A local child safeguarding practice review (LCSPR) commissioned under
The
Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018

‘VN21’

The Overview Report

March 2023

Nottinghamshire Safeguarding Children Partnership

Child Safeguarding Practice Review for Alison

1. Executive Summary

This review concerns three siblings aged 3 to 8 yrs at the time they entered care on Interim Care Orders in April 2020 and were placed with foster carers. The CSPR was initiated following the youngest child, Alison, having, for the 4th time in the year since becoming looked after, presented with multiple injuries for which there were no clear or adequate explanations from her foster carers. Two of the four episodes of injuries required significant medical treatment – serious damage to her pancreas which led to surgery to remove 70% of her pancreas and a fracture to her arm. In the other two episodes the injuries were of multiple bruising including in soft tissue areas of the body. There is no evidence that these injuries were non accidental but it was of serious concern that they were unexplained. The children were moved to other foster carers in March 2021. The three siblings are now in separate foster placements

The review sets out the sequence of events including the response to Alison's injuries. The key issues identified for the partnership by the review are:

1. The importance of recognising when to follow safeguarding processes on open cases when there is uncertainty about the cause of an injury or other harm that a child has suffered. In this case safeguarding processes were not used when Alison was found to have a serious injury to her pancreas and there was no clear accidental explanation for the injury.
2. The importance of the availability of services that address adverse childhood experiences and which services can help mitigate the impact on children of those experiences. There was a failure to recognise the trauma the children had suffered and how this would be reflected in the care required from their foster carers. Their foster carers were very inexperienced and had minimal guidance and additional specialist support

in their care of the children. There was no choice of a local foster placement for the children. This meant there was no matching of their needs to the foster carers level of skill and experience, in this case the foster carers had no previous fostering experience.

3. The importance of ensuring that formal meetings are effective in their primary purpose and do not become exercises to be completed. The children had Personal Education Plan meetings, looked after children reviews and health reviews none of which were effective in discussing some of the key issues in the children's experience and behaviour. For example, Alison was described as clumsy by the foster carers. This was never adequately explored in either health or looked after reviews. There were suggestions the children hurt each other and this was also not fully explored.
4. That staff or carer inexperience may affect service delivery and that additional support and systems may be necessary to maintain service standards and quality. The social workers involved in this case were inexperienced or inexperienced in the role they were undertaking. This was the foster carers first placement. The impact of the inexperience of key staff was not recognised as requiring additional supervision and support to ensure the children received the level of care they needed.

2. Reason CSPR Undertaken

2.1. On 26th March 2021, the Local Authority submitted a Serious Incident Notification (SIN) to Ofsted and the National Child Safeguarding Practice Review Panel (NCSPRP). This followed Alison having, for the 4th time in the year since becoming looked after, presented with multiple injuries for which there were no clear or adequate explanations from her foster carers. Two of the four episodes of injuries required significant medical treatment – serious damage to her pancreas which led to surgery to remove 70% of her pancreas and a fracture to her arm. In the other two episodes the injuries were of multiple bruising including in soft tissue areas of the body. These injuries required no treatment but were nevertheless significant in the absence of clear explanation of their cause. The number, pattern and seriousness of the injuries to Alison raised concerns in relation to the possibility of serious abuse or neglect or poor supervision of Alison by her foster carers. A 'rapid review'

was carried out in line with Working Together 2018 and a report submitted to the NCSPRP on 21st April 2021 which recommended that the case met the criteria for a Local Child Safeguarding Practice Review (LCSPR).

2.2. On 5th May 2021, a response was received from the National Panel which agreed with the decision to conduct a Local Child Safeguarding Practice Review.

2.3. The review will be conducted in line with the principles set out in Working Together 2018 and NSCP/NCSCP Interagency Procedures to Safeguard Children. The review period is from 23rd April 2020 to 26th March 2021. The 23rd April 2020 is the date Alison, and her siblings became looked after under Interim Care Orders (ICOs) and 26th March 2021 the date of the serious incident notification to Ofsted.

3. Alison pen portrait. The rapid review described Alison as "An affectionate and loving little girl. She seeks affection and reassurance from adults and responds well to this. Alison attends nursery 'with a smile on her face'. She speaks with nursery workers about important people in her life and is beginning to form special friendships within the setting. She always creates special attachments with main carers; this has been observed with her parents and her foster carers."

4. Family Composition. Ages are as at April 2020.

4.1. Birth Family:

Mother: 32 yrs
Father: 33yrs
Mary: 8yrs
John: 6yrs
Alison: 3yrs

4.2. Foster Family:

Foster Parent Male: 36yrs
Foster Parent Female: 36yrs
The Female foster parent's own parents who lived nearby played an active role in supporting the foster parents in their care of the children.

5. Key events from the chronology of multi-agency work with Alison.

5.1. Alison is one of three children with an older brother, aged 6 years and sister, aged 8 years in April 2020. There had been a long history of parental alcohol misuse and domestic abuse and, in spite of significant support provided through child in need and child protection plans and the public law outline process, the concerns continued. Matters came to a head at the end of March 2020 when the children witnessed serious domestic violence perpetrated by their father towards their mother. Alison's brother was injured in the process when trying to intervene to prevent his father hurting his mother. Alison's father was arrested, and care proceedings initiated. It is clear the children witnessed and experienced many traumatic events in the care of their birth parents.

5.2. On 23rd April 2020 an ICO was obtained, and the children became 'looked after' and moved to their foster placement. The children's foster carers were recently approved as foster carers. This was their first foster placement. They did not have children of their own and while the male carer had been a stepparent in a previous relationship for a considerable period of time, more than ten years, the extent and nature of his parenting of the stepchildren was not explored or known. The foster parents were approved for two children 0-18 yrs or three children if siblings. It was suggested that their first placements should be children under 10 yrs.

5.3. The children entered care following an application for an ICO. This meant there was some time, more than a week, to seek a potential placement for the children as part of the planning for their future care. The request for a placement was made late with only a few days' notice and the placement chosen identified at 4.15PM on the day the ICOs were made on the children. There were no placements available from within Notts CC foster carers. The placement request was sent out to independent fostering agencies which led to two potential placements. The one chosen was within 10 miles of the children's hometown in Nottinghamshire. The alternative placement was in Birmingham. The proximity of the placement chosen to the children's hometown was crucial in the decision to use these carers. The children were able to continue to attend their school and nursery from the foster placement.

5.4. There was a placement planning meeting on 28th April. These meetings focus on the immediate arrangements for the placement and are normally

attended by the children's parents, the children's social worker, the supervising social worker for the foster carers and the foster carers. The meeting should deal with responsibilities for communication between the children's social worker, the foster carers supervising social worker and the foster carers among other issues. They should agree who will lead on communication with other agencies including school and nursery in this case and with the birth parents. It appears roles in communication were not well enough defined at this meeting given the subsequent issues about communication and understanding of the roles of the supervising social worker, the local authority Court Team Social Worker (CTSW) and the foster carers.

