Derby City Safeguarding Children Board

Serious Case Review Overview report in respect of:

Child FD17

FINAL

Glenys Johnston OBE
Director Octavia Associates Limited

	Contents	Page

1.0 Introduction

1.1 On 25th November 2016 Derby City Council decided that the criteria for a serious incident notification to Ofsted were met and they notified Ofsted on 27th November 2016. The Derby Safeguarding Children Board serious case review panel considered the serious incident notification at meetings on the 12th December 2016 and the 16th January 2017.

1.2 On 30th January 2017, Christine Cassell, the Independent Chair of Derby Safeguarding Children Board, commissioned a serious case review into the involvement, care, and support of agencies in relation to a child, referred to in this report as Child 1, to identify any learning that may arise.

1.3 The concerns that led to this review were in relation to severe burns to the legs of nine-year old Child 1, thought to be caused by scalding from hot water in a bath or shower and the failure of his parents to seek medical attention, which resulted in severe and life-threatening infection.

1.4 Following the incident which led to the serious case review, several concerns were also identified about the care of the youngest child, Child 6, who had signs of significant neglect.

1.5 All the children were made subject to Interim Care Orders in favour of Derby City Council until 25th August 2017, by which time, the children had been returned to Slovakia to the care of their grandparents; at that point the Interim Care Orders were discharged.

1.6 On 13th July 2017 at Derby Crown Court the child's mother and father were charged with the neglect of Child 1 and his brother Child 6 to which they pleaded guilty, they were given 20-month prison sentences, suspended for two years.

2.0 The Serious Case Review Process

2.1 Derby Safeguarding Children Board decided that the most appropriate method of conducting the review was by using the extended Child Practice Review Model set out in *Protecting Children in Wales; Guidance for Arrangements for Multi-agency Child Practice Reviews (Welsh Government 2012)* as permitted by Department for Education (DfE) guidance. This model includes a multi-agency chronology, individual agency initial case summary and analysis reports and multi-agency meetings with the practitioners and managers involved in the case, to seek their views of what happened and why, and secure the most comprehensive information from a number of perspectives. The process also includes consultation with the family.

2.2 The purpose of the review is to:

- Determine whether decisions and actions in the case complied with the policy and procedures of named services and Derby Safeguarding Children Board.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were child focused.

- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources.

To protect the identity of the family, the following pseudonyms have been used

- Father
- Mother
- Child 1, the subject of the review, born July 2007
- Child 2, born March 2002
- Child 3, born February 2004
- Child 4, born July 2005
- Child 5, born April 2014
- Child 6, born August 2016
- Child 7 oldest sibling (date of birth unknown) lives in Slovakia

The full terms of reference are included at Appendix 1

2.3 I, Glenys Johnston OBE, Director, Octavia Associates Limited am the independent author of this report. I have extensive experience in social work practice, chairing Local Safeguarding Children Boards, reviewing and inspecting children's services and carrying out serious case reviews, I have previously undertaken serious case reviews for Derby Safeguarding Children Board, but I have had no involvement with this case.

2.4 A serious case review panel was established to provide oversight of the process and support me, as the overview author, this Panel met regularly and was made up of:

- Children's Social Care, Derby City Council – Service Director of Early Help and Children's Safeguarding
- Derbyshire Police - Detective Chief Inspector
- Learning and Skills Department, Derby City Council - Head Teacher of Virtual School for Looked After Children
- Derby Teaching Hospitals NHS Foundation - Trust Safeguarding Lead
- Derbyshire Healthcare Foundation Trust – Head of Safeguarding Children's Service
- Housing - Tenancy Sustainability and Safeguarding Manager
- Designated Doctor Southern Derbyshire Clinical Commissioning Group
- Designated Nurse Southern Derbyshire Clinical Commissioning Group

2.5 Each agency that was involved with the family was asked to undertake an internal review by a member of staff who had not previously had involvement in the case and provide an individual agency initial case summary and analysis report. These were critically reviewed by the Panel and further information was sought where necessary.

3.0 Context

3.1 Derby City is a multi-cultural city in the Midlands of England. Approximately 59,400 children and young people under the age of 18 years live in the City, this is 23.2% of the total population of the area. Of these children, approximately 25%, aged under 16 years, are living in low-income families. The proportion of children entitled to free school meals in primary schools is 16% (the national average is 14%) and in secondary schools it is 14% (the national average is 13%).

3.2 Children and young people from minority ethnic groups account for 24.7% of all children living in the area, compared with 21% in England. The largest minority ethnic groups of children and young people are (Asian/Asian British) Pakistani and (Asian/Asian British) Indian. The proportion of children and young people with English as an additional language, in primary schools is 27.6% (the national average is 20%) and in secondary schools it is 21% (the national average is 16.2%).

