A serious case review under Regulation 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations 2006

'Madison' (SCR PN16)

The overview report

Commissioned by the Nottinghamshire Safeguarding Children Board

February 2018

Contents

1 Introduction

1.1 Context of the serious case review

1. This serious case review examines the professional support given to a female child between the 1st November 2012 and March 2016, who for the purpose of the review is referred to as Madison.

2. There is no single index incident or event that triggered the review. Madison made disclosures/allegations of abuse and asked to be looked after by the local authority in March 2016 aged 16 years old. Madison had been living at home with her stepfather, mother and half-siblings.

3. There is a history of contact with several different services. For example, schools recorded concerns about Madison over several years dating back to primary education and had convened a number of multi-agency meetings and made referrals to children's services who had undertaken five assessments in 2003, 2006, 2008, 2010 and 2012. The GP service also had considerable contact over several years. In November 2012 the community paediatrician made a referral to CAMHS (child and adolescent mental health services) in relation to bullying, self-harm and grief reaction following the death of Madison's birth father (in 2000) and queried the possibility that Madison was experiencing emotional abuse.

4. Enquiries by the police and local authority in March 2016 involved Madison's four half-siblings being placed with relatives and Family Court proceedings were initiated. Those proceedings were ended in April 2017 when Madison's half-siblings returned to live with mother and Madison's step-father. Madison was not a party to those proceedings having been deemed old enough to consent to being looked after by the local authority without the consent of a parent or a court order.

5. Following a parallel criminal investigation by the police a file was referred to the Crown Prosecution Service (CPS) in the spring of 2017. A review of the evidence by a barrister resulted in the CPS declining a prosecution in March 2017. The reason for declining the prosecution and the factors that were considered are not disclosed to a third party including to a serious case review. The CPS are required to assess whether there is enough evidence for 'a realistic prospect of conviction'. This means that magistrates or a jury are more likely than not to convict. If a conviction is judged less likely, then no matter how important or serious the matters might be, a charge cannot be authorised.

6. A copy of the detailed narrative history was made available to the police senior investigating officer together with a request that the CPS were also given access to the information and asked to confirm that there was no additional information not previously considered by the police or the CPS.

7. The serious case review has no role in the parallel procedures and does not investigate allegations. The role of the review is to analyse the quality of the professionals'

response to information for the purpose of learning and development as it applies to events from November 2012.

8. In compliance with government guidance set out in *Working Together to Safeguard Children (2015)*, the review addresses whether the concerns being raised by professionals were enquired into and assessed with an appropriate level of rigour and whether there are lessons to improve future arrangements and inter-agency working and to better safeguard and promote the welfare of children.

9. For the purpose of clarity the use of acronyms is kept to the minimum. Family members are referred to by their relationship to Madison such as mother, stepfather or half-sibling. Madison has four half-siblings all of whom are younger. The eldest sibling is Sibling 1 and the youngest of the four siblings is Sibling 4. The respective ages of the four half-siblings in March 2016 was 14, 12, 11 and 9 years old. Professionals are referred to by their roles such as teacher, school nurse, GP, police officer or social worker for example.

10. There are four schools referred to in this report that Madison attended at different times from 2004. The first three are primary schools. Madison attended School 1 from February 2004 until April 2005 when she was transferred at her parents request to School 2 until September 2006 when she was again moved at her parents request to School 3 before Madison transferred to secondary School 4.

1.2 Rationale for conducting the serious case review

11. Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires local safeguarding children boards to undertake a review in accordance with the criteria and procedures that are set out in chapter four of *Working Together to Safeguard Children (2015*).

12. A local safeguarding children board should always undertake a serious case review when a child has been seriously harmed and abuse or neglect is either known or is suspected *and* there is cause for concern as to the way the authority, the local safeguarding children board or other relevant persons have worked together.

13. The circumstances of Madison's allegations and disclosures were discussed by the serious incident review sub group of the Nottinghamshire Safeguarding Children Board on the 15th June 2016. The panel agreed that the criteria for a statutory serious case review were met. Madison appeared to have suffered emotional and physical abuse over several years and there were issues to be examined in regard to what different organisations had known about Madison. There were concerns also that physical signs that could have been indicative of abuse were not recognised and that along with the evidence of emotional abuse and physical injuries had been insufficiently understood and enquired into.

14. The recommendation was ratified by Chris Few, the independent chair of the Nottinghamshire Safeguarding Children Board, on the 24th August 2016.

15. The expected timeline for completion of a serious case review described in national guidance is six months from the date of commissioning. The timeline for completion of the review is determined by the independent chair of the local safeguarding children board who can take account of factors that may have an impact on the timeline. This includes parallel processes such as the police investigation of the circumstances of Madison's disclosures already described at the start of this report.

16. This had implications for being able to schedule discussions with Madison or to contact either mother or stepfather.

17. The overview report is the property of the Nottinghamshire Safeguarding Children Board as the commissioning board and when published will be the final and public record for the review.

1.3 The methodology and scope of the serious case review

18. The review was conducted from the outset on the basis that this overview report would be published in full and without redactions. It was written on the basis that Madison would be given an opportunity to provide information to the review and to see the report and to discuss the content given her age and apparent level of understanding. Similarly, Madison's mother was given an opportunity to provide information to the review.

19. The methodology used to conduct the serious case review draws on best practice in proportionately balancing the need for sufficient rigour in regard to investigating the circumstances of professional involvement with Madison taking account of the parallel criminal investigation and securing the level of appropriate and informed reflection about the complex human, legal and organisational systems for the purpose of learning and improvement.

20. In the absence of a specific index event and the fact that the review is examining professional contact and decision making over several years the methodology primarily used an investigatory model for collating information from agencies with the analysis using elements of a learning review model for analysing the latent underlying conditions and identifying the various contributory factors that influence local systems and practice.

21. All services who had contact with Madison between November 2012 and March 2016 were required to provide a chronology of relevant and significant contact or information.

22. Organisations who were identified as having significant involvement with Madison provided a written account of their contact and their agency analysis against the terms of reference set out in the appendix that included an appraisal of learning for that service together with any action for implementing learning and improvement. These reports were provided by the following agencies:

a) Nottinghamshire Healthcare NHS Foundation Trust (NHCFT) regarding the provision of CAMHS, health visiting, school nursing services;

b) Nottinghamshire Police in regard to contact with the family and associated people and the criminal investigation of the circumstances of Madison's allegations/disclosures;

c) NHS Nottingham West Clinical Commissioning Group (CCG) in relation to the delivery of GP based health care services;

d) A report was provided on behalf of the schools and associated educational support services in relation to Madison;

e) Nottinghamshire Children, Families and Cultural Services Children's Social Care in relation to contacts, referrals and assessments in relation to referrals and conduct of enquiries and assessments;

f) Nottingham University Hospitals NHS Trust (NUHT); provided hospital treatment.

23. An information report was provided by the Nottingham City Council Children's Integrated Services regarding the referrals made to the city's social care services in 2000.

24. Information was collated about;

a) The extent to which evidence of emotional, physical or sexual abuse along with self-harm was disclosed, observed, recognised and understood by professionals; this should include how any historical information prior to November 2012 was considered;

b) The extent to which Madison's level of development was considered, enquired into and understood and what implications this had for earlier disclosure or intervention;

c) The quality and rigour of professional response at a single and multi-agency level; this will include how significant information or incidents were dealt with through contact, assessment or enquiry and action planning;

d) The quality of advice, support and supervision for professionals and the oversight of arrangements for children at risk of significant harm;

e) Identifying issues in regard to the capacity or resources of agencies across the continuum from delivering appropriate early help through to more assertive and statutory intervention when required.

25. The panel supporting the work of the review was comprised of senior and specialist agency representatives to oversee the collation and analysis of information and outcomes of the review and reporting to the Nottinghamshire Safeguarding Children Board. The panel representation encompassed senior and specialist professionals from children's education and social care services, criminal justice and health organisations. Information is included in an appendix to this report along with the relevant biographical details of Peter Maddocks the independent reviewer and author of this report.

1.4 Information about Madison and the family

26. Until March 2016 Madison lived with her mother, stepfather and four half-siblings in a district of Nottinghamshire that has a relatively low level of deprivation compared to other areas in the county. All of the family are white British and English is their first language. There is no recorded information about any particular cultural or religious affiliation.

27. Mother worked as a shop assistant until the birth of Madison in 1999 having married Madison's birth father in 1997. According to the GP's records, Madison's birth father died in early 2000 from a heart attack at the age of 31 years when Madison was not yet two. Mother was in the process of starting divorce proceedings. It is understood that mother already knew stepfather who is self-employed. He is the primary source of income for the family and works long hours.

28. Madison attended four schools in the county; three were prior to secondary education. Three school transfers occurred between February 2004 and September 2006 although the family have lived in the same area throughout.

29. After the parallel proceedings had been concluded Madison agreed to speak with the independent reviewer in May 2017. Madison was supported by two specialist trauma care practitioners who are working with Madison.

30. Madison found it difficult to accept and to understand why no further action was being taken in response to her disclosures. Madison described that it had taken a little while of being looked after by a foster carer to realise how different the care provided at home had been.

31. Madison asserted that her stepfather and mother had controlled the discussions between Madison and professionals and that professionals had not done enough to speak to Madison or to her half-siblings independently and away from home and from their parents.

2 Summary of contact by services and significant events

2.1 Summary prior to November 2012

32. There has been extensive contact with various services during much of Madison's childhood.

33. In 2000 when Madison was only a few months old and Madison's father was still alive, concerns about risk of harm were being raised with the city social care services. At that time the concerns appeared to be in relation to domestic abuse. There were reports of Madison being seen with bruises and Madison was the subject of section 47 enquiries in Nottingham city although were not taken to a child protection conference. This early history was not known to the county services when they began to get referrals from 2003 onwards.

34. Paediatric services had contact with Madison for several years from 2001 in regard to slow physical growth and speech development, falls and headaches. At the age of five, Madison was assessed to be about 18 months behind her peers. It is of note that by the time that Madison was in secondary education she managed to achieve five GCSEs at a grade C or higher.

35. There were numerous presentations to primary health care. Mother suffered from perinatal and post-natal depression when pregnant with Madison's half-siblings; the pregnancies occurred at short intervals and mother appeared to be responsible for caring for the sibling group due to the stepfather's long working days.

36. When Madison started primary school there were referrals to support services which included psychology, education welfare and speech therapy. Historical records held by the education service describe hair pulling, faltering growth and frequent absences from school. There are also records of minor or unexplained injuries, of Madison looking underweight and being frequently hungry. Various referrals for specialist assessment or support were declined by mother on several different occasions. There is a long history of Madison not being brought to appointments although some of these were rearranged.

37. The first recorded information that Madison's care and treatment at home was of a poorer quality compared to her half-siblings was in September 2003. The county children's social care services received their first referral from a concerned member of the public who reported that Madison was kept under surveillance by CCTV in her bedroom. Enquiries by social care services that included consultation with the health visiting service were completed and the case closed.

38. In 2004 Madison was sent to live with a relative for a short period of time when mother and stepfather reported that they needed a break from her behaviour. It was around this time that mother had first shaved Madison's head to prevent her pulling her hair out. It is notable that the concerns and behaviours that mother and stepfather

complained of at home at this and later times were not observed at school or in other settings.

39. In May 2004 Madison suffered a fractured left elbow. It was described at the time as a substantial fracture although there was a four hour delay before mother and stepfather had taken Madison for emergency treatment. No referral was made to children's social care services.

40. The first of several professionals or multi-agency meetings that have been convened over the years took place in October 2004 although did not include children's social care services who were not involved with Madison at that time. The meeting discussed difficulties that various professionals had in visiting the home as well as Madison's poor school attendance at School 1, constant hunger, the fractured elbow, mother's emotional and physical health and Madison not being brought to health appointments.

41. In 2005 there were efforts to encourage mother and stepfather to participate in a positive parenting group at a local family centre. The positive parenting group is based on an evidence based programme that provides practical methods to develop skills, confidence and strategies to support parents in meeting the needs of their children. It is intended to help any parent irrespective of their circumstances. There was minimal engagement (and eventually the family centre closed their involvement in early 2006).

42. In 2005 the education welfare service gave notice that Madison's school attendance needed to improve. Shortly afterwards the parents requested a change of school that would mean a longer journey for Madison; this took place in April 2005 when Madison was moved to School 2. Professionals interpreted this at the time as parents wanting to escape the increasing level of attention about Madison.

43. In November 2005 the school contacted children's social care services to discuss a bruise to Madison's face. The outcome was for no further enquiries at that time.

44. In May 2006 a multi-agency meeting convened by the education psychology service discussed Madison's continuing poor attendance record, bruising to Madison, negative comments being written in Madison's home school diary, her continued hunger, the parents continuing to report difficulty in managing her behaviour at home, her poor language development and the reluctance by the parents to engage with advice and support being offered. The education psychologist contacted children's social care after the meeting who agreed that a social worker would attend a follow up review meeting.

45. In June 2006 mother consulted the GP about her concerns that she did not love Madison; this information suggests that there were difficulties in mother's bonding with Madison over the years. She also discussed Madison's scratching of arms and her head banging. During the same consultation mother was clearly hoping that paediatric services were going to provide a diagnosis that would confirm that Madison had a diagnosable condition to explain the problems.