5.5. On 28th April at the placement planning meeting the Supervising Social Worker (SSW) from the fostering agency shared information that Alison's older sister and brother both had bruises on their bottoms. The older sister was attributing this to her brother. These bruises were observed by the foster carers on the day of placement 23rd April and reported to the fostering agency on the same day for Mary and 24th April for John. The Foster carers completed body maps once they had been given hard copies of body maps by the SSW. At the placement planning meeting the foster carer described Alison and her sister as accident prone, that their brother had punched Mary and that Mary was always picking Alison up and pulling her around. This information was followed up by the District Social Worker (DSW). The completed body maps were sent to the DSW on 29th April. The older two children were asked what had happened to cause the bruising on their bottoms and gave accounts of being hit by siblings or injury from climbing a tree. The Foster Carers reported the bruising promptly but there was delay in this being communicated to the DSW for follow up. The discussion of these bruises was the start of the narrative that the children including Alison were clumsy or accident prone.

5.6. The initial Personal Education Plan (PEP) meeting for all the children was on 12th May 2020. This meeting was described by participants as unorganised. The social worker leading the meeting had no previous experience of a PEP meeting. This meeting was particularly unsatisfactory for Alison and her nursery. Her sibling's needs dominated. They appeared to have greater

needs. Due to time pressures the discussion about Alison's progress and needs was brief and after some participants had left the meeting.

5.7. Social work responsibility for the children transferred from the DSW to a Court Team Social Worker (CTSW) on 22nd May. However, allocation to the CTSW was on 29th April which allowed time for a handover of responsibilities. The transfer point was the initial Looked After Children (LAC) review which both SWs attended on 20th May 2020.

5.8. On 26th May 2020 Alison and her foster mother had a telephone consultation with a Community Paediatrician as part of her Initial Health Assessment (IHA). There were no concerns identified or discussed about her emotional or behavioural health and wellbeing. She was described as clumsy by the foster carer but could throw and kick a ball, go up and down stairs and no concerns were expressed about her fine motor skills. Alison was 3yrs and 4mths at the time of this assessment.

5.9. On 1st June 2020 Mary was seen face to face for her IHA. Concern about tics were noted and that these were worse when Mary was worked up or anxious. There were other discussions in May with the SSW, John and Mary's school and the foster carers about the children's reaction to their virtual contact with their parents. The school thought the foster carers reactions, for example surprise at the children's ambivalence about contact, reflected their lack of experience.

5.10. On 11th June 2020 the foster carer noted a red mark on Alison's bottom. Alison said Mary did it. On 12th June the foster carer consulted the GP about Alison crying when passing urine and a face-to-face consultation was arranged. During the consultation the male foster carer told the GP that Mary had smacked Alison on the bottom a few days before. The GP noted a faded bruise on the left buttock and a red bruise to the right buttock. This consultation did not lead to any communication to the CTSW. It does not appear Alison was asked about this bruise and how it occurred either in the presence of the foster carer or alone.

5.11. Later in June the foster carers reported to the school they felt unsupported by the CTSW with managing expectations about contact between the children and their birth parents. The school noted that the foster

carers seemed to know little of the children's backgrounds and by late June the school noted their contact with the foster carers decreasing.

5.12. In July a permanence team SW started a sibling assessment which was undertaken by meeting face to face with the children in placement. This assessment was completed in mid-August and concluded the children should remain together at this stage. A referral to CAMHS had been made and further assessment of the sibling relationships recommended. The foster carers were reported as saying they would not be able to care for the children on a long-term basis. The foster carers described caring for the three children as very challenging. The sibling assessment report identified complex dynamics between John and Mary.

5.13. On 19th August bruising to Alison was noted by the foster carers. Alison when asked said Mary did it and then said she did not know. A safety plan was started by the LA which included a baby monitor in the children's bedroom. On 3rd September the SSW emailed the CTSW about John's behaviours. He had hit Alison in the stomach and punched Mary. A referral had been made for John to 'Hands are not for hurting' but this service was not provided as it is a service for parents and children together and a separate programme for children was not running. It does not appear that additional support for the foster carers was considered at this stage or later or ever provided. The CAMHS consultation took place on 8th September. The consultation was with a CAMHS Looked After Children Team practitioner, the foster carers, the SSW and CTSW and did not include the children. The CAMHS practitioner was an art psychotherapist. No reports were submitted prior to the consultation which was a discussion about the children. The children's behaviours were assessed as normal reactions to their adverse experiences. The foster carers were felt to be doing well with the children. No further role was identified for CAMHS and no other additional help for the children or foster carers was suggested. It is worth noting that at this point the children were still the subject of care proceedings and the future plans for the children were not settled. This uncertainty can impact on what therapeutic help is available to children. It is common for referrals for therapeutic work to not be accepted until plans for children are clear and they are in a settled placement.

5.14. On 14th October the foster carers contacted the GP about Alison being unwell and unable to keep anything down. A face-to-face appointment was offered. An injury to Alison's nose and a bruise to the side of her head were noted. Alison was said to have fallen off the sofa. Alison continued to be unwell and on 15th October the foster carers were advised to take her to the local emergency department. Alison was admitted to the local district general Hospital. On the 15th October a Consultant Paediatrician Dr A contacted Notts CC Emergency Duty Team to advise that Alison had pancreatitis and a linear bruise to the side of her abdomen which could be indicative of a blunt trauma. The CSC record said the foster carer was querying whether Alison might have been hit in the stomach by a swing.

5.15. In the Hospital notes blunt trauma to the abdomen was noted as a possibility. The foster carers while saying Alison often bumps into things and falls and often bruises could offer no explanation for Alison's bruises to her arms, legs and abdomen. Alison made no disclosure of trauma when asked in front of the foster carers. The hospital notes show that it was agreed with the CTSW that there would be a child protection medical on 18th October 2020. The CTSW spoke to Dr B on 16th October and recorded him as saying he felt obliged to carry out a CP medical. The hospital documentation and discussion with Dr B reflects that he was extremely concerned about the bruising evident and that while there were further medical investigations needed a CP medical should be undertaken followed by a strategy discussion. At this point Alison had already had a full examination with all her injuries documented and body mapped as well as clinical photographs taken. The CTSW is reported as saying the explanations from the carers were consistent with the injuries and there were no concerns about the carers. It does not appear that there was ever a clear consideration of whether there should be a strategy meeting to consider Alison's injury which would normally precede and make the decision on the need for a CP medical and whether to start a s47 child protection enquiry.

5.16. On 17th October 2020 Alison was transferred to a tertiary hospital with more specialist children's services for review by the surgical team. This was prior to the intended CP medical. By this time there was a diagnosis of pancreatitis of unknown cause. The transfer letter to this hospital notes that

there was no explanation for the bruising to Alison's arms, legs or abdomen and that there was no history of any witnessed trauma to Alison's abdomen. The letter gives the diagnosis as pancreatitis of unknown cause with the possibilities including blunt trauma or infection. The letter does not make explicit the possibility of the blunt trauma being of a non-accidental cause. The transfer letter from the district general hospital to the tertiray hospital does not mention a CP medical or the possibility of a strategy meeting.

5.17. There was a verbal handover to surgeons from the medical team at the district general hospital and the conversation is recalled as including concerns about potential non accidental injury as the cause of Alison's pancreatitis and the plan for a CP medical on 19th October. The district general hospital consultant recalls the team at the tertiary hospital stating they would proceed with the CP medical as required while Alison was at the tertiary hospital.

