See NSPCC Repository.
[15] For example see Lang CA et al, Maltreatment in Multiple Birth Children. Child Abuse and Neglect, 2013.
[16] See for example "BY" Blackpool Safeguarding Children Board 2018, Baby H Oldham Safeguarding Children Board 2018, Baby A and Baby B, Somerset Safeguarding Children Board, 2013.

86. The PSCB might consider further exploration of the professional response to multiple births.

ADDENDUM BY PLYMOUTH SAFEGUARDING CHILDREN BOARD

To support the oversight of the Considerations for the Plymouth Safeguarding Children Board and measure outcomes and impact upon practice arising, paragraph 84 has been extrapolated by the SCR Group as follows:

84. Whilst acknowledging there have been a number of significant practice developments since the events described in this report, this case draws attention to the need for the PSCB to see assurance that:

Early Help

- The dissemination of the new guidance and policy has been effective and that each agency's response to the Early Help initiative is evaluated by and acted upon by Plymouth City Council Children Young People and Families Service.
- There is clarity regarding which practitioners the practice developments are aimed at and how tools are to be integrated into practice.
- Early Help Assessments promote a child focus and outcomes for children and capable of considering family as a whole.
- Basic practice in responding to referrals is satisfactory and that all agencies understand the purpose and limitations of Early Help.

Response to Referrals

- Referrals into the Plymouth Referral and Assessment Service are reviewed against existing Children's social care records and evidence professional curiosity and professional challenge of services both external to and within Plymouth City Council, Children Young People & Family Services.
- Research is undertaken by multi-agency practitioners prior to attending a family home for a visit.
- The potential impact of adult mental ill-health on families and parenting capacity is well understood by practitioners and support better links between children social services and adult mental health services so that implications for children and families (if any) are made explicit in risk assessments.
- Practitioners feel competent and confident to have challenging conversations with parents and family members.
- Practitioner records show qualitative, reflective supervision, advice and management oversight.

- There is professional development work with practitioners within the Plymouth Referral and Assessment Service outside of the AYSE structure that provides continual professional development to social workers and managers.

- That any existing social work practice models are responsive, dynamic and triangulates multi-agency information through a single assessment that evidences clear, restorative and defensible decision taking with a whole family approach.

Development Delay and Neglect

- The multi-agency neglect strategy and supporting framework supports practitioners to focus upon the detail of a child's experience and consider what life is like for that child in the family.

- That multi-agency neglect tools measure parenting behaviour, its impact on children and expected improvements so as to provide an objective assessment and support inter-agency communication.

Hidden Men

- Practitioner professional curiosity understands who is in a child's life and either has caring responsibilities or is an adult actively involved or influencing the child's lived experience. This requires practitioners to move beyond focusing on main carers and adopt a whole family and contextual approach.

- Assessments and ongoing case records evidence this and demonstrate how this is either contributing to the risk or protective factors for a child, including triangulating records which may see that persons of concern have been linked to other households. This will need to be included in the risk assessment in order to safeguard.

- Supervision and management oversight provides support and challenge to ensure everything is known about who is involved in a child's life and what this means for the child. There should be challenging conversations where practitioners can test out their hypotheses around cases in order to accurately establish and assess risk of significant harm.

APPENDICES

Members of the SCR Group

- Detective Chief Inspector, Public Protection Unit, Devon and Cornwall Police (Chair)
- Designated Doctor Safeguarding Children, NEW Devon CCG
- Head of Safeguarding (Children and Adults) NEW Devon CCG
- Head of Safeguarding, Children Young People and Families, Plymouth City Council
- Plymouth Children Safeguarding Board Manager