46. In July 2006 children's social care accepted a referral from the health visitor which began an involvement by social workers until 2008 on the basis that Madison was a child in need rather than a child in need of protection. The referral described mother's concerns that Madison had ADHD and/or autism and self-harm (pinching).

47. Madison was moved to School 3 in September 2006 at the request of the parents who appear to have again been concerned at the increasing attention from services.

48. In October and November 2006 School 3 contacted children's social care to report information that included a bruise that Madison said was the result of colliding with a table at home, as well as her comments that she had not been fed on a Sunday and had been placed facing a naughty wall at home. The community paediatrician wrote to children's social care in October to confirm that a referral had been made to the CAMHS and expressing the concern that Madison was being emotionally abused. In December 2006 the school reported a mark to Madison's back. Social care services were already working with Madison and the family. The information was considered by the social care staff working with Madison who concluded that additional child protection enquires were not required.

49. In December 2006 the perinatal mental health consultant psychiatrist advised the GP about concerns regarding mother's bonding with Madison and the apparent scapegoating of Madison.

50. In early 2007 Madison was admitted for an in-patient paediatric assessment to explore Madison's emotional responses and reasons for her failure to thrive. Mother did not visit much and although Madison was needy of physical contact she looked to receive this from hospital staff rather than from her mother. Madison had a large appetite when at hospital. In spite of the apparent queries about neglect, no contact was made with children's social care services to tell them about this information and consequently children's social care services were not represented at the multi-agency meeting in March 2007 that was chaired by the paediatrician. The parents continued to decline involvement by the family centre.

51. In May 2007 as a result of a home visit by the paediatrician and children's social care and threats that child protection procedures would be invoked, the parents agreed to participate in work with the family centre during which they continued to deny that they treated Madison differently to their other children. The parents attempted to change the paediatrician. At the same time mother was consulting the GP about her poor quality of sleep, low mood and stress.

52. Children's social care services completed a further assessment in 2008. This described a positive picture of relationships within the family noting that the parents refuted the view of professionals that they were not meeting Madison's emotional needs. The assessment identified several positive aspects in parenting and the family relationships and the GP reported that Madison had gained more than two kilos of weight. The case was closed to children's social care services.

53. In January 2009 and again in May 2009 Madison was presented at the hospital emergency service with vaginal bleeding. She was not spoken to on her own nor was the consultant paediatrician consulted or asked to examine Madison and therefore no specialist medical assessment was conducted in order to establish whether the bleeding was indicative of abuse. In that regard the response was not sufficiently rigorous or compliant with professional and procedural standards. No contact was made by the hospital with children's social care services although a check was made as to whether Madison was the subject of a child protection plan.

54. A multi-agency meeting in March 2009 discussed several examples of Madison being treated less favourably compared to her siblings; dirty and worn clothing and shoes; poorer quality of lunch box provided from home; her hair cut short and her low weight. Madison also continued to regularly have bruises.

55. In February 2010 the school told children's social care services that Madison had bruising and was being treated differently and less well than her half-siblings. A trainee social worker was allocated the task of reviewing the history of concerns and the services that had been offered. Children's social care services did not participate in a multi-agency meeting in March 2010 but the trainee social worker did attend the following meeting in April 2010. The parents were at the meeting and denied there was any basis to the concerns being discussed. A social work assessment was completed although the parents did not accept the concerns and Madison was 'reluctant to talk'. The parents agreed to improve their 'supervision' of Madison and the case was closed to social care services in May 2010.

56. In September 2010 Madison moved to secondary school. In September 2011 the school contacted social care to report bruising and scratches to Madison. She was described as a socially isolated child. It was decided that social work involvement was not required.

57. In November 2011 Madison went missing for about two hours after school. The parents walked out of a return to school meeting.

58. In January 2012 Madison went missing again after school. The police completed a 'safe and well' visit.

59. This review is the first occasion when information has been collated from the various individual agency records and presents a compelling account about Madison's needs and circumstances over several years before 2012. It indicates a considerable level of resilience on her part.

60. This historical information establishes the context for assessing whether its significance was appropriately recognised and taken into account when more recent referrals and enquiries were being conducted from 2012 up until February 2016.

61. A great deal of the information that is held in various agency records was not known to children's social care services. Some of this is attributable to information not being reported or discussed with children's social care when significant information was being discussed; this included the concerns and in-patient assessment to explore Madison's slow development and the occasions when Madison presented with vaginal bleeding. It is also the case that there were opportunities when assessments or enquiries were made to seek information from relevant organisations and suggests that historically those processes were not as complete as they would certainly be expected to be under current standards and expectations of professional practice.

62. Education and health professionals had concerns about how Madison's emotional and physical needs were being met over several years. Historically, the concerns and queries raised about Madison's slow physical growth and development was not explained by organic or physiological factors and Madison has often been hungry and reported missing meals at home. This, together with two presentations with vaginal bleeding were not investigated through formal safeguarding enquiries and assessment because referrals were not made to children's social care services or to the police at the time to establish if there was evidence of abuse or not to be investigated. There were injuries not fully reconciled and on one occasion there was a delay of several hours in seeking medical care and treatment for a significant injury. There were incidents of going missing from home and self-harm.

2.2 November 2012 and discussion of a CAF

63. On the 1st November 2012 the school contacted children's social care services regarding a seven centimetre graze to Madison's shoulder blade. Madison said that the injury had resulted from a collision with the corner of a table at home while playing with the siblings. Children's social care suggested that a CAF (common assessment framework) should be considered by the school; the school were sceptical because of previous discussion with the parents who had made clear they would not want to participate in a CAF.

64. Madison did not arrive at school the following day; mother reported that the absence was because of bullying at school. Madison had been having some difficulty with some of her peers which on some occasions was thought to have been instigated by Madison and on other occasions was not. The school police liaison officer was asked to visit; this was a local police community support officer.

2.3 Disclosures at school and self-harm

65. On Friday the 9th November 2012 Madison, aged 13 years, told a pastoral support worker of being threatened the previous evening with a knife by mother after being in the lavatory. According to the information that was recorded by the police 48 hours later, the issue was mother feeling that Madison had not urinated enough. Madison agreed to speak with the school nurse during a scheduled session on the 19th November 2012. A referral was also made to children's social care.

2.4 Decision to undertake section 47 enquiries and social work assessment

66. The same day, the team manager decided the outcome was s47 enquiries and a strategy discussion. The decision to conduct an s47 enquiry before the strategy discussion had taken place implies a misunderstanding about the purpose and process of discussing the content and significance of information with relevant professionals and developing a strategy and agreeing the conduct of the enquiries and pre-dates the MASH (multi-agency safeguarding hub). In fact, the organisational arrangements at the time for convening strategy discussions that are described in paragraph 73 created the circumstances for social care to make the decision to undertake a visit before a strategy discussion. The social worker contacted mother and stepfather who gave consent for Madison to be spoken to.

67. Later the same day a social worker saw Madison at school with the school's designated teacher (for safeguarding). The teacher told the social worker about concerns raised by other students about Madison being physically assaulted, cutting to her wrist with a pencil sharpener blade or metal can, ripped pyjamas and inadequate bedding (no pillows or duvet). It was also reported that concerns went back to primary school. Madison's height and weight were reported as being lower than expected although no specific measurements are recorded or apparently discussed.

68. Madison told the social worker that she had been in the lavatory when mother had shouted at Madison saying that she was taking too long and that when Madison had come out, mother had pointed a knife at Madison in the kitchen. Madison said the knife had been very close to her and that she had felt 'a bit frightened'. The social worker noted that Madison presented as scared and looked anxious although does not clarify in any recording whether this may have been Madison's usual demeanour with a stranger professional or inferring worry about other factors such as the reaction from the family. Madison did not disclose any physical chastisement. The social worker noted that Madison had scratches on her arm/wrists which Madison said she had done and that she cut arms when worried. Madison also reported being bullied at school.

69. The social worker visited mother and stepfather later the same day and also saw the other children and spoke to them alone in the home. Mother explained that she had the knife in her hand and had waved it about while telling Madison off. She said she was telling Madison off for spending too long in the lavatory. The social worker noted Madison was very timid in front of her mother and stepfather, and looked 'worryingly' at the social worker and then at them. Again there is no record of clarification or inference about the significance or reason. None of the other children made any disclosure of abuse, and the social worker concluded there was no evidence to suggest Madison was being physically abused.

70. On Sunday the 11th November 2012 the police opened a CATS[1] (case administration and tracking system) entry in regard to the referral to the child abuse investigation unit (CAIU) from children's social care and their request for a strategy discussion in regard to the information from the 9th November 2012.

71. On the 12th November 2012, the social worker made a second visit to the family, and saw Madison, although not alone. The recording is very brief and notes that Madison presented as being 'more happy'; mother and stepfather said they had spoken with Madison about bullying, and that they had also spoken to the school; they had discussed a CAF which the parents had agreed to; Madison had been given a communication book to share information between the school, Madison and her mother and stepfather.

72. On the 12th November 2012 the designated teacher sent an email to the school nurse regarding concerns about Madison being bullied and the evidence of self-harm as a background for the scheduled session with Madison on the 19th November 2012. A second email to the school nurse later in the morning informed the school nurse about the disclosure regarding the incident with the knife on the 8th November 2012. In that email the issue in regard to the lavatory was mother's concern that Madison was constipated.

73. The police and children's social care service had a telephone strategy discussion on Tuesday the 13th November 2012 (and was after the social worker had already spoken with the parents and to Madison). At this time the practice for arranging a strategy discussion was to send an email to the police to formally request the discussion and provide some details of the case. An email had been sent to the police by social care on the Friday afternoon. The information had come in to children's social care mid-afternoon who judged that they needed a social worker to make a prompt visit given the information they had received. When the strategy discussion subsequently took place, it was agreed that children's social care would conduct their own single agency enquiry and update the police, having already undertaken two lone visits with Madison. The strategy discussion did not involve the school who had instigated the referral.

74. On the 14th November 2012 the school nurse received two further emails from the school. These described that Madison had run away from school on the 13th November 2012 having been called names and having had some belongings taken from her by other students. Friends had brought Madison back to school and to the inclusion centre. The second email described a conversation that Madison had with a teacher describing a hatred of school and that Madison wanted to kill herself.

[1] CATS (Case Administration and Tracking System) is the Nottinghamshire Police vulnerable person case management system since 2007. The system has three core modules; child protection, domestic abuse and vulnerable adults; although it can also manage any type of public protection incident. The CATS system was developed in the absence of a national database for child protection, and in light of the recommendation in Lord Laming's Report into the death of Victoria Climbié that Chief Constables must ensure their police force has in use an effective child protection database and IT management system.

75. Madison did not attend the scheduled session with the school nurse on the 19th November 2012.

2.5 Madison goes missing from home

76. On Monday the 19th November 2012 Madison went missing for just over two hours after school and did not return home until she was located at a local supermarket by her stepfather. The police were requested to attend after Madison had been returned home and reported that Madison was 'safe and well'. Madison had told a friend earlier in the day of a plan to run away to grandparents because Madison 'did not like her life'. Madison had also scratched her arms and had expressed thoughts of jumping from a bridge.

77. School staff were provided with advice about preventing verbal bullying of Madison. The designated teacher attempted to contact children's social care services but struggled to get through on the phone. The school nurse was updated by email that Madison was having a 'particularly difficult time due to receiving persistent unpleasant comments from a number of students'.

78. Madison did not attend school on the 21st November 2012; mother said this was because of the bullying and that Madison was too frightened. Madison was asked to write down what they would like to have done to make her feel safer. No information has been provided as to whether Madison ever did this. The school decided to convene a multi-agency meeting.

2.6 Madison identified as being a child in need

79. On the 21st November 2012 an agency children's social care team manager providing temporary cover decided that a child in need plan was required but in contradiction to this also decided to close the case; 'Concerns about Madison, which require CIN Plan. No concerns whatsoever in relation to siblings, therefore, s47s to be written up, briefly, and NFA. TM will then close.'

80. On the 22nd November 2012 email correspondence between the designated teacher and the social worker discussed concerns that the parents appeared to be deflecting concerns away from home and focussing on the bullying at school and that there were 'lots of concerns over a long period of time'.

81. A meeting on the 26th November 2012 at school discussed the support required to get Madison back into school. The meeting was attended by mother and stepfather along with the social worker and school nurse. Stepfather was described as very aggressive and unwilling to listen to any plans the school had. He wanted the two 'bullies' removed from the school and stated that Madison would not attend school until this had happened and that they would educate Madison at home; Madison subsequently moved to another class where she had a good relationship with the class teacher.

82. In the interview with the education IMR author, the designated safeguarding lead in the school reported that moving the two boys would not have been appropriate as one of them had social difficulties of his own and was in that class specifically because of a good relationship with the form tutor. On the same day the two students reported being accosted by stepfather in the playground and threatened because of the account they had given of an in-school incident involving Madison.

83. After the meeting the social worker asked the school nurse to refer Madison to CAMHS regarding the self-harm and to seek the consent of mother and stepfather.

2.7 Paediatric review and referral to CAMHS

84. On the 27th November 2012 mother and Madison were seen by a consultant paediatrician at the community paediatric clinic. They discussed the bullying and the self-harm that had involved using a blade from a pencil sharpener. Madison was described as subdued and unhappy. The paediatrician recommended that Madison should attend school and use the support of a mentor or counsellor. The paediatrician also made an 'urgent referral' to CAMHS. The referral letter included information about a history of the half-siblings bullying Madison and of Madison being treated differently. The letter mentions that Madison's birth father was believed to have died as a result of suicide; this is incorrect. The letter was routinely copied to the GP practice.