5.18. The Children's Safeguarding Team (SGT) of the tertiary hospital contacted the ward and said the doctors needed to speak to the CTSW about Alison's results and the explanation for the bruises. Over the following days the focus was on the treatment of Alison's pancreatitis. There was speculation about whether the pancreatitis could have been caused by an old injury. On 19th October 2020 the CTSW spoke to the two older children and the foster carers about possible causes including by a swing or a thigh injury from a new bike. These enquiries were not placed within any formal structure such as a s47 enquiry or strategy meeting to consider all the information available on a multi-agency basis. The older two children were moved to respite carers. One of the foster carers stayed with Alison on the ward and their care was observed to be appropriate at all times.

5.19. An entry for 19th October 2020 by the tertiary hospital SGT says that the ward gave an update that there were no concerns regarding Alison's injury and that she had pancreatitis. How the narrative changed to this conclusion is not clear. On 20th October the CTSW contacted the ward and spoke to a junior doctor. The CTSW was recorded as saying there were no concerns about Alison's bruises. The CTSW asked whether there was any medical reason why Alison might bruise easily and was told Alison had an abnormal Activated Partial Thromboplastin Time (APTT) on 18th October and

this test would be repeated. The APTT measures how long it takes blood to clot. The CTSW said she would call back the following day for further information on this test. On 21st October the tertiary hospital records note that the APTT was not raised but was low and the test did not need to be repeated. This meant the clotting of Alison's blood was normal. This normal clotting result is not noted in Alison's children's social care record. On 22nd October 2020 the tertiary hospital recorded that a CT scan did not show any older injury and that surgeons remain unsure as to the reason for the injury to the pancreas. On this date CSC record a discussion between a staff nurse and the CTSW that the pancreatitis was not caused by an injury and there were no concerns about any injury or bruising being a non-accidental injury. The nurse was recorded as saying the medical team were happy with the explanation of Alison being a little clumsy and there were no concerns, and a CP medical was not needed. The Tertiary Hospital record of this call says the nurse shared that the CT scan did not show any previous injury to the pancreas and that the surgeons remain unsure of the reason for the injury.

5.20. On 26th October 2020 the CTSW asked the foster carers about agreeing to care for the children long term with consideration of doing so under a Special Guardianship Order (SGO). The timing of this discussion reflects the court timetable for the care proceedings the children were subject to.

5.21. On 29th October 2020 Alison had an operation to remove 70% of her pancreas. The notes record a diagnosis of pancreatitis due to either infection or blunt trauma, most likely blunt trauma.

5.22. On 2nd November 2020 the CTSW visited Alison virtually and observed Alison had a close relationship with the foster mother. The SSW noted the foster carers lack of experience of dealing with trauma associated issues. The CTSWs understanding was that there were restrictions on numbers of visitors and that for Alison the foster carers were her listed visitors. In the circumstances of Covid visiting restrictions in hospital it is understandable why the CTSW did not insist on making an in-person visit.

5.23. On 6th November the tertiary hospital SGT visited the ward and reviewed notes for Alison and no safeguarding concerns were identified. There was no face-to-face discussion about AlisonA clinical discussion would

have been held if any safeguarding concerns had been raised. There was a telephone discussion between the SGT and the ward team later that day which clarified that there were no concerns about the foster carers on the ward. Alison was discharged on 11th November. There was no discharge planning meeting which the hospital would expect CSC to initiate. In the discharge summary to the GP no information was documented about any safeguarding concerns or that Alison was a looked after child.

5.24. On 24th November Mary told a member of school staff that she was "feeling guilty" and that "I just don't feel like I can hold my head up." The school tried to understand these comments further, but Mary could not articulate anything specific.

5.25. On 8th December 2020 Alison and her siblings were made subject of care orders with a plan of long-term fostering.

5.26. On 16th December 2020 Alison had a telephone appointment with the GP as the foster carers were worried she was unwell and was holding her wrist. Alison said she had fallen from a bed when jumping on it that morning. This was followed by a face-to-face GP appointment and visit to A and E where a broken arm was diagnosed. The GP had advised an x-ray during the telephone appointment but the foster father wanted to check with the GP before going to A and E. The GP when he saw Alison reported that the arm was clearly disfigured enough to require urgent treatment. This suggests it would have been more appropriate for the foster carers to take Alison to A and E as soon as the injury to her arm was seen. As well as a broken arm Alison had friction burns to her elbows. Alison did not provide any explanation for the friction burns. There were concerns that the broken arm was an unwitnessed injury and that there had been delay in presenting Alison for treatment. On 17th December the SSW said the children were giving different accounts of what had happened, and that Mary was very anxious about Alison. On the same day the CTSW had a discussion with the foster mother about whether Mary was involved in Alison's injury. Mary was reported as saying to her teacher "we can't tell the truth." She was also reported as telling a teaching assistant that she wanted to kill herself and that she did not have any friends. The school tried to contact the foster carers and the CTSW to discuss what Mary had said but without success. They did contact the

SSW who responded by email. The SSW acknowledged the concerns raised by the school and committed to discussing these concerns with the foster carers. The email was copied into the CTSW which meant the school did not see the need to follow up their concerns directly with the children's social worker. The SSW did discuss these concerns with the foster carers and the CTSW on the same day

5.27. The CTSW agreed a safety plan with the foster carers which included Alison sleeping in the foster carers room. On 18th December Mary reported at school that the foster mother had told her she was going to burn Mary and John's Christmas presents because they don't deserve anything, but they'll be able to watch Alison open her presents. The Foster Mother, when asked by the school, denied having said what Mary reported. Mary was distressed at school about feeling blamed for the injury to Alison. On 23rd December 2020 the CTSW discussed harm to Alison with Mary and John, with both children saying they had hurt Alison in the past. The CTSW's view was different to that of the school. The CTSW thought that the children seemed relieved that they could be open about hurting Alison and that the truth had come out. The safety plan was revised so that John and Alison shared a room with a baby monitor present.

5.28. On 4th January 2021 Alison fell and hit her face on a storage box. This caused a bruise to her left eye and between her chin and ear. This was recorded in the foster care log but not reported further. On the 6th of January 2021 Alison was bruised with a bump on the head when she walked into a door as the foster father was opening it. This was recorded in the foster carer daily log and not reported further. Alison had contact with her mother on 6th January and her mother reported the injuries to the CTSW. The CTSW followed up the bruising the following day and concluded the bruising was caused accidentally. On 13th January 2021 Alison attended nursery with a black eye. The foster mother said she had caught her eye on a cupboard door. This was not a further injury but was from the injuries recorded on 4th and 6th January. At a LAC review on 19th January 2021, it was said Alison's injuries may be a consequence of her clumsiness. This was disputed by the nursery she attended as they had not seen any evidence of clumsiness in nursery.

5.29. On 20th January 2021 the SSW emailed the CTSW to say that Mary seemed to be struggling with her emotions and requesting urgent support for Mary. On 21st January 2021 social work case responsibility transferred to a SW in the LAC team. This followed the conclusion of the care proceedings and was a normal part of the process for case management of LAC.

5.30. On 26th January 2021 Mary was reported by school as saying, “I don’t want to get into trouble because everyone thinks I’m hurting John and Alison and they’re lying – I’m not!”. The same day Mary was banging her head in distress about an injury to John. A further referral was made to CAMHS by the LAC SW for consultation about the children.