3.3 On 31st March 2017, there were 2,742 children in need in the City, this figure includes children subject to child protection plans and children in care, which equates to a rate of 461.6 per 10,000, which is higher than the comparator average in 2015-16 which was 385.3.

3.4 On 31st March 2017, 368 children in Derby had a child protection plan, this equates to a rate of 61.9 per 10,000 children, of these 2.3% were in relation to children from Roma families. This is higher than both the national (43.1) and comparator (50.7) averages in 2015-16, due to an increase of 54 plans being open at the end of the year.

3.5 Roma families in Derby tend to live closely together, so their children attend the same schools, where they represent a significant percentage of the total pupil numbers, 32% of children attending School A are from Roma families and 16% attend School B.

3.6 Ofsted inspected children's services in 2017 and judged the service to be 'Good' and the Derby Safe Guarding Children Board to be 'Outstanding'.

4.0 Summary of Background and Events

4.1 Child 1, the subject of the review was born in 2007; he lived with his parents and five siblings who are, at the date of this report, between fifteen and almost one years of age. Child 1, his four siblings and his parents came from Slovakia to live in Derby City in October 2015, Child 6 was born in Derby in 2016. The family are of Roma Slovakian heritage.

4.2 A combined chronology of the involvement of all agencies was produced from which the following key events have been extracted:

08/01/2016: An assistant health visitor practitioner and Derbyshire Fire and Rescue Service visited the property to see another family, they met mother and her five children on the doorstep of the family home and she explained that they were the new occupants of the house. Mother would not allow entry to the property and

appeared worried, saying her husband was at work. She said the family, four school-aged children and a toddler, had been in Derby for three months but she was reluctant to give the children's names. The family were not previously known to the health team, but mother agreed they could return for a health visit when her husband was at home.

21/01/2016: Child 1 and CH 4 were enrolled at School A.

24/01/2016: The Police were informed that a young child had been seen walking alone on the street near the family home. None of the child's siblings were at school.

10/02/2016: School A completed a non-verbal ability test on Child 1 and identified the lowest score ever recorded in school, he was eight years and seven months old on the day of test and had a score of a child under five years of age.

15/02/2016: The health visitor and the assistant health visitor practitioner undertook an initial home visit, the family were found to be living in a four bedroomed, privately rented house, sparsely furnished, in need of decoration, without smoke alarms and the front entrance needed to be repaired. Mother's brother-in-law stated that the children were registered with a GP and the health visitor discussed the need for the family to register with dentists and opticians. Mother reported no current concerns regarding the children, who were seen appropriately dressed, although a little unkempt, happy and sociable. No growth checks were completed as the children went outside to play during the visit. Mother and the other adults present were given advice about the children's safety including road safety. Mother gave her consent for information about the family to be shared with other professionals.

19/02/2016: An unannounced, opportunistic visit was made by the assistant health visitor practitioner and Derbyshire Fire and Rescue Service, mother declined a home safety check; several issues about the condition of the house were identified and a referral was made to Housing Standards.

22/02/2016: Child 2 and Child 3 were enrolled at School B.

3/03/2016: The assistant health visitor practitioner visited to complete GP registration forms which were not completed as mother was unable to remember the family's previous address. Child 1 and Child 4 absconded from school and were collected and returned to school by staff

09/03/2016: The assistant health visitor practitioner assisted mother to complete GP registration forms. Child 5 was noted to be at home, having been left there alone whilst mother accompanied the other children to school. School A contacted Children's Social Care to inform them and were advised to offer the family an early help assessment which was declined by the parents. Mother was advised to contact the New Communities Achievement Team for support and advice but this was not followed up by her.

10/03/2016: Child 5 aged two, was left at home, as it was raining, whilst mother accompanied her other children to school. The New Communities Achievement

Team support worker advised mother that this was unacceptable, and Children's Social Care and the Police were subsequently informed.

17/03/2016: Police were informed by school that Child 3 was not in school and had been seen trying to sell a bicycle, which it was thought he did not own.

21/03/2016: Child 4 was not in school, having been left at home to look after Child 5. Mother was again warned about the inappropriateness of leaving children at home alone.

05/04/2016: Children's Social Care convened a Section 47 strategy discussion with the Children's Social Care manager and the named nurse, the Police were not invited, and the children were not seen the same day.

07/04/2016: Housing visited the family home, all the children were seen at home without their parents, no referral was made to Children's Social Care however, a home visit was made by a Children's Social Care reception social worker who used Language Line to discuss the concerns about leaving the children alone, with the parents.

11/04/2016: The children did not return to school, following the Easter holidays and were not in school for the following two weeks.

13/04/2016: Father informed New Communities Achievement Team that his family had moved to Dover; he refused to provide their address.