85. A multi-agency meeting was convened by the school on the 3rd December 2012; this was apparently the first date that stepfather could attend due to his work commitments when arrangements were being made on the 21st November 2012. The designated teacher reported to colleagues at school that the social worker had advised that a CIN plan was not required because the plan of support had already been developed by the school and other services. The social worker had apparently expressed doubts that the parents would engage in a CAF and had advised that the level of engagement should be monitored as an indicator of future referrals to children's social care.

2.8 Further disclosures of self-harm and abuse

86. On the 13th December 2012 the PE (physical education) teacher told colleagues by email that Madison was very low and having a very tough time and kept saying that she hated school and wanted to kill herself and had placed the cord for opening and closing window curtains around her neck. The incident was reported to the school safeguarding team. This appeared to be a one off incident involving the use of cords or any ligature.

87. In a confidential internal email to pastoral care staff at school on the 14th December 2012, the designated teacher summarised concerns about Madison. This included being uncertain how long children's social care were going to remain involved and that

they had not escalated to CIN or to a safeguarding plan. Madison had been given a private notebook to record concerns to be only shown to specific staff.

88. On the same day Madison's mother consulted the GP practice about a headache that Madison had complained of for two days. A consultation with the GP noted 'no particular stress at moment but been bullied at school from start of term until three weeks ago'. There was no apparent discussion about the self-harm or referral to CAMHS that the GP should have been alerted to via the consultant paediatrician.

2.9 Children's social care withdraw and mother declines CAMHS involvement

89. On the 28th December 2012 children's' social care decided, having completed an assessment, that there was no role for them as Madison's needs could be met through universal services and that there were no concerns around safeguarding and that agencies could 'monitor and support'. The case was formally closed on the 24th January 2013.

90. On the 7th January 2013 the school nurse made a phone call to discuss the CAMHS referral with mother who told the school nurse that she had discussed the referral to CAMHS with Madison who was not keen to follow this up feeling that she was no longer self-harming. Mother was advised by the school nurse that a referral could be made at any time to CAMHS.

91. Madison told the school nurse during a one-to-one appointment on the 13th January 2013 that had initially been arranged for the 19th November 2012 of being generally happy at home and at school although there had been an incident of name calling Madison had spoken with a member of staff and the issue had been sorted out. Madison had lots of friends but mother did not like Madison going to out-of-school activities. Madison had no hobbies or activities but said that her home life was busy. Mother had discussed the CAMHS referral and had decided that it was not necessary. The school nurse made clear that Madison could change her mind at any stage.

92. On the 29th January 2013 the CAMHS clinical psychologist phoned the consultant paediatrician who commented that Madison had appeared very withdrawn at their last contact. The paediatrician was concerned that Madison was suffering neglect and was being treated differently at home from her half-siblings. It was agreed that a CAMHS consultation should be arranged for professionals working with Madison to attend on the 27th February 2013.

2.10 Anonymous referral of concern about Madison

93. On the 21st February 2013 an anonymous referral was made to the NSPCC reporting concerns about the emotional abuse of the children. The caller described having had concerns for about two years but reported that Madison had been heard screaming that morning. The referrer reported that there was often screaming and shouting and arguments to be heard. The caller said that Madison was the priority concern as she

always seemed to be shouting 'get off me' or 'let me out'. The information was reported to the MASH who decided that no action was required as it was deemed usual for a household 'with five children to be noisy' and that previous assessments had been completed and agencies were 'monitoring the children'.

94. The social worker wrote to NSPCC and mother/ stepfather to say that the threshold was not met, and there was no role for children's social care services.

2.11 CAMHS consultation identifies concerns in absence of children's social care

95. The CAMHS consultation meeting for professionals on the 27th February 2013 was attended by the paediatrician, the designated teacher, the school nurse, the clinical psychologist and the clinical nurse specialist. Children's social care services were not invited to the meeting; the reason is not known or recorded. The purpose of the meeting was to discuss how CAMHS might be able to offer support due to concerns about the impact of Madison's experiences upon their mental health and to discuss if there were safeguarding concerns.

96. According to the minutes recorded by health 'extensive safeguarding concerns were discussed' and it was unclear to the professionals at the consultation meeting as to why children's social care had closed the case; it was agreed that the paediatrician would make a further referral to children's social care services (which was never actioned); a chronology was requested from school.

97. On the 5th March 2013 Madison and mother went to the hospital (NUH) for a routine paediatric clinic review. It was noted that the self-harming had 'discontinued'; there was no physical evidence during the consultation of bruising or self-harm marks although it is not made clear what if any physical examination was completed. There was a discussion about the consultation with CAMHS and the decision to help work on improving mother and Madison's relationship instead of a psychological evaluation. Mother declined any help or support saying that the relationship between Madison and mother and stepfather was good; it was documented that Madison could 'speak to them freely'. The note of the meeting appeared to largely rely on mother's views and opinions rather than any distinct information from Madison although it was noted that there was good rapport in the clinic between Madison and mother. It was noted that Madison was well below the 0.4th centile (compared with 9th at the age of two)[2]. Madison was not brought to three subsequent appointments between March and September 2013.

98. On the 5th March 2013 the GP received a letter from the paediatrician summarising the CAMHS consultation meeting and the concerns discussed. The clinical nurse specialist also wrote to the GP on the 14th March 2013 regarding the consultation and

[2] Centile charts show the position of a measured parameter within a statistical distribution. They do not show if that parameter is normal or abnormal. They merely show how it compares with that measurement in other individuals. They are called centiles and not *per* centiles. If a parameter such as height is on the 3rd centile, this means that for every 100 children of that age, 3 per cent would be expected to be shorter and 97 taller. On the 97th centile, 97 would be shorter and 3 taller for example.

also confirmed that a referral was being made by the paediatrician to children's social care (which was not done) for an assessment and that CAMHS were closing the file in regard to Madison. CAMHS also wrote to the GP describing documented concerns regarding safeguarding and the relationship between Madison and mother.

99. On the 20th March 2013 the school made a note of a student reporting an email from Madison saying that she had cut herself and would show the marks to the student.

100. On the 8th July 2013 the school nurse spoke with mother to highlight that Madison had only had the first dose of HPV vaccination (human papillomavirus) due to Madison's absences from school. The school nurse agreed to arrange catch up on the HPV.

101. On the 9th July 2013 Madison reported being 'subjected to a number of unpleasant and sustained examples of verbal bullying' at school.

102. On the 24th September 2013 mother and Madison attended for the paediatric clinic review. Mother reported that Madison was being subjected to 'teasing' by her peers but was taking 'no notice' of it. Madison was reported to be sleeping well. It was noted that Madison's BMI (body mass index) had declined from previous clinic reviews[3]. This was significant given Madison's already small stature

103. The GP received a letter from the paediatrician confirming discharge back to the GP. This was the first record of information to the GP since the earlier correspondence following the CAMHS consultation six months previously.

2.12 Disclosures of self-harm and allegations of physical abuse in 2015

104. On the 25th February 2015 Madison spoke with pastoral care staff at school. Mother and stepfather did not want Madison to go to college to study textiles. Madison did not feel that staying on at school to study for A-levels would suit her. There had been lots of arguments at home about this. Madison also reported being hit by her half-siblings and Madison was just told to shut up when trying to say anything about sixth form. This meeting with the pastoral team was the first record in the school safeguarding file since July 2013. In the interim, Madison had consistently reported that everything was all right when asked. As part of the agency review for this serious case review it has been identified that there had been many examples of arguments between Madison and other students but no single incident had needed escalating during the months from 2013.

105. On the same day another student spoke to pastoral care staff and reported that stepfather had been 'hitting Madison again' and that her half –siblings were telling

[3] Body mass index (BMI) is a measure of body fat based on height and weight that applies to male and females. The BMI categories are:
Underweight = <18.5
Normal weight = 18.5–24.9
Overweight = 25–29.9
Obesity = BMI of 30 or greater

Madison to kill herself. The student did not know what role mother had in regard to the information. The student appeared to feel that mother was scared of stepfather. The student reported that the half-siblings has been scratching Madison's arms but had put socks on her arms when the marks became obvious and had put pins in the socks and arm. Madison was not making any disclosure herself.

106. On the 21st May 2015 Madison was taken to the hospital emergency department complaining of suffering pain in her chest for a week. Madison had seen the GP on two occasions and had been prescribed an anti-acid over-the-counter medication and blood samples had been taken. An ECG (electrocardiogram) and blood tests confirmed that Madison was not suffering from a significant condition or illness; a differential diagnosis of abdominal migraine was noted[4] in the hospital records although subsequent notification to the school nurse stated that a diagnosis was unspecified. Madison continued to complain of pain.

107. On the 11th August 2015 the school nurse wrote to mother and stepfather to highlight that Madison had yet to have vaccinations for diphtheria, tetanus and polio. It was recommended that they contact the GP to arrange to have those vaccinations completed.

108. On the 11th September 2015 a student asked to speak with the school's designated teacher for safeguarding. The student reported that during the previous term Madison had been telling this student about stepfather but had not wanted the information to be shared with anybody else. Information included Madison being made to get a Saturday job in order to contribute towards the cost of electricity; stepfather 'whipping' Madison with a belt; stepfather making Madison wear socks over her arms when going to bed and putting pins in the sock; white scars on the arms; the half-siblings scratching Madison's arms until they were bleeding. When the designated teacher spoke with Madison she said that there was nothing wrong.

109. A report to the designated teacher for safeguarding from a member of teaching staff on the 14th October 2015 summarised that Madison was not being allowed many options about what to do after Year 11 and was under pressure from mother and stepfather to continue at the school into the 6th form.

110. On the 15th October 2015 Madison attended a dermatology clinic regarding a skin mole. There was no comment about any evidence of skin lesions or self-harm inferring there were none to be noted.

111. On the 19th October 2015 Madison arrived at school dressed in a shirt with no jumper despite the weather being cold and saying that the jumper was not allowed until after the half-term break. Madison claimed a half-sibling had hidden other clothing belonging to Madison.

[4] Abdominal migraine is an idiopathic disorder (one in which a cause cannot be identified) typically occurring in about four per cent of infants, toddlers, children and adolescents. Abdominal migraines usually happen in young people who will later suffer from migraine attacks. Severe abdominal pain can occur with migraine attacks in adults as well. Sometimes they are called stomach migraines or migraines of the stomach.

2.13 Referral to MASH and social work assessment

112. On Thursday the 23rd February 2016 the school nurse received a chronology from the school of 'extensive child protection concerns' in regard to Madison dating from March 2003 through to February 2016.

113. On the 23rd February 2016 a teacher found out that a half-sibling had thrown away all of Madison's textile work and all of her ICT (information and communications technology) work.

114. On 25th February 2016 Madison showed the school's pastoral care staff a video clip on Madison's mobile phone of her hair being gelled as a punishment by mother following an argument with her half-siblings and mother watching and laughing; Madison does not like gel in her hair. The video clip had been recorded by one of the half-siblings and sent to Madison. In interview with the education IMR author for this review, the school's designated safeguarding lead commented that 'Madison knew that once these videos were seen she would be believed and this gave her the chance to disclose again and to be believed, unlike in 2012.'

115. Madison was scared of mother and stepfather finding out anything had happened again because they had threatened 'to kick Madison out of the house'. Madison also reported not sleeping well due to stress about sixth form and arguments with her stepfather. A half-sibling also kept wishing Madison to be dead. Madison was denied contact with her friends outside of school. Madison also described being required to put school and homework second to looking after and helping her younger half-siblings. Stepfather felt that school was a waste of time for Madison who would end up stacking shelves and was making Madison to feel generally worthless because of being told to go to her birth father's grave. Madison was scared of being forced to leave home but felt that she could not keep it 'bottled up any longer'. The designated lead tried to phone the MASH but was unable to get through on the phone so emailed for advice. After a subsequent discussion with the MASH the school made a referral which included the video described in the previous paragraphs.

116. After the school day had ended Madison had a further discussion with school staff to say that she had told them mostly everything and felt better and did not want to hide it anymore. Madison said 'Sometimes I think about doing stupid things and that maybe I would be better off dead like they keep saying'. Madison had never said anything like this before. Whilst Madison was with the teacher, mother sent Madison a message asking 'Why have you gone to Lower School?' (Madison had been seen by a sibling and reported to mother). This resulted in Madison collecting A3 paper from the teacher and then returning back within seconds with her mother on the phone and Madison saying in to the phone: 'Ask Miss 'A', I was getting paper. Do you want to speak with her?' Madison handed the teacher the phone who spoke briefly to mother and explained that all was well and Madison was collecting paper for a sibling (who doesn't go to this school but is often asked by home to collect some paper). The incident was significant in regard to the thoughts of self-harm and the degree of

control and coercion and the extent to which the siblings had been drawn into the controlling behaviour and surveillance of Madison.

117. This was followed up the following day (Friday) with further information from the school being sent to MASH regarding an argument the previous evening and a further argument that morning when Madison had attempted to complete homework in the school library. There were also emails on the school system which included a video of Madison being made to stand in the corner of a room at home as a punishment. The emails also show mother telling Madison what to do or not to say in regard the sixth form. Emails between mother and one of the half-siblings refer to Madison.