5.31. On 3rd February 2021 a call from a paediatric consultant at the district general hospital to the tertiary hospital SGT regarding the CP medical planned for 18th October 2020 was the beginning of the process to review all the medical contacts for the three children. The review looked at the causes of their injuries but particularly Alison’s and whether the injuries had been fully considered within a safeguarding framework. The records of the discussions that followed with the medical teams and the LAC SW involved indicated the lack of clarity about the decision making in this case in relation to the injury to Alison’s pancreas. The LAC SW said their understanding was that the tertiary hospital SGT made the decision that a CP medical was not required. The LAC SW was advised that the SGT never make these decisions. The exploration of the history from October 2020 led to escalation of the case between the tertiary hospital SGT and CSC.

5.32. On 27th February 2021 Alison had further bruising on her back which were observed when she was having a shower. Alison was seen at the children’s assessment unit. Her foster mother could not account for the multiple bruises on her body. It was agreed a CP medical was needed and it was also agreed Alison would go to the foster mother’s parents’ home. On 28th February there was a joint police and LAC SW visit to the foster carers and Alison as part of a S47 enquiry. At this point in the s47 enquiry the Police were not made aware of the previous injuries including to Alison’s pancreas and arm. This information was shared with the Police at a strategy meeting on 9th March. The foster carers could not recall incidents that could have caused the bruising. On 2nd March 2021 it was agreed Alison would

move to a new placement and she moved that day to a respite foster placement. On 9th March 2021 Mary and John moved placement.

6. Foster Carers Experience and Perspective

6.1. The Foster Carers and the parents of the female foster carer were interviewed as part of the review. The Foster Carers recognised that they were inexperienced carers and that however much training and preparation was provided the reality of caring for three children would be different. The Foster Carers had little information about the children prior to placement including about their education and schooling. They were told there were no behaviour problems. It does not appear that either the fostering agency social worker or local authority social workers discussed with the Foster Carers that they should expect the children to present behavioural and other difficulties given their history and that these would need to be observed and assessed during the placement.

6.2. The covid lockdown meant the Foster Carers did not have contact with other carers through training or activities organised by the fostering agency. Their primary support was from the parents of the female foster carer who lived very nearby and saw the children most days. Initially support from the fostering agency social worker was frequent but this reduced over time. The Foster Carers said they sought additional help with the care of the children and understanding their needs but this was not provided. The Covid restrictions meant access to in person NHS support services was restricted. The female Foster Carers parents thought the covid restrictions made a very significant difference because of the difficulties it brought in contacting other agencies who might have provided additional support and advice. The Foster Carers when they talked about difficulties in the care of the children and were distressed by those difficulties, were told they were doing a good job and to continue what they were doing. They did not feel their experiences in caring for the children were listened to.

6.3. Over time the Foster Carers found that John and Alison settled and responded to their care. Mary, they found a more troubled child who both at the time and in retrospect they felt would have been better placed on her own where she could receive the undivided attention of her carers. They were

also troubled by Mary's sexualised behaviour for example open mouthed kissing and this was not adequately addressed by either the local authority or fostering agency social workers.

6.4. The Foster Carers confirmed that the discussion about them caring for the children long term was not a careful exploration of the issues. What long term care would look like including parental contact was not explored. The Foster Carers felt under pressure to make a decision to fit with the timetable of the care proceedings. The Foster Carers confirmed their very limited contact with the local authority social worker and that the children were frightened of the local authority social worker who in a first meeting discussed difficult and sensitive issues with the children without adequate preparation. The Foster Carers were not given any feedback from the sibling assessment undertaken to inform the care proceedings and decisions about whether the children should be placed together or not. This assessment had important information about the sibling relationships that could have been valuable to the children's carers.

6.5. The Foster Carers and the female foster carers parents observed all the children to bruise easily and that Alison was clumsy. Alison was also observed to be tolerant of pain. She did not show when she hurt herself. The Foster Carers recorded injuries they observed in their logs as accurately as they could. The Foster Carers view that Alison was clumsy was never properly explored. Alison's nursery had a different view. The observations of Alison and whether she was unusually clumsy for a child of her age should have been systematically considered and expert assessment provided. This was not provided at least in part because of the Covid restrictions on in person services.

6.6. It does not appear there was a detailed discussion with the foster carers about how they supervised the children to ensure they were safe so that the foster carers could account for any injuries the children suffered. Given the foster carers lack of experience in caring for children and the demands of caring for three children, together with the lack of attention to the trauma the children had experienced this was a significant omission in the support offered to the foster carers and the children.

6.7. The Foster Carers felt they were not listened to during the placement and were not adequately supported in their care of the children.

7. Information on Social Work contact with the children and Foster Carers.

7.1. There were three local authority social workers allocated during the review period. The children were allocated initially to a DSW who had been working with the family when the children were children in need and had child protection plans. This DSW held the case when care proceedings were initiated and the placement of the children with foster carers was made on 23rd April 2020. The case transferred on 22nd May 2020 to a SW in the court team - CTSW. The date of allocation to the CTSW was 29th April 2020 allowing time for handover. Both the district and court team SWs attended the initial LAC review but the placement planning meeting preceded allocation to the CTSW. The children transferred to the LAC Team on 22nd January 2021 after the conclusion of the care proceedings and when the plan was for them to remain in care as foster children, with their current carers, and with the expectation that their foster carers would apply for SGOs. The allocation in the LAC team was on 19th January 2021 and the CTSW and the LAC SW attended the LAC review on 19th January 2021 which provided an opportunity for case handover.

7.2. Social Work Visits;

Date	Who was seen Virtual/In Person	Which SW	Other info
28/04/20	All the children – Virtual.	District SW	
19/05/20	All the children seen-in person	District SW	Goodbye visit
27/05/20	All the children-virtual.	Court SW	Statutory visit
22/06/20	All the children-in person	Court SW	Statutory Visit
19/08/20	All the children seen – in person	Court SW	Statutory visit – out of time.

14/10/20	All the children seen - virtual	Court SW	Not statutory as virtual. Regs changed 30/09/20
2/11/20	Alison seen in hospital- virtual	Court SW	Statutory visit – there were restrictions on in person visits[BE(&M1][GX2] in hospital.
23/12/20	All the children seen - in person	Court SW	Statutory visit out of time.
07/01/21	All the children seen – in person	Court SW	Statutory visit.
10/02/21	All the children seen – in person	LAC Team SW	Statutory visit
01/03/21	All the children seen – in person	LAC Team SW	Statutory visit.

7.3. Fostering agency SSW visits. There were at least 25 SSW visits between 12th March 2020 and 16th March 2021. For much of this period the visits were weekly – April to June 2020. In addition, there was frequent telephone contact between the SSW and the foster carers. The SSW "bubbled" with the foster carers and the children during the first lockdown.