14/04/2016: Children's Social Care decided to undertake a single assessment, although allocation of this work was delayed until 24th April as the social worker was on leave. The family were seen in Derby, so they were not in Dover, as father had stated on the previous day.

15/04/2016: Child 2 and Child 3 were not in school.

22/04/2016: Information from Children's Social Care records indicate that it became known that mother was pregnant, with Child 6.

27/04/2016: Children's Social Care visited and discovered the family were not registered with a GP, mother was advised to access ante-natal care. The education welfare officer (EWO) advised Children's Social Care of the children's poor school attendance.

28/04/2016: Children's Social Care became aware that the family had been known to move around Bradford and Derby, no information was sought from Bradford Children's Services. Children's Social Care asked School A to complete an early help assessment and arrange a team around the family meeting to develop a plan, no network meeting was held to discuss the level of support being provided by New Communities Achievement Team or how effective monitoring would take place.

29/04/2016: Children's Social Care closed the case.

04/05/2016: Child 5 was left at home alone. The family were still not registered with a GP. Children's Social Care requested a Section 47 strategy meeting with health and the Police, no referral was made to New Communities Achievement Team for support.

05/5/2016: Section 47 strategy discussion held, there was no involvement of schools or New Communities Achievement Team

26/05/2016: An initial child protection conference was held, the children were made subject to child protection plans under the category of neglect. A week later the case was allocated to a new social worker.

07/06/2016: The first Core Group meeting did not take place as an interpreter had not been arranged.

10/06/2016: Family GP registration was completed.

14/06/2016: The re-convened first core group was not held as the social worker was unavailable.

30/06/2016: A core group was held but incomplete as the parents did not attend, however, concerns were shared with those present.

11/07/2016: Children's Social Care contacted the Slovakian Authorities for information about the family. Significant information was subsequently provided (on 13th December) about previous concerns of neglect. Child 3 had sustained significant burns after falling in a fire and the family's first child, Child 7, was removed by the authorities and remained in Slovakia. All the children were given immunisations at the GP surgery, with support from an interpreter.

13/07/2016: A safeguarding GP practice review meeting was held to consider the concerns about the children, agreement was made to share information between the GP and the Derby Integrated Family Health Service health records.

27/07/2016: A pre-birth assessment was completed on unborn, Child 6.

03/08/2016: The health visitor visited the home and completed a growth and development review for CH5 and an antenatal contact for mother. The assessment identified that Child 5's needs were being partially met although the skin could have been cleaner; the family were registered with a GP and were accessing services with support. There was evidence of emotional warmth between Child 5 and mother.

16/08/2016: Child 1 and Child 4's names were deducted (removed) from GP registration as mother and father had not responded to letters sent to them. The GP practice was not aware that the children were subject to child protection plans.

17/08/2016: A review child protection conference was held, schools were represented by an education welfare officer, teaching staff provided reports but did

not attend due to school holidays; the children were stepped down to 'child in need' plans.

24/08/2016: Child 5 was seen alone on the street.

31/08/2016: Child 6 was born; maternity staff became aware of the involvement of Children's Social Care from mother who said this was due to non-school attendance. Police visited the family due to theft of bicycles, damage to a car and Child 1 urinating in public.

05/09/2016: Child 4 did not attend the first day at School B.

06/09/2016: All three older boys attended School B but with no uniform or equipment; on the same day, Child 3 left school without permission and Child 2 and Child 3 stole a bicycle from the school bike shed, the Police were informed.

12/09/2016: Child 2 and Child 3 left School B without permission, Child 4 swore at a member of school staff, Child 6 was not taken for a hearing test, and the social worker observed Child 6 to have a pillow and a quilt and explained the inappropriateness of this to mother.

14/09/2016: Child 3 left School B without permission. The health visitor completed a new born hearing test on Child 6, the records note that the baby's needs were being met by the family, no nappy rash was noted but safe sleeping would need to be reviewed in the next visit.

15/09/2016-4/10/2016: The older children's behaviour became increasingly challenging, they variously left school without permission and on one occasion Child 3 was returned to school by an unknown man and they were found smoking in school.

03/10/2016: Child 1 and Child 4 were re-registered at the GP practice.

05/10/2016: A child in need network meeting was held; concerns were raised about the older children's poor academic attainment and their anti-social behaviour. School B asked about escalating the concerns to child protection. Father was told that unless he and mother engaged with services by the next child in need meeting the children's names would be returned to a child protection plan.

06/10/2016: Child 2, aged 14, touched a female student's bottom.

06/10/2016-09/11/2016: School A attempted to meet the needs of Child 1 with a part-time timetable etc. The older children continued to be challenging in school, leaving the premises without permission and smoking. The Police received information that Child 2 and Child 3 were believed to be part of a gang and were carrying knives and stealing bicycles. Mother and father intermittently engaged with professionals but on occasions, the children were not taken to health appointments.