118. The information from school was processed by children's social care on Monday the 29th February 2016 and a new social worker visited school and spoke to Madison who confirmed longstanding physical and emotional abuse from mother, stepfather and half-siblings. The family were not informed of the visit or of the discussion, taking account of Madison's concerns. On the child enquiry form that records the information the social worker has collated that Madison had been known since 2004 (although there are records that go back to September 2003 in county and earlier contact with city social care services that was not identified until the review) and an anonymous referral of Madison having bruising to the face, was underweight and was petrified of mother and stepfather.

119. On the 2nd March 2016 the pastoral support assistant informed colleagues that Madison had reported a further argument at home with a half-sibling and stepfather. The half-sibling was alleged to have said they wished Madison was dead and that neither stepfather nor mother wanted Madison around and that the half-sibling wanted Madison to be hurt and did not know why Madison existed.

120. On the 4th March 2016 a team manager in children's social care decided that enquiries and assessment should be conducted under section 47 (Children Act 1989) and permission would be sought to make arrangements for Madison to become looked after under sec 20 of the same Act. Section 20 allows the arrangement to be made with agreement rather than going to court and securing an order. Madison was aged 16 and therefore in law was regarded as having the legal and mental capacity for giving or withholding consent on important decisions regarding arrangements about where she should live as well as other matters such as health care. It means though that the local authority had no parental responsibility which remained entirely vested with mother (and stepfather if he had acquired parental responsibility for Madison).

121. On the same day Madison was visibly upset at school and told school staff that she did not want to go home. Madison felt that she could not 'keep things in' and felt frightened of being hurt by the family if they become aware that Madison was making disclosures. School made contact with children's social care and spoke with a social worker. It was agreed that Madison should go home for the weekend rather than trying to make any other arrangements in a rush, to reassure Madison and that children's social care would be in contact with Madison on Monday.

122. On Monday 7th March 2016 mother phoned the school to 'rant and rave' about Madison being kept behind after school on the previous Friday. The pastoral assistant spoke with Madison later who reported being questioned about why she had been so late coming from school and that mother and stepfather did not believe Madison who had said that she was doing an English Controlled Assessment. Mother had obtained a copy of Madison's timetable so that a half-sibling could monitor Madison's whereabouts. Madison reported being hit by a half-sibling and also by stepfather.

123. A strategy discussion on the 8th March 2016 decided that a joint enquiry by children's social care services and the police would be conducted. It was agreed that Madison would become looked after within ten days to allow arrangements for an appropriate carer to be identified and that the half-siblings would be video-interviewed on the day that Madison was placed with a foster carer.

124. Madison continued to be expected to help the half-siblings and to complete homework for at least one of them.

125. On the 10th March 2016 Madison alleged that mother and stepfather had both hit and had pulled her hair the previous evening during an argument. Madison also reported that her mother was even angrier with Madison because she was not getting any additional money for Madison.

126. On the 11th March 2016 Madison made further disclosures at school about her treatment at home. This included the family having taken control of what Madison wears and hiding Madison's glasses and calling Madison 'the step' (as in stepchild). Madison also reported being woken in the middle of the night by mother who had removed a blanket from Madison's bed saying that Madison was not allowed to have it. Madison had become cold and had not slept.

127. On Monday the 14th March 2016 further disclosures were made by Madison at school. This included being made to wear clothing to school that hid the scratches caused when stepfather had tried to grab Madison. It was also reported that Madison had a nervous tic of tapping her fingers when anxious and mother and stepfather had devised a punishment that initially had involved a hand slap but now involved striking Madison's fingers with the inner cardboard roll from cling film. The school safeguarding file states that photographs of injuries were photographed and sent to children's social care. The injuries were to both of Madison's legs on the back of the knees.

128. On the 15th March 2016 Madison reported that stepfather on the previous evening had grabbed Madison by the arm and punched a hand. Pastoral care staff noted that there were marks on Madison's hand. Photographs were taken and sent to children's social care. Madison also expressed concern that when Madison was no longer living in the family home one of the half-siblings may become vulnerable.

129. On the 16th March 2016 Madison was moved to a foster care placement with her consent. Mother and stepfather were informed of the section 47 enquiries being

undertaken. The four half-siblings were spoken to separately at school by a social worker and a police officer; none of them reported any concerns or worries.

3 Appraisal of professional practice in this case

130. It is apparent that the review has collected a much more comprehensive account than was achieved during the assessments for example. In addition to the concerns already summarised it highlights areas such as Madison's early years, the style and quality of her attachment, mother's apparent isolation from support and levels of control and resistance that have not been explored.

131. When enquiries were made prior to 2016 they tended to focus on the immediate presenting issue or information. Efforts to provide advice, help and support relied primarily on the voluntary engagement by mother and stepfather and which was largely absent. They did not accept that there were issues or concerns and were influential in how information was processed at critical points.

132. An obvious question is what caused the response to be significantly different in February and March 2016. There are several factors. Madison was 16 and had the legal and the cognitive capacity to be heard independently and to make decisions for example about where she wanted to live. It ensured that Madison had the opportunity to talk to a social worker independently of a parent. The MASH had become more established and was providing more rigorous processing and triaging of information than had been apparent previously and was less reliant on decision making by any one single agency and created access to lead professionals who assisted in navigating the process of contacts and processing of information.

133. There was also a different social worker who had no previous contact or knowledge about Madison or her family and who was seen as taking a more child focussed and proactive approach to enquiring into and finding out about Madison's circumstances and concerns.

134. There was also the additional and tangible evidence available for example through video recordings and e-mails about aspects of Madison's life and treatment at home.

135. The difference in 2016 was that rather than be overly influenced by what previous enquiries and assessments had recorded there was a fresh approach to how information was investigated by social workers and by the police.

136. This review follows others in the county that identify significant levels of historical dissonance and disagreement between children's social care services and other practitioners from education and health that were not escalated through protocols that are designed to resolve differing thresholds of concerns about a child.

137. The people who have the most contact with children and have the best developed relationships are those who are more likely to observe or to receive information about a child's circumstances and notice the subtle patterns that will be less obvious to more cursory acquaintance. The people who often know the most about a child are not those who have the statutory powers to investigate and assess.

138. Madison's story emphasises the importance of mechanisms such as strategy discussions to help inform judgments about the relevance and significance of information and to develop appropriate strategies for conducting enquiries and has to include anticipating and thinking about how to deal with obstruction and resistance.

139. The statutory guidance published by the government in *Working Together to safeguard children* emphasises the importance of a child centred approach and highlights that safeguarding systems are less effective when the needs and views of children are lost sight of, or the interests of adults are placed ahead of what a child is saying or indicating in their behaviour for example.

140. The guidance also includes a summary on page 11 of what children say they need from professionals to help keep them safe. This includes having adults who take notice when things are troubling children, that there is sufficient understanding about what is happening, to be heard and to be understood and that action is taken; that children need an on-going and stable relationship of trust with those providing help and support; the child's views need to be respected with an expectation that they are 'competent'; that the child will have information and involvement in what will happen and an explanation about the outcome and reasons of processes such as enquiries and assessments; the child will have support in their own right as well as being a member of their family; and have access to advocacy to assist them in putting forward and having their views, thoughts and feelings considered.

141. The findings from the review include how professionals listen to, and give appropriate weight to the views, wishes and feelings of children; collate sufficient history of the child and their family including any previous concerns or contacts; are sufficiently aware and informed about the significance of self-harm; understand and are able to investigate information and evidence about emotional and physical neglect; are suitably alert to how a parent or primary care giver responds to concerns about a child; and how to escalate concerns within appropriate frameworks if and when the response by statutory services is deemed insufficient.

3.1 Voice of the child and their personal history and identity

142. Madison criticises how some professionals sought to understand and listen to her. For example, she feels that social workers prior to February 2016 did not spend long enough with her or with her half-siblings talking with them and independently from their mother and stepfather. Madison is critical about the extent to which her views and information had been given sufficient credence alongside the views for example of her mother and stepfather as well as her step-siblings. In this last regard Madison had felt let down at the time of the meeting with the independent reviewer that although now living with a foster carer there has not been a good enough explanation about decisions made in the parallel processes.

143. Following the meeting with the independent author and the NSCB Development Manager in May 2017, the Service Director, Children's Social Care Services met with

Madison to discuss the circumstances under which the judge in the Family Court proceedings had decided to conclude the application and the half-siblings were returned to stepfather and mother.

144. There are examples of where professionals have sought to listen to what Madison had been saying and to understand Madison's circumstances although it has been less evident in how it informed the statutory enquiries and assessments up until February 2016. Unsurprisingly, Madison has spoken the most to people in regular contact for example at school or spending time for example on the paediatric ward in 2006. It was the professionals with an ongoing relationship with Madison who heard and noticed information that was then interpreted or given less weight for example during social work enquiries when the views of mother and stepfather appeared to become far more influential.

145. Madison's independent voice was insufficiently recorded in enquiries and assessments completed by social workers prior to February 2016 which were limited and were influenced by what mother or stepfather said. A different inference was given by different professionals to the various issues that were raised by Madison.

146. There was a notable gap of several months between 2013 and the spring of 2015 when nothing was observed or recorded at school regarding Madison's circumstances. Children's social care involvement had ceased in early 2013. Madison told the independent reviewer of feeling that that she had not been listened to when referrals were made to social care services and she was not given enough opportunity to speak independently away from the influence of mother and stepfather. She lost confidence in any substantial action being taken and became concerned about the repercussions at home.

147. The implications of children feeling they are not being listened to with enough care and attention has featured regularly in serious case reviews and over several years.

148. In 2010 Ofsted[5] published a study of 67 reviews describing how key professionals such as social workers did not see children frequently enough or did not ask the child about their views and feelings; key professionals did not listen or give sufficient weight to the adults who tried to speak on behalf of a child or talk to professionals who could provide important information about the child; parents or the child's carer prevented key professionals from seeing or listening to a child; professionals could become distracted and preoccupied with the needs of the parent or the parents' wishes and overlooked the implications for the child.

149. The extent to which there is so little factual information about Madison's history on important issues such as her early years and the loss of her birth father is an indication of inadequate history and context for enquiring into more recent issues.

[5] Ofsted (2010). The voice of the child: learning lessons from serious case reviews. A thematic review of Ofsted's evaluation of serious case reviews from 1 April to 30
September 2010. London: Ofsted

3.2 Contact, request for service and enquiries

150. There were four contacts with children's social care between November 2012 and February 2016.

151. The first contact on the 1st November 2012 concerned a seven centimetre graze to Madison's shoulder blade. Children's social care services did not accept the contact as a referral, advising instead that a CAF should be used. There is no record on the part of either children's social care or the school as to how far either agency drew attention to the prior history that included minor but unexplained injuries and a poor level of engagement with previous offers of advice and help through a CAF.

152. The second contact a week later on the 9th November 2012, concerned Madison's account of mother waving a knife the previous evening; this was processed as a referral with the decision to undertake enquiries under s47 of the Children Act 1989. A request for a strategy discussion with the police for the purpose of planning the enquiries was made the same day but was not processed for 48 hours and the discussion did not take place until the 13th November 2012; four days after the original referral. By that stage the social worker had already spoken with Madison at school and had visited the family on two occasions and had already made a decision that Madison had not been subjected to any abuse including physical threats. The strategy discussion did not involve any other professionals who had originally raised the concerns. The police and children's social care services are now co-located with other agency partners in the MASH which provides greater opportunity for more timely strategy discussions involving all of the relevant agencies.

153. When the social worker had first visited the school to speak with Madison, the school's designated teacher had informed the social worker about concerns raised by other students regarding Madison's home life; this included allegations of physical assaults, inadequate bedding and her ripped pyjamas. There was also a discussion about self-harming behaviour and that this and the other concerns went back over several years to primary school. The social worker observed scratch marks on Madison's arms. None of these additional concerns apparently featured in the conduct of enquiries or were raised in the subsequent strategy discussion with the police.

154. The conduct of the enquiries had a narrow focus on whether Madison had been threatened with a knife. Although there is a description of Madison looking frightened there is no recorded evidence in regard to how Madison's feelings were explored and the enquiries were closed down on the basis of mother and stepfather's explanations and reassurances. Madison went missing from school on the 13th November and again on the 19th November 2012. The narrative that was accepted was that Madison was being bullied at school and this was the cause of Madison being upset and unhappy; this was a narrative that the parents raised more than once. The social inclusion co-ordinator's concerns that this was deflection by the parents was not accepted by children's social care.

155. The decision to close the enquiries was made on the 21st November 2012 by an agency team manager who despite having agreed that Madison was a child in need (CIN) and that a plan was required, stipulated that the case would be closed. The decision was made unilaterally and although it is apparent that other agencies did not comprehend the rationale, no individual attempted to escalate the concerns. It is not known what other factors the team manager was dealing with at the time such as overall workload or availability of social worker capacity that may have been an influence. The decision looks contradictory and was not challenged at the time.

156. The third contact in February 2013 via the NSPCC from a member of the public reported concerns about screaming and shouting over several months and of emotional abuse; it resulted in the recently established MASH deciding that no further action was required on the basis that large households were intrinsically noisy, that there had been recent assessments and that agencies were monitoring the children presumably through the plan that children's social care were not party to. The latent conditions for downplaying or minimising concerns arising from potentially flawed enquiries and undue optimism about the monitoring through health and school are noted.