7.4. The chronologies and IMRs evidence problems in the relationship between the CTSW and the foster carers and other agencies. The SSW did not feel the CTSW responded in a timely way to communications. The children appeared to have a negative view of the CTSW. The children had described the CTSW as a "scary lady". The SSW described acting as a mediator in communication between the CTSW and the foster carers. The SSW was asked by the foster carers to be present for some of the CTSW's visits to the children because of these concerns about how the CTSW discussed some issues with the children. The issues centred on use of what was seen as not age-appropriate language in discussing the future plans for the children and

why they were in care e.g. language which was negative or too adult about their birth parents. The SSW records show messages left for the CTSW asking for contact, which the SSW felt needed then to be confirmed in writing.

8. Response to the Key Lines of Enquiry.

8.1. To what extent were established processes and procedures followed in the collating, analysis and processing of information received? Explore how agencies worked together to respond to the information and any concerns identified, whether they were clear about their role and whether the right agencies were involved to protect and support Alison.

8.1.1. Mary, John and Alison were looked after children. They were the subject of care proceedings for most of the review period which meant additional scrutiny of their needs and the plans for their future by the Family Court. They had LAC Reviews, Personal Education Plans (PEPs) and related meetings and initial and subsequent health assessments. These various processes were completed for all the children without addressing the issues of concern which are the subject of this CSPR and which have led to the children having multiple placements. These processes require effective social work leadership to work well which was not evident in this case. NCC has a programme of post qualifying training for social workers which includes a teaching partnership with local universities, an aspirant team manager programme, a proactive consultant team and senior practitioners in social work teams to advise and support less experience colleagues. Other agencies noted that the problems in this case were not seen in other work and therefore this case was not indicative of wider systemic issues, including of SWs being able to act as effective lead professionals.

8.1.2. Alison has had two significant serious injuries one of which remains unexplained and other episodes of bruising which are also unexplained. The gaps in process, procedure and analysis are as follows:

8.1.3. The placement planning meeting was ineffective because it did not clearly establish the lines of communication and responsibilities between the foster carers, their SSW, the DSW and other agencies. The SSW and the DSW were both inexperienced. The SSW had worked in a social

work team for eighteen months after qualification which undertook work from initial referral to children being looked after. The SSW had worked for the fostering agency for a year and had been involved in making five other placements before supervising this placement. This was the foster carers first placement, so they had no experience as to what to expect in terms of who they communicate with and about what. The DSW had never conducted a PEP meeting before and this inexperience was reflected in what was a very unsatisfactory meeting for the nursery and school. The CTSW though experienced was an agency worker and new to Nottinghamshire and may not have had a secure grasp of what was required of her in terms of communication with the multiple parties involved in this case while it was in care proceedings. The CTSW was also completing a parenting assessment as part of the care proceedings which is a large and complex piece of work undertaken to a tight timescale. These pressures impacted on time available to see and develop relationships with the children and their foster carers.

8.1.4. The information that the foster carers were new to fostering and had limited previous childcare experience did not seem to be understood as a key issue. The SSW was aware of this, but it is unclear how far other workers were or if they were how far they grasped the implications of this for the children and what advice and support the foster carers needed. The schools formed a view that the foster carers seemed inexperienced and naïve, but this view does not seem to have been taken up and explored either by the SSW or the CTSW. The foster carers were unsure what they could legitimately share and discuss with the school and maintain confidentiality and this may have contributed to the school's view of the foster carers. The foster carers view of Alison as clumsy was accepted without wider reflection of what the basis was for this or what the implications of this were for Alison's care or early discussion with the nursery who knew Alison well and saw no evidence of Alison being clumsy. There was discussion about the children's presentation and how the foster carers understood their needs, including a consultation with CAMHs which was overall positive about their fostering skills. As the children were not seen in this consultation and it was a single meeting

this was a very limited assessment of the children's needs. This discussion was not linked to the early bruising Alison experienced, the indications the foster carers were struggling to manage the three children and the indications of rough and aggressive play between the children which included hitting, punching and dragging across the floor. The information about the children, how they behaved in placement and their lived experience was not brought together in the early months of the placement for a deeper multi-agency discussion.

8.1.5. There was also no evidence of consideration of what additional support the foster carers would need in a demanding first placement. The Foster Carers account shows they were struggling which was not surprising. It is very surprising that they were not provided through their fostering agency with a foster carer mentor or buddy or fostering support worker whom they could use for practical advice on care and for day-to-day reflection on their experience as carers and on what the children brought to the placement. The absence of a mentor or fostering support worker seems a major gap in the fostering agency's provision. That this was not provided or sought by the SSW may reflect the inexperience of the SSW and the CTSW's lack of familiarity with what should be expected to support foster carers. The extent the foster carers were struggling was not picked up within the statutory review process.

8.1.6. The presentation of Alison with pancreatitis in October 2020 was a critical incident. Alison had 70% of her pancreas removed and this could have life changing consequences for her. The cause of the pancreatitis remains unexplained, but the medical consensus now is that blunt force trauma is the most likely cause. The sequence of events is set out in the chronology, but this does not provide a clear account of why this presentation of Alison with a serious medical condition did not lead to either a strategy meeting or a s47 enquiry or another multi-agency discussion where the cause of her pancreatitis could be fully explored on a multi-agency basis and with input from medical teams treating her. The lack of a proper process to consider this injury meant the cause of Alison's pancreatitis was not fully considered close to the time of the injury. This reduced the chances of establishing the cause of the injury

which was in the interests of Alison, her siblings, and her foster carers. The injury remains unexplained.

8.1.7. Using the CSC records the consideration of how to proceed seems to have been:

8.1.7.1. On 16th October the treating physician at the district general hospital advised the CTSW that he felt obliged to carry out a CP medical. The physician did not have a sense of the foster carers having done anything wrong but felt a CP medical was a necessary course of action. The CTSW queried whether a CP medical was warranted, and it was agreed it was not urgent and could wait until the following Monday 19th October 2020.

8.1.7.2. Alison was then transferred to the tertiary hospital and on 17th October the CTSW spoke to a nurse and the CTSW notes state 'CP medical not performed due to ongoing investigation'. Investigation in this context meant medical investigations. At this point Alison's medical treatment needed to take priority.

8.1.7.3. On 22nd October the SW spoke to a staff nurse and the CTSW notes say: "She (staff nurse) confirmed that pancreatitis has NOT been caused by an injury, they are not concerned about any injury/bruising in regards to non-accidental injury, have spoken with foster carer etc…. they are happy with the explanation of Alison being a little clumsy, they have no concerns in this respect." The tertiary hospital chronology records this call as the nurse sharing that the CT scan did not show any previous injury to the pancreas and the surgeons remain unsure as to the reason for the injury. These are very different accounts of the same call.

8.1.8. Following this sequence of calls there was never a strategy meeting or other multi-agency consideration of the cause of Alison's pancreatitis. There was speculation about infection, an old injury predating her entry to care and some kind of recent blunt force trauma. The CTSW and CSC seem not to have appreciated the importance as Alison's "parents" of having a full discussion with her treating medical team of the nature of pancreatitis, it's possible causes and consequences. The seriousness of the injury does not seem to have been grasped. From the medical side

the focus was on treating Alison and there seemed to be no one who took a wider view of the need to discuss the cause of pancreatitis with the CTSW and CSC. The tertiary hospital SGT did look at Alison's notes but did not pick up that the case needed a multi-agency discussion.