12/10/2016: The health visitor made a six-eight week visit to Child 6, the records comment that the baby's basic needs were being met; Mother was seen to be an

experienced parent who appeared to have a good level of support available locally, but the health visitor was slightly concerned about her level of understanding of the information she provided. Child 6's weight gain had slowed a little and would require review in two weeks; the nappy area was sore with an inflamed rash on the buttocks but also extending down legs from the groin, the health visitor prescribed 1% Clotrimazole cream, its appropriate use, when to stop and when to seek a GP review. No further concerns were recorded.

27/10/2016: Home visit by the health visitor, who recorded her observations; Child 6 was an alert active baby and there was good weight gain, following the 9th centile, some remaining skin inflammation on the abdomen, under the axilla and to the head and neck. The health visitor advised mother to increase the strength of Child 6's feeds and gave advice on hygiene, bathing and the use of the skin cream.

31/10/2016: Last visit by health visitor to see Child 6 and complete an assessment of needs review, she recorded that the baby's needs were being partially met. She discussed the missed GP appointment which mother had asked to be made and the importance of not leaving the baby on sofa with only the younger children to supervise.

07/11/2016: Child 1 was seen by the social worker; this was the last time CH1 was seen by a professional before the injury to CH1 was found.

09/11/2016: Child 1, who had not been in school since term resumed after the autumn half-term holiday on 31/10/2016, was reported to New Communities Achievement Team by his father to have scalded his feet in the bath and was being treated with 'gels' from the GP, and as a result, he would not be in school for a few days. It is therefore considered likely that the burns occurred on or just before this date. The information was noted in the safeguarding records of School A but not referred to Children's Social Care by them or New Communities Achievement Team.

10/11/2016: Child 2, Child 3 and Child 4 were on reduced timetables at school and at this point they were attending as follows: Child 2: 76%, Child 3:63% and Child 4: 71%.

11/11/2016 (a Friday): An email was sent to Child 1's social worker from the care and guidance team leader (C&GTL) at School B, raising, amongst other issues, his being off school because of burns to his feet. A visit was carried out by the care and guidance team leader to discuss a sibling who had truanted from School B. Child 1 was not seen and was reported by mother to be at his aunt's house. The care and guidance team leader was told that Child 1 would not be in school for a further four weeks, due to the burns. This additional detail was also communicated by email to the social worker.

15/11/16: The social worker undertook a home visit, but no one answered the door and it is not known if anyone was at home. The social worker picked up the email which had been sent on the 11th November, but not seen by her, as she was out of the office and had no mobile 'phone on which to access email.

16/11/16: A child in need network meeting was held at School A, following which, the social worker made two unsuccessful attempts, to see Child 1 at home. At the first visit, no one answered the door. On the second occasion, the social worker was told by mother and a sibling, that Child 1was in Slovakia with his father.

17/11/16: The social worker visited again but was there was no response. The education welfare officer subsequently told the social worker that father had been seen in Derby that day, so he was not in Slovakia as reported.

18/11/16: The social worker saw the older siblings in school with an interpreter who confirmed Child 1 was still at home, as a result, the social worker visited the home and gained access. She found Child 1 in extreme pain and visibly shaking. He had burns on his legs which had not been treated and appeared infected and he could not walk. The social worker took him to hospital immediately and he was then transferred to the Nottingham Burns' Unit.

18/11/16: Following Child 1's admission to hospital, the Police obtained Police Protection Powers to safeguard all five siblings.

18/11/2016: Derby Teaching Hospitals Foundation Trust completed a child protection medical on Child 6 which identified significant indicators of neglect.

18/11/2016: A Section 47 strategy meeting was held.

19/11/2016. Child 2 and Child 3 left their foster home and made their way home overnight. Child 3 was later discovered to have significant self-harm marks on his body and said he took drugs to reduce the pain caused by his self-harm.

21/11/2016: Child 1, Child 5 and Child 6 were made subject to Interim Care Orders in favour of Derby City Council and remained in foster care. Child 3, Child 4 and Child 5 were made subject to Interim Supervision Orders and remained in the care of their parents.

22/11/2016: Child 5 was examined by the GP.

23/11/2016 Child 5 was examined by a Community Paediatrician.

4/12/2016: An invitation to an initial child protection conference was received by agencies.

5.0 Feedback from the practitioners' and managers' events

5.1 On the 5th June 2017, a practitioners' event was held as part of the serious case review. Professionals from a wide range of services who had been involved with the case attended, except for the social worker, due to ill health; she was seen separately by me on 22nd August 2017, her views are largely consistent with the practitioners at the meeting on the 5th June and any different points have been incorporated. Attendees were provided with the key events from the multi-agency chronology and the discussion addressed the key issues in the terms of reference.