157. Although education and health professionals discussed their concerns at various meetings that included multiagency meetings at school and a CAMHS consultation there was no further contact with children's social care until February 2016. There is no evidence of paediatric challenge in regard to the three appointments that Madison was not brought to.

158. The fourth and final contact with children's social care in February 2016 was processed as a referral and allocated to a social worker who had no previous contact or involvement with Madison or with the family. The referral coincided with a chronology being collated for the first time by the school and Madison having video clips on a personal mobile phone as well as on her school email account.

159. The initial contact with MASH sought advice via email having not managed to get through by telephone. The referral was made on the Thursday 25th February 2016 which was followed up the following day with further information. The referral was not apparently processed until Monday 29th February 2016 when the social worker made a visit to the school to speak to Madison. The decision to undertake s47 enquiries was made a week after the initial contact when the decision was made to seek authorisation for Madison to be placed with a foster carer. A strategy discussion with the police did not take place until the 8th March 2016 which again did not involve any of the professionals who had extensive contact and information about Madison or had initiated the referral although there were daily conversations taking place between school and the social worker.

160. The purpose of the strategy discussion is to agree a plan for the conduct of enquiries and the logistics of coordinating tasks that involve specialist police officers and social workers that will be more complex where there is a sibling group to consider as well as the nature of the concerns. Although there was a great deal of communication on

a daily basis between different people and organisations, this is not a substitute for a strategy discussion.

161. The strategy discussion confirmed that a joint enquiry by the police and social care would be completed. By this time the social worker had already had direct discussions with Madison and there were daily conversations taking place in school. Madison was placed with a foster carer on the 16th March, over two weeks after the initial referral.

162. In summary, the extent to which a mind-set had been established for processing information about Madison contributed to limited enquiries being made until February 2016; the process of conducting strategy discussions was beset with delay and did not share all of the relevant information and excluded participation by professionals initiating the concerns. There was limited consideration of any previous history; the first time that a chronology was developed was in February 2016. The creation of the MASH in December 2012 has been accompanied by an improved format for recording enquiries and assessment which includes past history and a more structured consideration of factors such as resilience and considering what information is unknown.

3.3 Responding to cruelty, neglect and emotional harm

163. Government guidance and local procedures generally describe harmful treatment of children as being abuse that can be one or a combination of different categories ranging from emotional and physical abuse through to sexual exploitation of a child. Child cruelty is more often than not discussed at the point at which charging decisions are being made. In other words the mind set during enquiries is generally not about cruelty but establishing whether there is evidence that a child has or is suffering harm from abuse.

164. Child cruelty is an offence applicable to a child under 16 and incorporates neglect as set out in the Children and Young Persons Act 1933. The law does not define 'wilful' but guidance from the Attorney General[6] clarifies that it means 'deliberately doing something which is wrong, knowing it to be wrong or with reckless indifference as to whether it is wrong or not'.

165. It is rare for professionals to use the language of cruelty or to discuss whether parental action is wilful or not.

166. There are many reasons for this, not least a well-founded desire to work with parents some of whom are dealing with a multitude of challenges and difficulties. There are circumstances however where a discussion is necessary as to whether parental behaviour may be crossing a threshold in regards to consciously and deliberately treating a child in a particular and wrong fashion that represents wilful

[6] Attorney General's Reference No 3 of 2003 [2005] 1 Q.B. 73 cited by the College of Policing https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/child-abuse/key-definitions/ accessed on 12th July 2017.

cruelty. It has to be considered as a formulated hypothesis that guides the planning and conduct of enquiries.

167. Neglect is a notoriously difficult area for professional practice. Except for the most extreme and clear examples of a child's basic physical needs not being met it can be problematical getting professionals from different disciplines to develop a consensus about what constitutes significant harm for a particular child.

168. Identifying and responding to neglect requires a focus on what is happening to the child and how are they being affected rather than what parents want to describe or attribute.

169. Neglect is also more complex to identify and assess due to being a constellation of factors that occur over time rather than being one defining event or incident.

170. Having information collated into one definitive record is a foundation for identifying and evaluating the significance of different factors. An assessment by a social worker under the Children Act 1989 should provide an opportunity to collate information from different sources whether it is part of s47 enquiries or is being conducted as a child in need assessment under s17.

171. Failure to thrive and developmental delays can be a manifestation of neglect and therefore needs to be considered and as far as possible ruled in or out as possible factors; it is important that appropriate assessments are completed to establish whether there is anything other than the primary care and family environment to explain what is happening to a child. Referrals were not always made to children's social care services; some of the contacts such as when Madison was seen at the hospital with vaginal bleeding sought information, for example about whether Madison was the subject of a child protection plan, rather than being a referral of concerns. The information from health does not appear to have been factored in to the assessments prior to February 2016. This included primary health practitioners such as the GP as well as specialist paediatric services.

3.4 Madison's self-injury or self-harm

172. The serious case review panel was divided as to whether Madison's self-injuring behaviour such as her hair pulling was representative of self-harm. Some of the difficulty lays in the lack of detail recorded at the time and there is little information recorded about the factors that were contributing for example to Madison pulling her hair. The referral to CAMHS was clearly an effort to give an opportunity to explore concerns about self-injury. It is a fact that there is no evidence that Madison ever sought to injure herself so seriously as to threaten her life.

173. Research shows that many of the children and older adolescents who harm themselves are struggling with intolerable distress or unbearable situations. Common problems include physical or sexual abuse**,** feeling depressed**,** feeling bad about themselves and relationship problems with partners, friends, and family. Children may

be more likely to harm them-self if they feel that people don't listen to them, they feel hopeless, isolated, alone**,** out of control or powerless; feeling as though there's nothing they can do to change anything.

174. It is because self-harm can be a vital sign of something being wrong in a child's life that it is important that it does get appropriate, well informed and sensitive attention from professionals and deserves comment in this review.

175. The term self-harm covers a wide spectrum of behaviour and severity and is a behaviour that can escalate and result in serious injury or worse whether intentionally or not.

176. Madison's pulling of hair was first reported in 2006 when she was still in primary school. Trichotillomania is a condition where a person feels compelled to pull their hair out although this is not a diagnosis that has been made in regard to Madison[7] and is not a matter that the serious case review is in a position to give any opinion. Diagnosis requires a careful assessment by a suitably qualified and experienced professional. Diagnosis needs to distinguish between behaviour that is for example a tantrum rather than behaviour that is comforting the child. For children and adolescents with trichotillomania, hair pulling is focused and/or automatic. When it is focused, the children who pull their hair intentionally do so as a way to relieve distress or tension. For example, they pull their hair out as a relief for their overwhelming urge to pull hair and they may develop a ritual for hair pulling, such as finding the right hair to pull. When hair pulling is automatic, children will pull out their hair without even realising they are doing it. For example, pulling hair while reading, watching television or when bored. For school children aged 5 to 12 years trichotillomania may be a simple habit or a sign that the child is anxious or under stress. When children start pulling their hair at this age, there is typically other causes for the problem, which may be school-related stress and/or an indication that something is worrying the child. It is often difficult for children at this age to put their feelings or troubles into words so they may pull hair as a form of relief for their stresses. Finding out what might be causing stress to the child is important, and was a motivation in making the referral to CAMHS.

177. Evidence of any self-harm should not be ignored although the response needs to be appropriate and to not be an overreaction. Collecting basic information such as the history of self-harm, the frequency of incidents, the types of methods of self-harm, the triggers, the psychological or emotional purpose for the child of the self-harm, the extent to which they are disclosing and are open to support along with any indication of suicidal ideation and/or behaviours are what an assessment should be exploring with the involvement of specialist consultation as and when appropriate.

[7] A diagnosis will be guided by certain criteria such as repeatedly pulling out hair that results in noticeable hair loss, repeated attempts for them to stop pulling out their hair, the hair pulling causes additional distress at school or in social situations, and the hair loss is not due to another skin or medical condition, or the symptom of another mental disorder.

178. In very general terms children and young people fall within two broad categories of risk from self-harm. Lower risk is associated with little history of self-harm, a generally manageable amount of stress for the child and evidence of some positive coping skills and external support.

179. Higher risk is more likely to be associated with children and young people who have a more complicated profile; they report more frequent or longer term self-harm behaviour, use methods with a higher degree of lethal consequences and /or who are experiencing chronic internal and external stress with fewer positive sources of support or have less well developed coping skills.

180. Although Madison's self-harm was the subject of a referral to CAMHS which resulted in mother declining any involvement, the formal enquiries and statutory assessments became more preoccupied with other matters such as for example whether mother had been threatening Madison with a knife. Some of this doubtless reflects a tendency to deal with more tangible issues. The self-harm was also largely treated as an issue that CAMHS was expected to deal with.

181. Recognising and exploring self-harm is one important aspect of understanding the child's voice being visible evidence of wishes and feelings about aspects of their life that are stressful and difficult to deal with. The voice of the child can be manifested in several different ways. It is not just what children say but also what they cannot or will not talk about and about their behaviour and interaction with others around them.

182. Further guidance developed by the county council's education psychology service has been published in an electronic format and is available through the Nottinghamshire Safeguarding Children Board website and on the county's school portal. Additionally, a copy of the guidance has been sent to all head teachers in the county. The guidance includes signposting to local and national support for school staff, individuals, peers as well as parents/ carers.

3.5 Managing parental control, disengagement and resistance

183. The extent to which mother and stepfather controlled how information was presented and processed by different professionals is significant. It occurred in regard to the various health assessments that were conducted historically and also continued to influence how social care for example conducted some of their enquiries during the scoped period from November 2012. The control was displayed in displays of verbal anger, threats to make complaints or to change key professionals or schools and threats of legal action (in 2008). This has influenced how decisions have been made and had repercussions for Madison who is now ostracised by her family.

184. There was significant dissonance in the level of difficulties and problems being reported by Madison's mother and stepfather in regard to behaviour compared to when at school for example.

185. The thwarted attempts by different professionals to explore concerns was raised for example by some school staff although was not explored in any of the formal enquiries and assessments. Parental resistance has featured in other reviews in the county and other areas of the country.

186. The level of disengagement has had implications for Madison having access to services such as CAMHS. Additionally, other aspects of Madison's health care needs for example in regard to immunisations were delayed.

187. There has been a reluctance to acknowledge concerns that have been raised at various times and both parents declined to participate for example in work with the local family centre; on occasions they have sought legal advice to emphasise their opposition. They have denied that Madison was treated differently to their other children in spite of the evidence that was collated by the school in particular.

188. There is evidence from serious case reviews and from research that highlights the importance of exploring and understanding how a parent or care giver responds to concerns and is processing information. Are professionals dealing with parents who have the capacity and insight to acknowledge that there are issues to address or are they facing attitudes and behaviour that is obstructive and uncooperative or the there are other barriers to understanding? Three broad categories of uncooperative behaviour are identified from practice and research.

a) Hostile and threatening behaviour; which produces damaging effects, physically or emotionally, in other people including professionals;

b) Non-compliant behaviour; involves proactively sabotaging efforts to bring about change or alternatively passively disengaging;

c) Disguised compliance (often manifested as disguised resistance); involves significant adults in a child's parenting and care not admitting to their lack of commitment to change but working subversively to undermine the process.

189. The non-acceptance of needs or problems produce different forms of resistance and, indeed, even parents within one household may respond differently to concerns. In several works, Bentovim (1987 and 2004[8]) argues that parents' failure to take responsibility for their children's circumstances, their dismissal of the need for change or treatment, their failure to recognise their children's needs and the maintenance of insecure or ambivalent parent and child attachments are all key indicators of a poor prognosis in regard to a diagnosis that a child has suffered or is at risk of suffering significant harm.

[8] Bentovim, A., Elton, A. and Tranter, M. (1987) 'Prognosis for rehabilitation after abuse', Adoption and fostering, vol 11, no 1, pp 26–31.
Bentovim, A. (2004) 'Working with abusing families: general issues and a systemic perspective', Journal of family psychotherapy, vol 15, no 1/2, pp 119–135.

190. To complicate matters considerably, parents may say that they accept the need for change, and can even appear motivated towards that end, whereas, in reality, they are actually opposed or indifferent. From the evidence provided to the review the only time that there appeared to be some co-operation was in response to children's social care services indicating that they would escalate their level of intervention.

3.6 Communication between professionals and use of local multi-agency frameworks

191. There was a great deal of communication between different services going back several years.

192. Although Madison was identified as being a child in need in November 2012 the decision taken by the agency team manager was to close the case and therefore no CIN plan was put in place.

193. Most of the meetings convened by school and health based professionals from time-to-time to discuss concerns about Madison were outside of the local frameworks or pathways to services.

194. The CAMHS consultation meeting did not involve either of the two agencies that have the statutory responsibility for conducting enquiries, namely the police and children's social care services. Although there was a decision to make a referral to children's social care services this was not done. The reason for this is not known.

195. The strategy discussions that were conducted in regard to enquires under s47 were completed after action had already been decided by children's social care, although there was a great deal of contact between the police, social care and education, the logistics of coordinating the availability of specialist police and social care professionals and making sense of information about a child, requires a structured appraisal and plan that is updated and reviewed. Strategy discussions are not one-off events.

196. There were other occasions historically, for example when Madison was presented at hospital with vaginal bleeding on two occasions within six months, where the level of communication within agencies such as the hospital, or with other services such as children's social care, did not achieve a good enough level of enquiry and resolution as to whether Madison was abused or not.