8.1.9. When Alison suffered a broken arm in December 2020 there was a plausible explanation but there was concern about a further unobserved injury. This led to the CTSW putting in place a safety plan. While this was appropriate a fuller review of the circumstances of the injury and of the supervision of the children was needed. The concerns from the school about what Mary was saying about being blamed for hurting Alison were not given sufficient weight and should have been given more prominence in considering how well cared for the children were and the nature of their experience.

8.1.10. When Alison had further unexplained injuries in February and the tertiary hospital SGT reviewed the whole history of her injuries this then led appropriately to a s47 enquiry, information exchange and discussion between the tertiary hospital SGT and CSC. Alison and her siblings were then moved from the foster placement.

8.2. Consider whether agencies sought the correct expert advice at the time in relation to the injuries suffered by Alison.

8.2.1. As noted in section 8.1 the correct expert advice was not sought for Alison's pancreatitis and its possible causes. The reasons for this seem to lie in the CTSW and CSC not grasping the seriousness of the injury, understanding that blunt force trauma is a common cause of pancreatitis and that the treating medical teams focused on managing Alison's medical care and did not step back to consider the cause. This was not helped by the transfer between the district general hospital and the tertiary hospital at a crucial stage. The view from the district general hospital that a CP medical was needed seemed to be lost sight of in the transfer and when this was not followed up by CSC this was not followed through. The CSC view that the injuries were consistent with the carers explanations and that they have no concerns appears to have become the accepted view. There was no questioning of this within the medical

teams involved and no discussion between the CTSW and medical team apart from a brief update from a junior doctor about blood results.

8.3. Consider the 'looked after' status of Alison and the impact this had on the responses of professionals to presentations made, including the role of the final statutory looked after child review and health reviews.

8.3.1. It appears that Alison being looked after and in a foster placement reduced the level of enquiry about her injuries and there was less concern about the lack of or different explanations for her injuries. The assumption was that her foster carers were able to manage her and her siblings' care and that there would be benign explanations for any injuries. The inexperience of the foster carers and the demands of caring for three children with a history of exposure to domestic abuse and neglect does not seem to have been adequately considered.

8.3.2. The children had statutory LAC reviews as required. The review set for January 2021 was delayed because of the safeguarding concerns but subsequently proceeded. The safeguarding concerns were discussed in the review including the safety plan in relation to Alison from her siblings. Alison's clumsiness was discussed. The Independent Reviewing Officer sent an alert to the Court Team Manager following the review as the CTSW had not completed sufficient visits to the children in person. The review did not appear to be used as a forum to challenge the narrative about Alison being clumsy or that her siblings were the likely cause of her injuries. The review does not appear to have taken a sufficiently broad view of the children's welfare and considered the full range of possibilities for Alison's injuries or what might be happening for the children in placement including the information from Mary that was available from her school. The reviews did not take a sufficiently proactive role in establishing what the experience of the children was.

8.3.3. The health reviews were undertaken as required with the January LAC review noting that Alison should have another health assessment as she was under 5yrs. The health reviews did not seem to play a role in surfacing concerns about the children's care and experience.

8.4. Consider the commissioning of the placement for Alison and siblings including the suitability of the placement and the matching to the children's

needs. This consideration should include the wider context of placement choice for children with the needs of Alison and siblings at the time the placement was made.

8.4.1. The commissioning of the placement was undertaken in haste. This is business as usual for placement commissioning and reflects the demand pressures on the placements system. There was a choice between local foster carers and carers living in Birmingham. That local carers were chosen even though this would be their first placement was understandable. Beyond proximity there was no matching of needs. The lack of choice reflects the chronic local and national shortage of foster placements.

8.4.2. What was then missing was consideration of what these very inexperienced foster carers would need in terms of support to successfully care for three children who have each had multiple adverse childhood experiences. While there was little evidence that the children would present any specific difficulty e.g. there was no evidence of a learning difficulty or additional physical care needs it was safe to assume that caring for three children who had no prior relationship with the foster carers would be very demanding. The implications of this do not seem to have been given due consideration by either the fostering agency or CSC. For the fostering agency support for the foster carers seemed wholly left to their SSW who was inexperienced and having to rely on her own social work knowledge and skills to support the carers. The agency did not have additional resources to assist the SSW in advising and supporting the carers such as advice from a psychologist or access to expertise in the provision of therapeutic care.

8.4.3. The fostering agency was small and the SSW had a small caseload which meant there was time for the SSW to provide support to the carers and this was done with frequent visits and other contacts. However this could not compensate for relative inexperience or the benefit of having the observation of an experienced fostering support worker or foster carer acting as a mentor to the foster carers.

8.5. Examine the assessment, approval, support, training, supervision and reviews of approval provided to the foster carers in the context of their role as foster carers and the needs of the children they were caring for.

8.5.1. The foster carers assessment was adequate but contained significant gaps. The most important was the absence of any depth of consideration of the foster father's previous experience as a stepparent. There was an over estimation of the level of experience of childcare of both carers. The foster mother had not been a parent or step-parent and had limited child care experience working in a nursery and as a nanny for 1 to 2 years. This was described as 'a vast amount of experience in caring for children.' This was not an accurate description of the foster mother's level of experience.

8.5.2. The foster carers were provided with training during the assessment and approval process and subsequently were completing the Training, Support and Development Standards (TSD) for foster carers. They were trying to complete this programme at the time of their annual review and reapproval in February 2021. The Foster Carers recognised the gap between what can be learnt in training and preparation and the reality of caring for three children. Comments were sought from the network working with Alison and her siblings for the foster carers review and no negative comments were made.

8.5.3. The Foster Carers received frequent and conscientious support from the SSW. However, it is very surprising that they were not provided with an experienced foster carer mentor or when they experienced difficulties in managing the children's care and behaviour a fostering support worker. The difficulties the children presented were not unusual and within what would be expected for children removed from their parents following abuse or neglect. The early months of the placement were all in the first Covid 19 lockdown, but this does not seem to explain why additional support was not provided. It does not seem to have been on the menu of services from the fostering agency and was not sought by the SSW or the CTSW. This absence of a demand for additional support may reflect the inexperience and or lack of knowledge of what should be provided of the SSW and the CTSW. The SSW and CTSW should have

been more robust and proactive in seeking additional help for the foster carers. Their supervisors should have recognised that more was needed and ensured this was provided by the fostering agency.

8.6. Identify whether the correct notifications were made to the LA and to Ofsted by the fostering agency in relation to the injuries to Alison and any other significant events for the children.

8.6.1. The fostering agency made three Schedule 7 notifications to Ofsted. These related to Alison's October hospital admission for pancreatitis, her broken arm in December 2020 and the initiation of a child protection enquiry in March 2021. Ofsted only asked for additional information following the March 2021 notification. The Ofsted online notification form asks the agency to identify the type of incident/event and offers a choice of ten possible types. Once a choice is made the form goes to a specific page which asks for more details. The form does not allow multiple choices or the expression of uncertainty at this point. The notification in October was submitted under the heading 'Serious Illness or serious accident of a child placed with foster parents.' The March notification was 'Instigation and outcome of any child protection enquiry involving a child placed with foster parents.' The detail of the October notification stated that 'as the hospital has confirmed illness may be caused through injury a safety plan has been drawn up.' Ofsted did not follow up this lead.