5.2 Derby Safeguarding Children Board and I are very appreciative of the way practitioners engaged in the discussion and sought to identify why things did or did not happen. Their reflectiveness and focus on learning is commendable however, please note that the views summarised below, are theirs and are not necessarily shared by me.

Assessment

Was previous relevant information or history about the child and/or family members known and considered in assessment, planning and decision-making?

- The capacity to seek previous relevant information about children who come into Derby City was identified as 'challenging'.

- Practitioners found the parents reluctant to share their history and information with them, this was said not to be unusual with Roma families who are anxious about what use will be made of the information, i.e. will it lead to their children being removed from their care?

- Schools are unable to see children for whom places are applied for, if they do not live in Derby before they join the school; schools are reliant on families informing them that their children attended a previous school and where, there is no national database to check where children have attended, and GPs do not have the capacity to see every new patient for an introductory meeting and gather background information.

- New Communities Achievement Team has learned that families from the Roma community are sometimes reluctant to engage with them because they see them as part of the community and therefore they leave families to seek information, when they are ready to do so. It was difficult to use New Communities Achievement Team to fully support the family as the worker's hours did not coincide with father's, who worked night shifts.

- The social worker did not contact the Slovakian Welfare Authorities, although she wanted to, as she did not receive advice on how to do so by her managers. The information once acquired was significant.

- Midwifery services tried to find out information about the family from Children's Social Care, whose response focussed on the school attendance rather than broader concerns about neglect; this is not accepted by the social worker who is sure she would have shared information about neglect and children being left unsupervised. However, the midwife should have been invited to child protection and child in need meetings.

- It was noted that there does not seem to be a good system for making sure community Police are aware of addresses and the names of families, where there are child protection plans in place. There was a lot of contact with them via the Safer Neighbourhood Team but in this case, it was unclear what they knew of the concerns about the family; had they done so this would have helped in gathering a more informed view of the poor supervision of the

children and neglect issues. It was noted that local intelligence officers brief the team on a weekly basis and this should be checked to ensure the right information is getting through to officers.

How effective was the assessment of mother's understanding of professional concerns and her ability and willingness to address these?

- Professionals recognised that there was not a shared understanding of mother's capacity to understand the concerns of professionals and if she did, whether she could address them. They felt that the ability to get a parenting assessment at an early stage, particularly when language difficulties are a factor is limited, unless this is secured as a part of care proceedings and ordered by the Court.

- Professionals were of the view that the family were not isolated as mother's sister was living on the same street and another sister was around for a while, professionals assumed that this would provide some additional parenting support.

- Romanes is a distinct language with different dialects however, there are a limited number of qualified Roma interpreters as Romanes is not a language for which interpreter services have been commissioned in Derby City.

- Practitioners felt that father could communicate in Slovakian and he had a reasonable command of English. Mother's behaviour also indicated that she had some limited understanding of Slovak. Some practitioners held the view that there was a "selective" understanding of Slovak by the parents, depending on the context of what was being discussed.

How effectively were agencies able to contribute to the analysis of risk and safeguarding concerns both at the point of the decision to remove the children from child protection plans and in the period following the de-escalation from child protection plan to child in need status?

- School A staff observed that although appropriate issues were included in the child protection plan, there was insufficient consideration of the difficulties and effectiveness by the core group and the implementation of the plan was not monitored or updated, as events changed, and concerns increased; they did not think the children should have been stepped down to children in need. They reflected that whilst they had submitted information to the review child protection conference, they did not escalate their concerns on hearing, when the summer holidays ended, that the children's names had been removed from child protection plans and should have done so. They reflected that the learning from this case has made them clearer about escalation and their responsibility to do so.

- The Police did not attend the review child protection conference and this is usual in Derby City. However, a question was raised about how the Police should be informed if their attendance is required. The Police did attend the child in need network meeting.

- Neither the GP or midwifery service received an invitation to be involved in the pre-birth assessment of the un-born baby, Child 6

- There was some unfamiliarity with the Derby Safeguarding Children Board process of raising a case with a Child Protection Manager either about a child protection concern or to bring forward a child protection conference. Practitioners reflected that discussion about this case had emphasised the need for everyone to take responsibility for escalating concerns and satisfying themselves that actions have been taken.

- Some attendees were not aware that when they pass concerns verbally to Children's Social Care or leave a message, these should always be confirmed in writing.

- In respect of the incident where Child 5 was found on the street, after the children's names had been removed from the child protection plan, there was recognition that leaving a message for a social worker is not the same as making a written referral, and this is something that would be done in future.