197. The IMR from the hospital has described work done by the trust to ensure improved responses are being achieved when children present with signs or symptoms that might be indicative of sexual abuse. Supported by this and previous reviews, a Genital Symptoms Flowchart being developed and introduced in NUH and also across the region (Flowchart for health professionals when a child / young person presents with genital symptoms). If the flowchart been in use it would have resulted in a referral to children's social care being made, due to the initially unexplained vaginal bleeding.

198. This pathway has been developed to aid GPs in recognising sexual abuse and provides guidance on action which should be taken. To complement the work in the hospital work has also been undertaken with primary health services. Child sexual abuse, child sexual exploitation and managing disclosures of sexual abuse have been addressed in GP Protected Learning Time (PLT). In 2014 a session on child sexual abuse (recognising sexual abuse) was delivered by a consultant paediatrician. Child sexual exploitation was a theme at PLT in 2015. This training was delivered by Designated Nurse for Safeguarding Children. In 2016 training was provided in relation to managing disclosures of sexual abuse. Survivors of child sexual abuse were involved in the delivery of this training. Recognition of child sexual abuse has also been addressed in GP Safeguarding Leads training across the clinical commissioning groups.

3.7 Quality of assessment and plans

199. Assessment of a child's needs and circumstances is the foundation upon which effective statutory professional help is provided when a child is in need or requires safeguarding from significant harm. Four assessments had been completed prior to 2012.

200. There is little information about Madison's early life including the impact of her birth father's death, the quality or type of attachment that Madison had with mother (or stepfather); the developmental and growth issues and concerns about self- harm are areas that were not explored and led to a reliance on the conflicting narratives between Madison and other members of the family.

201. An effective assessment explores the capacity of parents to meet the particular needs of a child and takes account of the emotional, psychological and physical resources including the quality and style of care giving by each of the parents. Very little information has been available about stepfather. Mother has clearly faced her own emotional and physical challenges and appears to have taken a great deal of the responsibility of parenting a large sibling group where there had been little space between successive pregnancies and births.

202. An assessment cannot just be a narrative. It requires professionals to analyse the significance of information that is collated (and the significance of any information that is not available or cannot be verified).

203. In developing an insight into the level and nature of risk to a child there has to be an exploration of what protective factors or sources of resilience can be identified alongside the factors that indicate vulnerability for a child.

204. For example, research indicates that older children with good attachment, good self-esteem and a good relationship with a sibling combined with a higher IQ will indicate higher levels of resilience compared to another child. In this case the assessments have not revealed and explored this sort of information clearly enough.

205. Similarly, parental history of domestic abuse, significant substance misuse, chronic psychiatric illness, isolation, experience of being abused as a child, having been looked after and had multiple placements or are fearful of the stigma or suspicious of statutory contact are contra indicators to consider alongside protective factors that include positive social support, a positive parental childhood, good parental health (mental and physical), education including workplace qualification and stable employment. The assessments do not provide sufficient information on these factors.

206. Family and environmental factors that are significant in regard to indicators of vulnerability include a run-down neighbourhood, a poor relationship with school, poor social support, poverty and social isolation. The factors in regard to protection and resilience include a committed adult for the child, a good school experience, strong community and good services and support. The assessments do not provide sufficient information about these factors.

207. It is noted that Madison experienced a disruption to her education when mother and stepfather chose to move Madison in response to queries being raised and despite apparently having friends at school she had very limited contact with them or with other social and activities outside of the school.

208. Assessment, as described in national guidance, should be a dynamic and ongoing process that has the capacity to analyse information and respond to the changing needs or risk faced by a child. A good assessment helps avoid delay in providing help and can monitor and record the impact of any services delivered to the child and family. The focus should be on the child. The assessment needs to show appropriate rigour in checking relevant information and providing a record of evidence that can demonstrate appropriately balanced judgments are being made.

209. Assessment also has to involve specialist knowledge and expertise to explore specific areas of risk or need. Examples from this particular case include the evidence of slow development in Madison's early years that involved paediatric admission and assessment but did not involve children's social care services; the presentation with vaginal bleeding that did not involve either a consultant paediatrician, a specialist medical assessment or involvement by children's social care. Work has already addressed this and been described in previous sections.

210. Assessment also has to have the ability to formulate or hypothesise about a child's needs and circumstances. This is important for example when a child is presenting with self-harm or delayed development or with physical symptoms such as vaginal bleeding. Seeking the views of all relevant parties including parents is important but should not just be taken at face value.

211. Asking parents and extended families how they parent or to explain the reason for behaviour or physical symptoms is not always the most reliable way of finding out what is happening in the home. Watching parenting in action and looking at how a child interacts, behaves and generally presents themselves can be much more

informative. What is the quality of the child's clothing and their quality of nutrition for example?

212. Interaction is not the same as 'attachment'. Parents may overcompensate or put on a display for strangers and particularly professionals who have positions of authority but parents are generally not able to sustain this for extended periods of time. A child cannot be assumed to have a secure attachment style because they are smiling or by just observing a parents behaviour or listening to their assurances. Determining the quality of attachment is a skilled and sometimes prolonged task that will not be achieved for example through a short process of enquiry and initial assessment. In this case mother apparently had concerns about the quality of attachment with Madison that she tried to raise with the GP. Many children who are abused are compliant and eager to please. Children can be torn between trying to protect their parents from coming to the attention of the authorities and the child protecting them-self. Children can also feel coerced and become anxious about the repercussions of telling somebody in authority about what is happening.

213. In this case there are none of the classic signs of concern detected or discussed that are common in serious case reviews that examine the abuse of children such as significant mental illness or substance abuse. The early history of domestic abuse was unknown to most of the services. Little information is apparently captured about the daily lived experience at home for Madison and for her half-siblings. Referrals about noise and shouting were regarded as the expected characteristics of larger sibling households rather than signifying a household where there is chaos and/or abuse.

214. Our understanding of the harm caused to children by neglect has grown. It is now better understood that children who are emotionally deprived are more likely to develop mental health problems, have less well developed social and relationship skills, and become involved with the criminal justice system.

215. Neglect does not have to be wilful and as discussed earlier in the report there is no statutory definition in regard to what is wilful but it is generally understood to be deliberately doing something which is wrong, knowing it to be wrong or with reckless indifference as to whether it is wrong or not. There is no definable threshold for when a minor neglectful act becomes a criminal offence. For the purpose of criminal prosecutions, each single incident must be examined in the context of other acts or omissions in which the poor treatment of a child arises.

3.8 Use of the local escalation processes

216. As with all human behaviour and interaction, people can make ill-informed judgements or not take the correct action for a variety of reasons. A great deal of child protection work and especially in regard to issues such as neglect and emotional abuse rely on professional judgment. The same legal system that gives powers and responsibilities to protect children also sets out legal protection for parents and families on matters such as privacy and a right to family life without interference from

the state. A great deal of child protection work is not about gross acts of cruelty that can be seen for what they are but rather are far more nuanced and opaque.

217. The Nottinghamshire Safeguarding Children Board recognises that professionals can disagree about a judgment or decision and has published a policy and pathway for professionals to escalate their concerns if they believe another professional is taking a wrong decision and is unwilling to discuss it[9].

218. The Pathway to Provision is the written policy and guidance describing the respective thresholds for identifying and responding to children in need or requiring protection. This framework has been in place since 2010 with the latest updating (version 6) in 2017. Multi-agency problem solving meetings (MAPS) introduced in 2014 and evaluated in 2015 have provided an additional opportunity for reflection and challenge when cases become stuck or unresolved.

219. The escalation procedure sets out the following advice.

220. 'Problem resolution is an integral part of interagency working to safeguard children. It is often a sign of developing thinking within a dynamic process and can indicate a lack of clarity in current procedures or approach. Professional disagreement is only dysfunctional if not resolved in a constructive and timely fashion.

221. Effective working together depends on an open approach and honest relationships between agencies and a commitment to genuine partnership working. As part of this there needs to be a system in place to enable disagreements to be resolved to the satisfaction of practitioners and organisations involved. The aim should be to resolve difficulties at practitioner level between organisations, where this is possible, but where not the disagreement should be escalated until a resolution is achieved. Disagreements should not be left unresolved.

222. Disagreements could arise in a number of areas, but are most likely to arise around **thresholds, roles and responsibilities, the need for action and communication**.

223. Although it is apparent that several professionals had misgivings about the slow pace of response at critical moments, none of them used the escalation procedure which was last updated in July 2015.

[9] Resolving Professional Disagreements (Escalation Procedure)

4 Analysis of key findings for learning and improvement

224. Themes described in other recent serious case reviews in the county are also present in this review; to some extent this reflects the historical timeframe that predates, for example, the implementation of MASH and the development of the neglect and assessment toolkits.

225. The learning from the review includes;

a) Systems for collating and sharing information about patterns of care and behaviour that represent neglect of a child; distinguishing between behaviour that might indicate cruel rather than neglectful care;
b) Children more readily disclose information to adults such as teachers or health practitioners with whom they have regular contact and have been able to develop trust;
c) Professionals with statutory powers of enquiry and investigation such as social workers and police officers have far more limited time or opportunity to achieve similar levels of trust;
d) Enquiries and assessments need to give sufficient emphasis and focus to the voice and presentation of the child as well as to information provided by people in regular contact with the child;
e) Professionals, particularly when conducting enquiries, being sufficiently aware and sceptical about how parents or other adults may seek to influence how information is processed;
f) Resolving difference of opinion between professionals who are trying to raise concerns with statutory services such as children's social care services and the use of escalation processes;
g) Recognition and response to self-harm.

226. The review recognises that significant changes have been taking place particularly in regard to how contact, referral, enquiries and assessments are conducted. A previous SCR (NN16) called on work to be undertaken on developing self–harm policies across schools in the county. Schools have been provided with guidance in responding to self-harm. The guidance on self-harm in the county safeguarding procedures was updated in April 2017. The establishment of the MASH provides better opportunity for professionals from different disciplines to process the significance of information being presented and for following up and clarifying.

227. Similarly, there has been significant work undertaken in regard to the neglect of children specifically and in June 2014 the local authority published a social work practice briefing entitled *Working with Children at Risk from Neglect*.

228. The introduction of flowcharts supported with training is improving the capacity of health professionals to investigate and diagnose child sexual abuse and exploitation.

229. The key findings arising from this serious case review are therefore intended to complement the developments in services and practice and the findings of earlier reviews rather than duplicate previous recommendations and include;

a) Having access to a relevant chronology of information to provide context for enquiries and assessments;
b) The danger of losing sight of the needs and views of the child and placing the interests or views of adults ahead of these;
c) Children's loss of confidence when professionals are unable or unwilling to take sufficiently effective action in response to their concerns;
d) Children expecting to be treated as having competence, to be informed and engaged in the process of enquiry and assessment and expect to have explanations and to be informed about what decisions are being taken and why;
e) Promoting opportunities for the child's views, wishes and feelings to be heard and understood.

230. In providing any recommendations, reflections and challenges to the Nottinghamshire Safeguarding Children Board, there is an expectation that there will be a response to the key findings in regard to the following:

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

231. The Nottinghamshire Safeguarding Children Board will determine how this information is managed and communicated to relevant stakeholders. The formal response should form part of the publication of the serious case review.

232. This review has provided the most comprehensive collation of information in regard to Madison and her concerns about her circumstances prior to becoming looked after.

4.1 Chronology and history as context for enquiries and assessment

233. This review has considered detail about events prior to 2012 to make the point that potential signs about risk or unmet need were largely out of sight in the disparate records kept by different agencies. Matters were compounded when undue reliance was given to the single agency enquiries by children's social care services and undue confidence was given to the robustness of previous assessments influencing subsequent enquiries.

234. None of the services had a complete chronology of contact and concerns regarding Madison until early 2016. The school collated a chronology for the first time in

February 2016 although this had been discussed in 2013. The point has been made that it was at school that Madison's circumstances were raising most concerns over several years.

235. A clear chronology of events can show where risks lie although it can be hard to find the time to do them especially if the immediate presenting information simply seen at face value is not triggering concerns about a child's safety. The analogy of a jigsaw only revealing the real picture when disparate pieces are brought together into a coherent whole is often used to describe the difficulties when responding to neglect for example.

236. Serious case reviews regularly highlight that abuse and neglect is more likely to be identified and therefore prevented from continuing when a good chronology has been collated. It is the underlying patterns in history and behaviour that can be detected and the isolated event or incident that appears insignificant and can be down played in isolation can be identified as a warning sign when it is placed in its proper context.

237. Unless a child's history is visible and easily accessed, opportunities to intervene more effectively will be missed. It is critical to understanding what is happening to a child and helps inform judgments for example when and where a more assertive and authoritative approach is required rather than alternatives that rely simply on goodwill or consent that are solution focussed or strength based interventions. If a child is experiencing wilful maltreatment in whatever form, it is important that this is recognised.

238. Postponing chronologies until several years have passed or concerns have reached a level where statutory intervention has been agreed mean that the task of collating a chronology is time consuming and complex and intervention has probably taken longer than it should have. Professionals are not negligent in ignoring the value of chronologies; the pressure of work that all of the various people working with or coming into contact with Madison are considerable.