8.6.2. CSC were kept informed by the Fostering Agency of injuries and illness and any other significant events for the children.

8.7. To what extent has the current Covid-19 crisis impacted either the circumstances of the child or family or on the capacity of the services to respond to their needs?

8.7.1. The IMRs do not give a sense of the Covid-19 crisis having a major impact on the circumstances of the children or the foster family in the review period. That said there is no doubt that Covid-19 and the lockdown did have a significant impact on the capacity of all services to respond to need. The Foster Carers see the Covid-19 restrictions as having had a significant impact on the placement and the support they received. It changed how the children were seen with visits made virtually which was inherently very unsatisfactory for any SW trying to develop a

relationship with the foster carers and the children. The children's school and nursery remained open, and they attended regularly but there were interruptions due to isolating due to Covid infections and during Alison's period of illness in Autumn 2020.

8.7.2. The fostering agency does not say that Covid-19 was the reason there was no offer of a fostering mentor for the foster carers. In "normal" times the foster carers would have met other foster carers in training sessions, and this would have given them the opportunity to start to develop their own fostering support network. The foster father had periods on furlough, and it appears this meant his work pattern was more unsettled than usual. However, this also meant he was around more which was a positive at the beginning of the placement when the foster carers were adapting to the demands of caring for three children. It is not clear if this had any impact on the capacity of the foster carers to meet the children's needs.

8.7.3. The children's contact with their parents was virtual during lockdown and this added to the inherent difficulties of managing contact. Without lockdown contact might have used the children's school and nursery, familiar places for them and their parents, which might have facilitated better contact.

8.8. Examine how the impact of severe early childhood adversity and abuse, disability, language and communication difficulties and culture were considered and factored into the way services responded to the needs of the child and her carers.

8.8.1. Alison and her siblings had suffered severe early childhood adversity. It was to be expected that they would have additional needs and would present behavioural and emotional difficulties following removal from their parents' care. That said they were making progress in school and nursery and while below age expected levels in their learning and development they were seen as able to reach age expected levels with encouragement and safe and secure care. All three children could express themselves in relation to their age and development. There was discussion about whether the children needed additional support and they were the subject of a CAMHS consultation which identified that the

foster carers seemed to be managing them well. Their primary need was for sensitive therapeutic parenting. It is not clear they needed another specific therapeutic service.

8.8.2. The description of Alison as clumsy was too readily accepted without a much fuller exploration. This description was challenged by her nursery. The paediatrician who undertook Alison's initial health assessment had no concerns about her fine motor skills. However, the narrative of Alison being clumsy remained and the Foster Carers and the female foster carers parents are very clear that Alison was clumsy relative to other children of her age and stage of development. The narrative that her siblings were hurting Alison in rough play was also not sufficiently explored or the related issue of exactly how the children were being supervised. These issues should have been much more fully explored between the foster carers, Alison's nursery school and those supporting the children and the foster carers.

8.8.3. The sibling assessment identified difficulties in the sibling relationship and a further psychological assessment was recommended which was not provided. The CAMHS consultation did not suggest there was a need for a psychological assessment. In retrospect it appears other professionals gave more weight to the CAMHS consultation than such a consultation, undertaken without written reports or seeing the children, should have carried. The psychological assessment was not requested as part of the care proceedings. There is a presumption in care proceedings to not seek additional expert assessment unless there are very clear reasons to do so. The information from the sibling assessment does not seem to have been used to inform discussion about how the foster carers should respond to the children's needs. This was a missed opportunity to respond to the children's individual needs.

8.8.4. The information provided for the review did not comment on cultural issues. It is not evident that these were significant in how the children's needs were responded to.

8.9. Was there evidence of child focus and the voice of the child influencing how services were provided? Was there a good enough understanding of the lived experience of the children?

8.9.1. There were significant gaps in hearing and understanding the children's voices. The nature of the early difficulties the foster carers experienced in caring for the children were not fully explored. The information from the sibling assessment which included significant direct work with the children was not used to inform the work with the children in placement. The children's school and nursery felt that their experience and knowledge of the children including what the children said to them was not given sufficient weight or adequately explored. This included the description of Alison as clumsy and Mary expressing that she was not allowed to tell the truth. The Foster Carers felt their views and experience were not given sufficient weight or that they were listened to.

8.9.2. The CTSW's contact with the children was limited by it initially being virtual and then when in person visits were possible such visits being less than the statutory minimum which at every six weeks is already infrequent. Nottinghamshire procedures say frequency of visits in the first year of being LAC is:

- On the day the child is placed, to assist in the placement process.
- Within one week of the start of the child's first placement and within one week of the start of any subsequent placement.
- Then at intervals of no more than six weeks during the first year of any placement.

8.9.3. The CTSW is described as having a difficult relationship with the children and the foster carers. The SSW acted as an intermediary on occasions. The nature and frequency of the CTSWs contact with the children was not enough to allow the CTSW to form relationships with the children that would help her hear and understand their wishes and feelings. The contact was less than the statutory minimum. Of the CTSWs contacts most were concerned with difficult topics such as the children's time with their birth parents, and discussion of injuries and incidents. There was insufficient time with the children on neutral or fun topics that could help develop the CTSW's relationship with them. The lack of time by the CTSW with the children and the foster carers meant the CTSW did not have a firm basis to understand the experience of the

children in the placement including being able to discuss any issues of concern with the SSW. This lack of time with the children and foster carers impacted on the discussion about future plans for the children and what seemed a rushed consideration of whether the foster carers wanted to care for the children long term and whether they were going to be able to do so. There was a very rapid turnaround from the carers saying they were struggling and could not offer the children longer term care and this becoming the plan.

8.9.4. There was not a good enough understanding of the children's lived experience.

8.10. Were there any gaps in service that may have led to a different outcome? Were there opportunities to have escalated concerns about the level or the quality of response or service being provided?

8.10.1. There were significant gaps in service. These were:

- The lack of choice of foster carers for these children. Other than proximity to home there was no ability to consider the match of these carers to the children's needs.
- The SSW was inexperienced working with inexperienced foster carers and does not appear to have had sufficient supervision and support from the fostering agency that recognised the gaps in the SSW's knowledge and experience.
- The foster carers were not offered either an experienced foster carer as a mentor to support them in their first placement or a fostering support worker to provide advice and support.
- The CTSW though experienced in terms of years post qualified did not give a sense of experience in this area of work. The direct work with the children was inadequate in terms of quality and quantity. It is not clear whether this reflected the CTSWs skills and knowledge or that the worker was struggling with workload in a new team and new LA.
- The CTSW did not grasp the significance of the diagnosis of pancreatitis, and it appeared that in supervision the need for the LA as Alison's "parent" to fully explore how she had a serious

injury to her pancreas and explore this with the treating clinical team was not recognised.

- While the primary responsibility for leading the consideration of Alison's pancreas injury as a non-accidnetal injury was with CSC, when this was not done no one within the medical teams treating her took a lead in challenging CSC that Alison needed a CP medical and or consideration of the injury in a multi-agency forum such as a strategy meeting.