- There were views from professionals at the review child protection conference, that the points of views of attendees were listened to and informed the decision to remove the children's names from child protection plans however, there was insufficient recognition that there had been deteriorations by that point.

Plans

- Practitioners thought that the child protection and child in need plans seemed to be very responsive on a day to day basis but did not capture the wider picture. It was suggested that had there been more monitoring of the overall aims and tasks for the plans, this may have led to better engagement.

- Roma Complex Case meetings no longer occur. Previously they had provided the opportunity for multi-agency discussion about families who needed support and or monitoring. It was felt that this has had an impact on the ability of practitioners to liaise and discuss concerns about local families and make sure the right plans and links are established between relevant agencies.

- Practitioners felt that the decommissioning of the Specialist Health Visitor role (including the Assertive Outreach Team for New and Emerging Communities), the Language Centre and the Roma Complex Case Meetings had collectively made the job of engagement with the Roma community more difficult.

Barriers, Staff Support and Supervision

- Health practitioners felt that their staff support and supervision arrangements are in place and effective, in their organisation, there are criteria for mandatory discussions of priority cases in supervision, for example children who are the subject of a child protection plan.

- There was a question about whether all other agencies have identified those categories of risk that must be discussed at every supervision meeting.

- The schools involved in this case had weekly meetings at which the designated safeguarding lead was present, and they were therefore able to discuss the concern emerging in school, including in relation to this case.

- It was noted that awareness raising events are in place for parents and families in the community. This is to help them understand the services that are available, as well as the expectations of their living in the UK, if they are new to the country

- Given all the difficulties that had occurred, practitioners felt that it was a testament to the good work done with the family that they had stayed in the area

- There was a view that there were some positive relationships with the family with a determination to work with the family and improve school attendance and attainment and access to services

- School A has invested in support from New Communities Achievement Team with a member of staff available to parents every day to try and help them with a diverse range of needs and requests.

- Practitioners noted that this case illustrated the challenges of supporting one family with several children which meant children could not easily be spoken to alone, and there are many others with similar complex needs, hence previous comments about the significant impact of the decommissioning of specialist services for families and professionals working with new, emerging communities

Feedback from the Managers' event

5.3 On 5th June 2016, a separate event was held to gather the views of managers involved in this case. A wide range of agencies, including Children's Social Care was represented. Again, the engagement of all attendees was commendable and their reflectiveness in identifying why actions happened has led to good learning. The Derby Safeguarding Children Board and I are fully appreciative of their contribution.

5.4 The following points were noted from the discussion; they are not all endorsed by me.

Assessment

- Children's Social Care did not gather information from the Slovakian Authorities when child protection concerns emerged and therefore significant information, subsequently gathered during the proceedings in the family court was not known to them. Clearly the new and additional information about the neglect of the children in Slovakia has a bearing on the assessment and the "culpability" of the parents.

- The single assessment was not routinely shared with other agencies. This is contrary to the Children's Social Care guidance for staff. There is an issue as to whether this should be included in Derby and Derbyshire Safeguarding Children Board Safeguarding Children Procedures.

- In respect of the Specialist Health Visitor role (as part of the Assertive Outreach Team for New and Emerging Communities), it was suggested that the previous post holder had made a significant contribution to the support of Roma families in Derby and the loss of this post has had a detrimental impact.

- In terms of the assessment of needs, it was suggested that arrangements are in place for new arrivals to Derby and that school admissions are being managed with contact being made with parents.

How effective was the assessment of mother's understanding of professionals' concerns and her ability and willingness to address these?

- There was a view that mother did have capacity but that she needed things explained to her in a simple and straightforward way, for example she had difficulty telling the time by looking at a clock, but could manage to attend appointments on time, when she wanted to.

- Whilst Roma is the family's main language, both schools felt that both mother and father had been left in no doubt about the need for the supervision of Child 5 and that it was not acceptable to leave her on her own.

Plans

- There was a general view that, on reflection, the right issues had not been in the child protection and child in need plans and that the core group had been ineffective.

- There was agreement that it would be helpful to obtain an update of the frequency of visits by the health visitor and midwife between the end of the child protection plan and the incident that gave rise to the serious case review, to assess whether this had been appropriate.

- It was hypothesised that the review child protection conference's decision to remove the children's names from child protection plans, may have been interpreted by agencies as the end of the concerns and led professionals to be less worried.

Barriers, Staff Support and Supervision

- On reflection, it was noted that in this case there may have been the need to support the social worker more fully and that they may have felt isolated and unfamiliar with Roma culture and the complex and challenges presented by families like this: this view was not shared by the social worker who said she had worked with several Roma families and was familiar with their culture and

beliefs, although the number of children in the family made it difficult to see them separately.

- There were opportunities to co-work closely with schools who have many Roma families and draw on their understanding of this community and the community's confidence and familiarity with schools in Derby.