239. The point to be made is that although it is social workers who are often expected to collate a chronology, this case illustrates that the same discipline is important for other services and practitioners. In particular, schools and health workers who come into contact with children on a regular basis have to be able to see information in an appropriate context. It cannot rely on memory or episodic note taking. Clearly the style and detail of a chronology in a school or clinic setting will be different to the chronology that a social worker can be expected to collate in regard to court proceedings for example but the central principle and benefit is the same and gives additional weight if and when contact and referrals to one of the statutory services is required.

4.2 Balancing the needs and views of the child and parents

240. Safeguarding systems falter when the needs or views of a child are subsumed by the views or interest of significant adults such as a parent.

241. Parents will naturally want to have an opportunity to express their views and wishes regarding their child. Although parents may indicate a willingness to cooperate this can disguise their true levels of cooperation or understanding. In this particular case there was an example when teaching staff were reluctant to raise concerns to avoid Madison being moved for example to another school.

242. Children face many barriers in talking about what is causing them distress and if and when they do disclose information may retract statements in response to what a parent may say or the response of a professional.

243. Children can be scared, feel they are to blame for breaking up a family, are not sure what 'normal' is in regard to other families, feel embarrassed, do not want to get people into trouble, believe they have dropped enough hints or given enough indication but this has been missed or disbelieved and they begin to feel 'what is the point'.

244. Children need time and reassurance to be able to openly talk about what might potentially constitute abuse. This was a significant concern for Madison that has continued beyond the decision to live with a foster carer and the conduct of subsequent enquiries. Madison worries about her half-siblings.

245. Understanding the barriers that a child has to overcome and the resilience that they need to have requires more than human empathy. Professionals who have responsibility for conducting enquiries need to have a secure theoretical base and a systematic and structured approach to planning and conducting enquiries and assessments.

246. Managerial oversight should ensure that there is clear evidence about how the child's views, wishes and feelings have been adequately secured during enquiries and assessment.

247. The MASH is providing a triage for informing the initial scoping of enquiries which provides further rigour in the processing of initial information and making decisions about the most appropriate level of help and support. The MASH is not a substitute for detailed strategy discussions.

248. In this particular case, the occasions when supervision did not provide a sufficiently clear record of how effectively Madison's views had been secured included the closing of the s47 and child in need enquiries in December 2012 and relied on a relatively narrow line of investigation. There was no oversight of the referral in 2013. During the enquiries in March 2016 Madison told the social worker that mother and stepfather had given Madison an ultimatum during the previous enquiries that if Madison talked about abuse again they would not want Madison to remain at home. The team manager did not ascertain whether Madison had expressed any views about the timescale for any arrangements for Madison to be placed with a foster carer in March 2016 and for her to return home on the Friday afternoon. The strategy discussion that

guided the enquiries did not include the school staff who had extensive and ongoing contact with Madison, although it is acknowledged that there was a great deal of discussion with school staff.

4.3 Child focussed enquiry and assessment and dealing with competence

249. In law, all children 16 and over are treated as having competence to make significant decisions such as medical treatment or where they wish to live. In addition to the principle of competence all children over the age of 16 are presumed to have the mental capacity to make and communicate a decision. The principle of competence and capacity is predicated on a child having sufficient understanding about a particular matter being decided and the associated options and consequences, has the ability and capacity to retain and weigh the information in regard to the associated benefits and disadvantages and can communicate their decision.

250. The law is therefore clear that at 16 children have clear rights to be consulted and to be listened to in regard any concerns they might be raising but also in regard to any decisions being made that affect them. In practice children's competence is not that clearly presented and the transition from assent to active consent is gradual. A definitive standard for competence assessment in children does not exist and it is left to individual practitioners to make their own judgement that also needs to take account of the specific circumstances of the matter in which the child's competence and capacity is relevant.

251. Madison wanted her views to be heard; she felt that although specific teaching staff demonstrated that they were listening to what Madison was saying and took her views seriously this was less evident for example when social workers spoke with her. Teachers noticed when Madison was troubled and showed a good understanding that action was needed.

252. Child focussed enquiry has to recognise children and young people as individuals with rights that are distinct from a parent for example including being able to participate in major decisions about them consistent with their age and understanding. They also expect to have an explanation about the outcome of enquiries and assessments.

253. Madison has expressed her disappointment at not having a clear and direct explanation about the decision made by CPS. She was disappointed not to have been consulted about being made party to the family court proceedings. A meeting with the Service Director, Youth Families and Social Work provided an opportunity to discuss the circumstances under which the Family Court made the decision to end the proceedings brought by the local authority.

254. The NSPCC published a summary of research identifying ten pitfalls in the conduct of enquiries and assessment and how to avoid them[10] that are reproduced in an appendix to this report given their applicability to the learning from this review. The first of the pitfalls is that an initial hypothesis is formulated on incomplete information and accepted too quickly.

255. The commentary on practice earlier in this report encourages practitioners to develop a hypothesis or formulation about a child's circumstances that goes beyond the face value of information presented for example by a parent. The pitfall is that practitioners become committed to a particular hypothesis or viewpoint and do not seek out information that may disconfirm or challenge it. In this case there were key episodes, for example when Madison was presented at hospital for paediatric assessment, or with vaginal bleeding, the self-harming and information about cruel or neglectful treatment that invited a formulation to be confirmed or challenged more robustly.

256. What the pitfalls do not articulate is the susceptibility of practice and decision making to human bias and influences. Humans do not think and act according to algorithms. We have an inbuilt tendency to selectively search for information that supports or confirms our beliefs or hypothesis that we have already made. It effects how we perceive the world and process information, how we encode or give meaning to that information and interpret the significance and relevance of it to our judgments and decisions for example in regard to whether a child is at risk or not.

257. This process of confirmation bias helps us structure our world and also with developing problem solving strategies and is an especially valuable resource in responding to the circumstances and information associated with complex child safeguarding practice. It is both a strength that is also a weakness and can be barrier that can blunt our curiosity, have an impact on our critical thinking and lead to polarisation and divergence between different individuals and organisations.

258. This can be most explicitly manifested, for example, in discussions about thresholds and the extent to which a child's circumstances have reached a point at which statutory involvement for example by children's social care is necessary. If the acceptance of a referral or the conduct of fuller enquiries and more detailed assessments rely on a confirmatory bias that assumes evidence or information has already established at the outset about the nature and degree of need or risk it blunts curiosity and also creates the latent conditions in which the true nature of risk or need remains hidden or misunderstood.

4.4 Promoting opportunities for the views, wishes and feelings of children to be explored and understood

[10] Broadhurst. K, White. S, Fish. S, Munro. E, Fletcher. K, and Lincoln. H (2010); *Ten pitfalls and how to avoid them. What research tells us*. NSPCC

259. Madison's resilience in dealing with her home circumstances and the extent to which her voice was downgraded shows an unusual cognitive and emotional capacity on her part.

260. Doubtless, being enrolled at good schools with effective pastoral care and committed staff who clearly were taking notice of what she said was important. Effective participation in education is an important source of resilience.

261. For children to speak about abuse or things that are causing them distress takes great courage and their need for effective emotional and practical support will be considerable.

262. The conduct of enquiries require appropriate planning to achieve better levels of situational awareness that take account of all relevant information. Planning should include appropriate professional advice and support that is informed by research and evidence of good practice.

263. The work already taking place in the county is an example of how arrangements are being improved. It will often be people like teachers who are hearing or observing information about a child's circumstances rather than social workers who have far more limited contact with a child.

264. The people who know a child well and have a longer term perspective can be very effective in helping to combat the confirmation bias that might beset professional enquiries already discussed in earlier parts of this report. Loss of situational awareness in multiagency teams of professionals can result in poor or damaging outcomes.

265. Situational awareness is the ability to identify, process, and comprehend the critical elements of information about what is happening to the team with regards to the core task, for example, of achieving protection of a child. Loss of situational awareness is manifested when for example people become fixated on one element of information to the exclusion of new information, there is a reliance on 'gut instinct' and there are unresolved discrepancies.

266. The panel are agreed that well directed enquiries and assessments and applying the type of learning that has been described in other sections of this report are the best assurance that Madison and other children are properly heard and understood. Fundamentally, these rely on people always managing to find the right response.

267. Lessons are being learnt in ensuring that professionals who feel that their concerns are not getting an appropriate response will use escalation processes.

268. Professionals who are raising concerns about a child need to satisfy themselves that the concerns and circumstances of the child are being properly understood and be willing to use the escalation processes if required. Designated lead professionals have an important role in offering advice to their colleagues and if necessary help in using the protocols.

269. The extent to which children's wishes and feelings are ascertained and taken account of is now part of Ofsted's framework for inspecting the arrangements made by local authorities to protect children. As part of that inspection process the importance of independent advocacy has been raised and several local authorities have been advised to improve or establish access to independent advocacy as part of child protection arrangements.

270. Madison has been clear in saying that she feels her concerns, views and wishes were not considered enough when formal enquiries were being undertaken.

271. Changes such as the implementation of the MASH, the work in regard to improving strategy discussions, developing practice in regard to assessment and self-harm and the protocols for managing investigation and diagnosis of sexual abuse are creating a more robust context for responding to children.

272. The focus on promoting the escalation procedures with professionals and the evidence that this is being increasingly done with good effect leads the panel to make no further findings or recommendations.

4.5 The learning and improvement for the Nottinghamshire Safeguarding Children Board to consider

1. Does the Nottinghamshire Safeguarding Children Board have sufficient information and confidence about how the voice of the child is sought by professionals and appropriately informs judgments and decision making during enquiries and assessments?

2. Is the Nottinghamshire Safeguarding Children Board satisfied that policy and guidance in regard to the recognition and response to self-injury or self-harm by children supports appropriate professional practice and is being implemented effectively enough across multi-agency partnerships that include schools, primary health and youth work settings?

3. What information does the Nottinghamshire Safeguarding Children Board have that chronologies are appropriately collated and analysed to inform judgments and decision-making when concerns are raised in regard to child abuse including neglect by organisations providing services to children?

4. The Nottinghamshire Safeguarding Children Board should ensure that appropriate professional briefings and practitioner learning events on the findings from this review are completed.

Appendix 1 Terms of reference identified by the serious case review team for further investigation by the key lines of enquiry:

1. Comment upon the extent to which the information, views, wishes and feelings of PN16 were sought and recorded appropriately in regard to significant points of contact and whether at any time the views or comments of parents were influential in how information from or about PN16 was processed.

2. Collate and provide analysis about your agency's response to any disclosures of self-harm and/or suicidal thoughts including third party disclosures.

3. Collate and provide analysis about your agency's response to any reports of emotional or physical abuse. Was the response compliant with expected professional standards and internal procedures and with NSCB/NCSCB Interagency procedures?

4. What assessments or enquiries were made by your agency as a result of information received and how effective these were these in addressing risk and promoting PN16's safety and well-being?

5. What indicators in regard to behaviour or other aetiology presented by PN16 could have been indicative of abuse including self-harm were observed and recorded by your agency and were they sufficiently recognised and acted upon appropriately?

6. Collate and comment upon the effectiveness of information sharing and case coordination within your agency and with other relevant agencies.

7. Are there any issues in relation to the training, knowledge or workload capacity of people in your agency that is relevant to understanding how PN16's needs were recognised and dealt with?

Appendix 2 Membership of the case review team

Service Director, Youth Families and Social Work	Nottinghamshire County Council
Inspector	Nottinghamshire Police
Acting Service Director Education, Standards and Inclusion	Nottinghamshire County Council
Associate Director for Safeguarding and Social Care	Nottinghamshire Healthcare NHS Trust
Director of Quality and Performance	Mansfield and Ashfield Clinical Commissioning Group (CCG)
Associate Designated Nurse for Safeguarding Children	NHS Newark and Sherwood CCG (working on behalf of NHS Newark and Sherwood CCG, NHS Mansfield and Ashfield CCG, NHS Nottingham West CCG, NHS Nottingham North and East CCG and NHS Rushcliffe CCG)
Head of Safeguarding	Nottingham University Hospitals NHS Trust
Group Manager, Historical Abuse	Nottinghamshire County Council
Group Manager, Safeguarding and Independent Review	Nottinghamshire County Council
Development Manager (child deaths)	Nottinghamshire Safeguarding Children Board
Independent reviewer	(author of this report)
Professional support	
Child Death Administrator	Nottinghamshire County Council

Appendix 3 Ten pitfalls and how to avoid them[11]

1. An initial hypothesis is formulated on the basis of incomplete information, and is assessed and accepted too quickly. Practitioners become committed to this hypothesis and do not seek out information that may disconfirm or refute it.
2. Information taken at the first enquiry is not adequately recorded, facts are not checked and there is a failure to feedback the outcome to the referrer.
3. Attention is focused on the most visible or pressing problems; case history and less "obvious" details are insufficiently explored.
4. Insufficient weight is given to information from family, friends and neighbours.
5. Insufficient attention is paid to what children say, how they look and how they behave.
6. There is insufficient full engagement with parents (mothers/fathers/other family carers) to assess risk.
7. Initial decisions that are overly focused on age categories of children can result in older children being left in situations of unacceptable risk.
8. There is insufficient support/supervision to enable practitioners to work effectively with service users who are uncooperative**,** ambivalent, confrontational, avoidant or aggressive.
9. Throughout the initial assessment process, professionals do not clearly check that others have understood their communication. There is an assumption that information shared is information understood.
10. Case responsibility is diluted in the context of multi-agency working, impacting both on referrals and response. The local authority may inappropriately signpost families to other agencies, with no follow up.

