1 Background and Concerns

Five children, aged between 8 years and 15 years with a long background of Children's Social Care involvement around physical harm/ domestic abuse, history of numerous injuries over the years which appear accidental but unexplained and indicating lacking supervision or chaotic household. In October.2020 child 7 disclosed at school he had witnessed domestic abuse between his mother and her partner and alleged he and child 6 suffered physical abuse from mother's partner. CSC /police completed a joint visit and proposed that mother's partner leave the home and not have contact with the children until further assessments were completed. Mother's partner refused and became very aggressive, in front of the children. Extended family members attempted to obstruct police and social workers. Child 5 had a suspected broken collarbone and medical assistance had not been sought, his grandparents state this happened when mother's partner was at work and child 5 was in his mother's care. The Children were made subject to Police Protection and became looked after

2 Purpose of the Review?

The purpose of a Line-of-Sight review is to identify learning for the multi-agency partnership which will strengthen the safeguarding system. Beyond individual cases reviews they also provide a window into wider systems (ways of working/ processes) which may need to be changed. In this case it was felt that there was an opportunity for learning and practice improvements in several areas.

3 Key Lines of Enquiry

- Were the voices of the children gained in the context of the injuries when no clear evidence of significant harm
- If the information had been compiled in a multiagency chronology, would the course of action have changed
- Impact of mother's behaviour and non - engagement drawing the focus to her needs on the children

4 Key Practice Episodes

Expected good practice

- Good communication of safeguarding concerns by probation and partnership working between FFP and school.
- Chronology of past services completed prior to the case being allocated.
- Timely Initial Health Assessment, Health Care Plan based on assessed need

Areas for improvement

- Police investigations and VRI being focused on potential to charge as opposed to safeguarding welfare and use in family court.
- Use of a Health chronology could have identified the level of DNAs and injuries at an earlier stage.
- Dental decay not seen as a sign of neglect by involved agencies.
- The family were viewed at a universal level family by the health visitor and should have been assessed as needing targeted support.
- Voice of the child was difficult to assess due to chaotic home environment.
- Focus by agencies on parental issues, parental behaviour impacted on the level of challenge provided by agencies.
- The children experienced a high level of injuries over a period of time which were not fully assessed in the context of the home environment and parenting.
- The urgency of the need to complete the viability assessment impacted on its quality.
- Lack of collated chronology across health in respect of dental delay, DNAs and childhood injuries.

5 Learning

Chronologies: Ensure managers have oversight of the line-of-sight chronologies that are submitted as part of the review.
Interface between Childrens Public Health provision and the Children Looked After Team: No formal agreement in place with NLAG and the LA as to who will lead on certain aspects of health when a child becomes looked after and no formal agreed handover.
Dental neglect: Dental issues were recognised as neglect and should have been picked up earlier. Inconsistent use of the neglect tool GCP.
School readiness: There were several issues that should have been picked up as part of school readiness including, injuries re lack of supervision, dental decay and development.
Child's voice: There was evidence of the voice of the child being captured by agencies, but difficult to assess due to the chaotic home environment.
Achieving best evidence: Child 7 not given the opportunity to give a video recorded interview as part of the section 47.
Strategy discussions: Confusion around police attendance at strategy meetings was identified and differences between the recording by CSC and the police re the reason for this.
Resistant parenting: Mother's behaviour was felt to be a reflection of her reluctance to engage with agencies on a meaningful level which resulted focus on mothers needs rather than the children.
Viability Assessment of family for placements: Identified relief that the children were placed with extended family however need to ensure the family placement is appropriate and the dynamics within the family relationships are understood.
Terminology: Reference to mum led to confusion with probation believing this was grandmother rather than mother. Names should be used and recorded.

6 Progress/Impact

Recommendations and action plan have been developed which includes:

- Birth to 5 years is concentrating on school readiness.
- The Early years preventative work is looking at dental decay.
- Reconsider content of the commissioning agreement between NLAG and CPHP.
- Update plans by the police to provided Specialist Child Abuse Investigation Development training (SCAIDP) to staff within the integrated front door
- The LOS case info chronology to be reviewed to include managers signature and record of sign off

7 Further information

- Line of Sight process
- Threshold of Need
- Referral Process
- SCP Training
- SCP Policies & Procedures