8.10.2 There were opportunities to escalate concerns. These were:

- In the early months of the placement when Alison had a number of minor injuries a fuller consideration of their cause and the nature of issues in her supervision by the foster carers and relationship with her siblings should have been undertaken.
- When Alison developed Pancreatitis. This should have led to a strategy meeting or a multi-agency and multi-disciplinary discussion of the nature of Alison's injury and it possible causes.
- When Alison suffered a broken arm which again raised issues about levels of supervision and relationships with siblings. This opportunity should have included the information from Mary which she gave at school about her experience in the foster home.

9. Single Agency Learning and conclusions.

9.1. NCC Youth, Families and Social Work – Gaps and missed opportunities.

9.1.1. More in person visits by CTSW.

9.1.2. Responding to the requests for more support from the SSW.

9.1.3. August 2020 enquiries not professionally curious

9.1.4. Convening of a strategy meeting in October 2020 in response to pancreatitis

9.1.5. Not progressing the psychological assessment recommended by the permanence team following the sibling assessment.

9.1.6. Not unpicking the sibling relationships and the unusual level of harm to Alison attributed to the siblings

9.2. Fostering Agency.

9.2.1. Ensuring discussions are held with professionals who know most about the children to ensure a full picture of their needs, characteristics etc. are known prior to considering potential matches with carers.

9.2.2. Need for the agency to ensure strong and formalised liaison relationships with all the LAs with which they work.

9.2.3. The importance of protecting fostering agency staff so that their decision-making responsibilities are commensurate with their experience and role.

9.2.4. The agency to reflect on and review the training given on recording and information sharing for foster carers to ensure that all carers understand the importance and relevance of this.

9.3. Nursery and School

9.3.1. The children may have benefited from more considered, consistent and coordinated support in regard to their emotional health and wellbeing.

9.3.2. Whether questioning the explanation of Alison's injuries as being a consequence of clumsiness could have been escalated more effectively.

9.3.3. Whether the opinion others have of the contribution of education settings can quiet the voice of these settings in meetings.

9.3.4. The changes of SW responsibility may have undermined the quality of communication experienced by the education settings.

9.4. Tertiary Hospital

9.4.1. There was little evidence that robust safeguarding discussions and advice were sought or that the differing medical professionals all came together to collate the findings from their investigations of Alison's pancreatitis.

9.4.2. No evidence of the surgical team and the CTSW ever having a face-to-face discussion.

9.4.3. The body map completed at the district general hospital show that the injuries to Alison were numerous and at best due to inadequate supervision from her carers or at worst inflicted.

9.4.4. Little evidence Alison was spoken to alone.

9.4.5. Information sharing within the tertiary hospital was fragmented. Advice and discussion should have been sought from named professionals and the SGT by those responsible for her care.

9.5. Actions completed by the tertiary hospital

9.5.1. Case investigated by DATIX system and discussions had with the surgical team.

9.5.2. An additional safeguarding training session for the paediatric surgical team has been facilitated by the Named Doctor Safeguarding Children and Named Nurse Safeguarding Children.

9.5.3. Tertiary Hospital children's safeguarding team will contact their safeguarding colleagues from other organisations when a child is transferred to Tertiary Hospital for whom there are safeguarding concerns.

9.6. District General Hospital Trust.

9.6.1. The initial concerns about the injuries Alison sustained in October 2020 when she was presented at the district general hospital should have led to a strategy discussion. A strategy discussion would have provided a clear route for the decision of whether a CP medical was required or not.

9.6.2. The District General Hospital Trust Safeguarding team to review transfer and handover processes to ensure safeguarding is fully handed over and documented.

9.6.3. To strengthen the use of terminology within existing training packages when discussing cases with CSC so as not to minimise concerns.

9.7. Nottinghamshire Healthcare NHS Foundation Trust.

9.7.1. For the Voice of the Child Pathway to include clear timeframes for initiation.

9.7.2. For the Voice of the Child Contact pathway to be fully embedded in operational practice.

9.7.3. For practitioners to be reminded of the importance of professional challenge, the use of supervision and escalation when working with a case where there may be differing professional opinions.

9.7.4. For practitioners to be reminded of the importance of professional curiosity when presented with unclear information.

9.7.5. CAMHs Children Looked After and Adoption Team consultation reports to be routinely shared with the Healthy Family Team of the healthcare trust.

9.8. Nottingham and Nottinghamshire CCG

Actions completed by CCG

9.8.1. The communication relating to seeing children and vulnerable people face to face after initial triage assessment was cascaded again and reiterated at the GP Safeguarding Leads learning and development session in July 2020.

9.8.2. GP practice to reflect on the case with reference to considering missed opportunity and consider the learning noted about communication with the multi-agency team when children who are Looked After are registered with the practice.

9.8.3. In July 2021 GP Safeguarding Leads received a briefing about LAC and Primary Care responsibilities with the expectation that this is then cascade within the practices by the leads. The sessions were delivered by the Specialist Practitioner for Primary Care and LAC and additional updates and information will be added to sessions.

Learning:

9.8.4. Concerns about the presentation of a situation for a Looked after Child should be referred to Social Care as a safeguarding concern. According to the multi-agency policy and procedures the following should happen: **“When new information comes to light regarding a child that is already open to children social care it is the responsibility of the allocated social worker to arrange a strategy discussion/meeting promptly”.**

With reference to this case the GP wasn’t alerted. Currently the MASH health team wouldn’t have received the referral as the case was already open to CSC. The author suggests that the multi-agency guidance is reviewed to ensure that they are robust and that we are assured all key professionals are included in strategy discussions.

9.8.5. When new referrals on open cases are received by the MASH, we need to ensure that GP and all relevant professionals are made aware.

9.8.6. When sibling groups are registered and identified to be placed in the same foster care placement for all checks on records to reflect accurate details and be cross referenced.

9.9. Nottinghamshire GP out of hours service

9.9.1. No specific learning or conclusions.

10. Partnership Learning

10.1. The importance of recognising when to follow safeguarding processes on open cases when there is uncertainty about the cause of an injury or other harm that a child has suffered.

10.2. The importance of the availability of services that address adverse childhood experiences and which can help mitigate the impact on children of those experiences.

10.3. The importance of ensuring that formal meetings are effective in their primary purpose and do not become exercises to be completed.

10.4. That staff or carer inexperience may affect service delivery and that additional support and systems may be necessary to maintain service standards and quality.

11. Recommendations.

11.1. The Partnership is provided with information from NCC on the difficulties of securing placements for children and what NCC is doing about this problem including improving the timeliness of placement requests

11.2. The Partnership to ensure that the pathways for communication between CSC SWs and NHS acute children's services are clear. This pathway should include clarity about who can provide authoritative information about safeguarding concerns, including the progress of child protection enquiries and related medical assessments, and about the treatment and health of looked after children in acute hospital settings.

11.3. The partnership seek assurance that transfer arrangements between acute health services include explicit reference to safeguarding concerns where these are present.

11.4. The partnership is aware from a more recent rapid review and a strategy discussion audit that in some situations, such as for Alison, the procedures are not being adequately followed when new concerns arise for some looked after children and children with ongoing statutory involvement.

The partnership should develop a SMART action plan to address how new concerns are responded to for looked after children, which should include effective multi-agency communication and consistent application of the relevant procedures about strategy discussions and discharge planning meetings.

Colin Green
28th December 2022
Independent Review Author