[11] Broadhurst. K, White. S, Fish. S, Munro. E, Fletcher. K, and Lincoln. H (2010); *Ten pitfalls and how to avoid them. What research tells us*. NSPCC

Appendix 4 Biographical summary of the independent reviewer

The safeguarding children board commissioned Peter Maddocks as the independent reviewer who has written this overview report.

He has over thirty-five years' experience of social care services the majority of which has been concerned with statutory services for children and families. He has experience of working as a practitioner and senior manager in local authority services and of working in national inspection services and with the voluntary sector. He has a professional social work qualification and MA and is registered with the Health and Care Professions Council (HCPC). He undertakes work as an independent consultant and trainer and has led or contributed to several service reviews and statutory inspections in relation to the safeguarding children. He has undertaken independent agency reviews and has provided independent overview reports to several local safeguarding children boards in England and Wales as well as regularly working on domestic homicide reviews for several community safety partnerships. He has not been employed by any of the services contributing to this serious case review. He has completed training for overview authors and independent reviewers including the application of systems learning and participation in masterclass professional development.

Addendum

The independent reviewer identified learning and improvement for the Nottinghamshire Safeguarding Children Board (NSCB) to consider as follows.

1. Does the NSCB have sufficient information and confidence about how the voice of the child is sought by professionals and appropriately informs judgments and decision making during enquiries and assessments?

NSCB response

- Training - an anonymised case study highlighting the learning from Madison's experiences will be utilised in professional training.
- Audits – there is now a specific question asking how professionals have captured the 'voice of the child' in all NSCB multi-agency audits
- Policy and guidance – A new practice guidance document "Good Practice Supporting the Voice of the Child" was included in the Interagency Safeguarding Children Procedures in January 2018
- The annual Section 11 audit requires NSCB member organisations to provide evidence as to how young people contribute to the planning, delivery and evaluation of services.
- The NSCB Executive receives regular updates from the Local Authority on how social workers capture the 'voice of the child'.

2. Is the NSCB satisfied that policy and guidance in regard to the recognition and response to self-injury or self-harm by children supports appropriate professional practice and is being implemented effectively enough across multi-agency partnerships that include schools, primary health and youth work settings?

NSCB response

- Nottinghamshire County Council Education Department, together with the Child and Adolescent Mental Health Service (CAMHS), have produced specific guidance *'Young People & Self-harm: Guidance for Schools'.* This has been introduced at a launch event in November 2017 and seven workshops are being held during the spring 2018 term across the county for education professionals working in secondary schools.
- Policy and guidance – the 'self-harm and suicidal behaviour' chapter of the Inter-agency Safeguarding Children Procedures was updated and strengthened in February 2018.
- A new website has been developed by Nottinghamshire County Council Public Health in partnership with Notts NHS Healthcare Trust, *'Health for Teens'* which is available for young people to access support for their emotional and physical health and wellbeing. The NSCB jointly funded the project and contributed to the consultation during its development. The website links young people to appropriate local health and wellbeing services, and supports young people to manage their health and wellbeing. It features interactive content, films and quizzes written by experts and includes topics as wide ranging as exam stress to anger management, and from spots

to alcohol. It also offers a text service where teenagers can text their school nurse for confidential health advice and support.
- Training – an e learning course 'Self-harm and Suicidal Thought in Children and Young People' is available for professionals via the NSCB website.

3. What information does the NSCB have that chronologies are appropriately collated and analysed to inform judgments and decision-making when concerns are raised in regard to child abuse including neglect by organisations providing services to children?

NSCB response

- Health and Nottinghamshire County Council colleagues are involved in ongoing work through the 'Connected Nottinghamshire Board' to link IT systems which will provide further opportunity to produce effective chronologies.
- Policy and guidance – the Interagency Safeguarding Children Procedures contain a practice guidance document 'Guidance for Practitioners: Completing Chronologies and Genograms.' This guidance was updated in May 2016.
- Nottinghamshire Schools have been provided with a sample 'Child Protection Confidential File' audit template which contains a question on use of chronologies. Schools have been provided with guidance on the use of chronologies and some secondary schools are investing in IT solutions which allow them to produce a chronology.
- In 2016 NSCB completed a multi-agency neglect audit which featured a question on the use of chronologies. The audit identified deficiencies in the use of chronologies and an action plan was developed to address this.
- Training – NSCB has held two multi-agency training workshops each year in 2015/16, 2016/17 and 2017/18 on neglect, which included input on the use of chronologies.

4. The NSCB should ensure that appropriate professional briefings and practitioner learning events on the findings from this review are completed.

NSCB response

- NSCB will publish the Serious Case Review
- Produce a Learning Bulletin giving a summary of the key learning points from the review
- Include the learning in the NSCB newsletter for professionals
- Include the learning in relevant multi-agency training including 'Working Together', 'What's new in safeguarding?' and 'Learning from Serious Case Reviews' workshops
- NSCB member organisations have a responsibility to cascade the learning in their own agencies.

Individual agencies who contributed to the serious case review were requested to provide an update on actions taken by their organisations relating to issues identified in the review.

Response from Nottinghamshire Clinical Commissioning Groups (CCGs)

- Child sexual abuse, child sexual exploitation and managing disclosures of abuse have been addressed in GP Protected Learning Time (PLT) across Notts. CCGs from 2014 to 2018.
- In 2016 additional training was provided in relation to managing disclosures of sexual abuse. Survivors of child sexual abuse were involved in the delivery of this training and addressed over 500 GPs and practice nurses across Nottinghamshire.
- Recognition of child sexual abuse was addressed in GP Safeguarding Leads workshops across the CCGs in 2016.
- Consultant Paediatricians in Nottinghamshire developed a 'Flowchart for health professionals when a child/ young person presents with genital symptoms'. This pathway is to aid GPs in recognising sexual abuse, and provides guidance on action which should be taken. It is now incorporated into the NSCB multi-agency practice guidance.
- "Madison's Story" has been shared with Safeguarding Leads across the Notts. Health Community, and learning and themes have been shared and discussed at the Notts. Safeguarding Children Health Partnership Group and the Nottinghamshire CCG Safeguarding Committee.
- A briefing was included in CCG Newsletters, September 2017, to emphasise the importance of health professionals offering young people time alone when there are possible safeguarding concerns or where they have information about concerning behaviour, to afford opportunities for disclosure of abuse.
- A safeguarding template has been developed for GP SystmOne records, which prompts professionals to respond to risk factors.
- The CCGs have communicated with Health Education England in relation to the lessons learned from this case to inform GP training programmes

We continue to promote the message of listening to the voices and experiences of children and young people at every opportunity, and have confidence that there is greater understanding of this across the NHS community as a result of the actions above.

Response from the Nottinghamshire Healthcare Foundation Trust

- Escalation continues to be highlighted across the Trust both within briefings to staff from reviews and within safeguarding training. The issue was also recently highlighted at the Leadership council as a key theme from the learning from reviews. Over the coming months we will be rolling out a programme of Lesson Learned seminars across the Trust, to encourage staff to reflect on the learning from reviews and how this should impact upon their own practice and that of their teams – escalation will be included within this workshop. It will also be included in learning shared with our safeguarding link practitioners.

  The Trust has a clear escalation process in place in line with the multi-agency procedures. Escalation is now monitored by the divisional safeguarding leads. Where themes are identified, they are raised across the divisions via divisional safeguarding forums and are discussed with appropriate colleagues in partner agencies.

- CAMHS consultation - Following on from another recent SCR that the Trust was involved with, consideration was given to reviewing the consultation model. It was felt that the model itself is a sound model with a focus on supporting the professionals involved with a child at a time when active therapeutic intervention is not in the child's best interests. The model was quality assured in order to confirm it is fit for purpose.

  All CAMHS consultation cases are now discussed during the practitioner's safeguarding supervision to assist the practitioner to reflect on whether the consultation is effective and if it is remaining focused on the specific needs of the child and family. This process ensures the voice of the child is heard and can support the practitioner to identify when escalation is required. Embedding these discussions within the practitioner's supervision also ensures that all CAMHS consultation cases have robust managerial oversight. The safeguarding supervision framework has recently been reviewed and relaunched, with specific training for managers who are delivering supervision. It is anticipated this will result in more robust supervision – the model is being externally evaluated by the University of Nottingham.

  In this case a CAMHS follow up consultation was available to professionals but was not utilised. The profile of the availability of these CAMHS consultation follow-ups has been raised and as a Trust we can now evidence that these are readily conducted.

- The learning from this review will be shared upon publication via a written briefing to staff as well as through the 'Lessons Learned' events, two 'Safeguarding Matters' events and via the safeguarding link practitioners meetings.

Response from Nottingham University Hospitals Trust

- Nottingham University Hospitals (NUH) have been involved in the production of the 'Was not Brought' animation and this has been embedded into the safeguarding training provided in 2017. The term Was Not Brought is now being widely used when children fail to attend appointments rather than 'Did not attend'. This is to help staff acknowledge that children need to be brought to medical appointments by parents or carers. This clearly places the responsibility onto parents to ensure that children and young people have their medical needs met.

- The newly produced *Flowchart for health professionals when a child/ young person presents with genital symptoms or injury* clearly sets out the process to follow when a child or young person presents at NUH with symptoms which may be caused by sexual abuse. This group of patients are now routinely being seen by, or discussed with the community paediatrician who has expertise in this area. If there is a disclosure of sexual assault/ abuse by the child or young person then an immediate referral is made to the police and children's social care.

- Safeguarding training at NUH includes the need to listen to the 'voice of the child' and encourages staff to be curious and alert to the fact carers may sometimes give the appearance of cooperating with agencies to avoid raising suspicions and that this may not give an accurate picture of what life is like for the child (disguised compliance). The importance of completing chronologies (a list in date order of all the major changes and significant events in a child's, adult's or family's life) has also been promoted. Chronologies assist in identifying concerns and help professionals to better understand what is happening in the life of a child or young person.

- To help clinicians (doctors etc.) provide better care of children with long and complex histories NUH are undertaking work to consider including a problem list within children and young people's electronic records. These lists are already included in the letters written by the community paediatricians. This allows clinicians to better understand existing/ historical concerns which assist with the formulation of appropriate plans of care including, where appropriate safeguarding plans.

Response from Nottinghamshire County Council (NCC) Children's Social Care

- Quality Management Framework – an ongoing framework for the regular auditing of individual cases by managers across the department, including senior managers. Increasingly this audit programme has been complemented by seeking direct feedback from children and young people who have had involvement of a social worker. This work is undertaken by Social Work Practice Consultants and colleagues from the Quality and Improvement service, independent from the social workers involved. Feedback is then disseminated to social work staff and managers – focused on what young people have experienced as working well and what is viewed as unhelpful.

- The Child and Family Assessment process has been in place since February 2016; this is complemented by increased focus on the use of specific tools to promote evidence-based assessments. This includes the use of the Safeguarding Assessment and Analysis Framework – which is a national model to promote robust assessments, systemic analysis to predicting the likely outlook for the child in cases where there are safeguarding concerns.

- The revised Child and Family Assessment has a specific focus on the ensuring that the voice of the child is listened to with a section of the assessment exclusively dedicated to ascertaining and recording the views, wishes and feelings of the child.

- The Pathway to Provision thresholds document is well-embedded since its first launch in 2010. This enables a shared understanding across agencies of thresholds for referrals to early help/social care and also signposts professionals to the use of the escalation process if there are disagreements between agencies as to the nature of intervention provided.

- Managerial oversight of children in need cases has been strengthened by the introduction of specific guidance. This is also subject to the routine auditing of cases under the Quality Management Framework.

- Multi-agency Problem Solving Meetings were introduced in 2014 to provide an opportunity for professionals to consider together cases where there is concern as to lack of improvement in outcomes for a child.

- The effectiveness of the work of the Multi-Agency Safeguarding Hub (MASH) has been kept constantly under review to ensure a robust response to new referrals and timely throughput for assessment where required. When needed, additional staffing has been agreed to ensure that there is adequate capacity within the MASH.

- Improving the effectiveness of strategy discussions has received senior management oversight with a specific group of managers from social care, Quality and Improvement, and the police engaged in taking this work forward. This is to ensure that all relevant professionals are included at the outset in agreeing the appropriate way forward and actions to be taken. In 2016 all Team Managers attended workshops

led by the Principal Social Worker and Group Managers regarding their role and responsibilities when chairing strategy discussions.

- Improved processes for obtaining information from GPs are now in place in the MASH.
- Social workers have been provided with a new and improved training programme including:
    - *Assessing Risk and Sexual Abuse* – several events run since September 2016. All Newly Qualified Social Workers access this training during their assessed and supported year of employment
    - *Direct work with children workshops* – over 20 events run since March 2016. In addition all Newly Qualified Social Workers access a *Communicating with children* course during their assessed and supported year of employment

<u>Response from Nottinghamshire County Council (NCC) Education</u>

- Education Department staff will undertake work to identify the reasons for continuing issues with escalation by schools.

  We will identify and examine examples of casework where escalation has worked effectively to resolve professional disagreements. We will identify the factors that contributed to these successful outcomes. This will look, inter alia, at the role of the education representative on MASH.

  We will interview a sample of school staff with safeguarding responsibilities in order to: establish what their understanding of the process is; explore why they have or have not used it; consider what further arrangements regarding escalation they would find helpful.

  We will use the information from the above work to inform ongoing training for school safeguarding staff.