6.0 The engagement of the family

6.1 From the outset of the serious case review, Derby Safeguarding Children Board were committed to seeking the views of the family and two carefully planned meetings were convened by the social worker for me to meet them. Mother and father attended the first meeting on time but were unable to stay for more than a few minutes, they did not attend the second meeting and when an interpreter telephoned father, he said neither he nor his wife would be attending the meeting and they did not want any further meetings with me to be arranged.

6.2 It has therefore not been possible to gather the views from the family about the services they received.

7.0 Diversity and cultural issues

7.1 To understand the events that took place, it is helpful to understand the beliefs and culture of Roma Slovakian people. The following is extracted from "Project Education of Roma children in Europe" http://www.coe.int/education/Roma. Slovakian Romas are not a homogenous group, many will have similar beliefs, but some may have changed these over time, nevertheless some aspects of the following explain why Roma Slovak parents may still have deeply held cultural beliefs, even though they seek to adapt to the culture in the UK.

7.2 Roma society is based around the group of close kin, which in most traditional Roma communities forms a single household, in settled communities, members of the extended family share living quarters with the nuclear family. Roma people tend to live a segregated life, apart from the surrounding society through generations and centuries of exclusion and suspicion.

7.3 Traditional Roma families educate their children at home by allowing them to participate in all family activities, including economic activities; children observe, participate, and gradually assume a share of responsibility for the extended household. School is a Gadže institution, it represents everything that outsiders stand for and everything that separates Roma from outsiders: rigid rules, obedience toward a person in authority who is not part of the family, oppression of children's own initiative and withholding responsibility from them, imposition of arbitrary schedules, and perhaps the most difficult of all, the separation of children from the rest of their family, for long hours.

7.4 School is thus seen as potentially, interfering with everyday Roma life. Indeed it is seen as a threat since it removes children from their parents' sphere of influence, and weakens their confidence in the ways and traditions of the Roma household, the school situation thus conflicts with Roma morality, with its protection of the family

unit. Finally, mixing with non-Roma children in adolescence carries with it the danger of liaisons with outsiders that threaten to alienate Roma children from their homes and traditions, and even to separate them from their families permanently through permanent relationships or marriage.

7.5 In many countries of Central and Eastern Europe, integration with other children was limited because of the almost automatic referral of Roma children to special needs schools. Such schools only contributed, however, to the stigmatisation of the Roma, while still disrupting traditional family life and weakening parents' ability to act as successful role models. In most Roma communities, it is now recognised that school cannot be avoided for young children and families reluctantly send their children to primary schools, hoping at least that they will benefit from the opportunity to acquire some key skills such as basic literacy, which can prove useful to the family. Many Roma families recognise the relative freedom of school attendance but may encourage their children to miss school occasionally as a way of signalling that loyalty to the family and participation in important family events has precedence over anything else.

7.6 Parents will attempt to maintain respectful but distanced relationship with the school, always siding with their children in the event of conflict, as yet another way to teach their children the value of mutual support and reciprocal loyalty. Most Roma parents withdraw their children from school before they reach puberty. Parents often give several reasons for this, most commonly cited is the fear of drugs, violence and other threatening behaviour that is often associated with secondary schools especially in deprived areas, another is the fear of alienation from their home environment, and a further, more specific reason is the fear that boys and girls might be called to participate together in sex education classes, which, in the Roma context, would shame them and require much effort to restore their honour in the eyes of others within the Roma community.

7.7 The parents in this case were reluctant to share their views or provide important information, as commented elsewhere, this limited the opportunity for professionals to understand their experience of services, to understand their child rearing practice and their own experience of being parented. This information could have included whether they had any reservations about engaging with services or concerns about the children attending school. Their unwillingness is an important learning point to be understood within some of the broader experiences of Roma Slovakian families.

7.8 The children in this family behaved differently to many of their peers in school, who adapted and settled well, Child 1 was clearly unprepared for school, even being in a building and required intensive 1:1 supervision and support. The older children began leaving school premises or not attending. Professionals who worked with many Roma children in Derby highlighted the difference between this family and many others.

8.0 Analysis and learning

8.1 The following information has been extrapolated from the detailed scrutiny of multi-agency involvement and reflection by practitioners, managers and Panel members. The serious case review panel and I have identified some areas of good

practice and the learning that can be equally derived from these**.** However, several areas have been identified where multi-agency practice could be improved to provide better safeguarding arrangements across agencies in Derby. The following section addresses the key questions posed in the terms of reference.

Was previous relevant information or history about the child and/or family members known and considered in professionals' assessment, planning and decision-making in respect of the child the family and their circumstances?

The period from January to March 2016.

8.2 The family were known to the Police, Housing, the Fire Service, School A, the Health Visiting Service and the New Communities Achievement Team at times between the 8th January and the 9th March 2016 during which concerns about the very young children being left at home alone, being found alone in the street, living in poor housing with no smoke alarms, and not being registered with a GP were noted. None of these were reported to Children's Social Care until the 10th March and the agency reports provided for this review do not include comments as to whether on reflection, and with the benefit of knowing what subsequently happened, this should have happened. In my opinion, the thresholds for referring to Children's Social Care for exploration with partners, were met and the children should have been referred as the incidents occurred. It may be that concerns were seen as issues common to other Roma families, but this was not acceptable, professionals should make decisions about referrals on the basis of each individual child, rather than their view of other families in an area or from a different culture.

8.3 The family first became known to Children's Social Care on 10th March 2016 when School A reported that the previous day, Child 4, aged 10, had stayed at home to look after his two-year old sister and this happened again on the 21st March; the school were advised to complete an early help assessment and the following day New Communities Achievement Team raised concerns and the school were advised by Children's Social Care to speak to the parents which they did, appropriately using an interpreter to explain to the parents that this was not acceptable practice. It was assumed that this action was thought by Children's Social Care to be sufficient as no further action was undertaken until, following a reported concern by housing on the 7th April 2016, that two of the older children and a young girl had been found unsupervised at home and their parents were not expected to return until 7.00 pm, Children's Social Care progressed the case to a referral, and visited the family and the following day, started a single assessment.

8.4 When the single assessment was undertaken some information was provided by schools in relation to the children's poor school attendance; the behaviour, distress and attainment of Child 1, the behaviour and attainment of Child 4 and some of the children being left alone at home. However, the fullest possible information was not sought by Children's Social Care to provide a comprehensive picture.

- No information was sought from the Authorities in Slovakia, I understand that this is not always requested unless the case is in proceedings; it is perceived as an onerous task, information takes time to be provided and it is more difficult if the parents provide limited

information. However, had information been sought from Slovakia previous information about the care of the children i.e. that the eldest child has special needs and is in the care of the Slovakian Authorities, due to concerns about the parents' capacity to cope, (despite additional family support) and their relationship with the child and that Child 3 also experienced significant burns by 'falling into a bonfire', would have been made known. Professionals cannot force parents to reveal information about themselves, but they need to maintain a respectful uncertainty/healthy cynicism about what is being said or withheld, even in the face of resistance from them.

- No information was sought from Bradford where at least Child 2 and Child 3 lived around December 2009 and June 2010, when they were aged seven and five, as GP appointments were made. It is not known whether they attended school in Bradford during this period, but subsequent checks confirmed they were not known to Bradford Children's Social Care.
- No information was sought from the authorities in Dover where they were also thought to have lived.
- The Police held information about previous concerns, an incident of domestic abuse with another woman and alcohol use by Father and low level criminal activity by both parents but disclosure was not sought from the Police by Children's Social Care at the outset, when the first single assessment was being undertaken.

8.5 The single assessment was completed on 26th April 2016, within 20 working days, in accordance with required the timescales of 35 days, Children's Social Care records show that the social worker found it difficult to engage the parents to produce a family history and the language barrier was a constant difficulty throughout.

8.6 The content of the assessment was deemed to be of an acceptable standard by the Children's Social Care author of the individual agency initial case summary and analysis report to this review, although this is debatable given the lack of the above information. It concluded that as there had been no further reported incidents of the children being left unsupervised at home the case would be closed to Children's Social Care and School A would be asked to monitor the situation and support the family through a team around the family, although it was not known whether the family were in agreement with this. By the time the single assessment was completed Children's Social Care were aware that mother was pregnant and had not received any ante-natal care, the family were not registered with a GP and school attendance remained an issue. I support the view of the Children's Social Care author of the individual agency initial case summary and analysis report that these outstanding actions should have been referred to the Vulnerable Children's Meeting for further consideration and the identification of a named professional to lead the monitoring of the situation.

8.7 There is no record that the single assessment was shared with the family or other agencies although Derby City procedures state that:
"The outcomes of the assessment should be:

- discussed with the child and family and provided to them in written form. Exceptions to this are where this might place a child at risk of harm or jeopardize an enquiry;
- taking account of confidentiality, provided to professional referrers and;
- given in writing to the agencies involved in providing services to the child with the action points, review dates and intended outcomes for the named child.

8.8 No further assessment was commissioned to inform the Children's Social Care report to the initial child protection conference and no further work was undertaken with Child 1 who was said to have 'anxious eye contact' and the Children's Social Care conference report was not shared with mother.

8.9 During the period before the initial child protection conference, Children's Social Care and Primary Care knew that mother was pregnant however, no information was shared with the midwife and there was no invitation to attend the conference.

How effective was the assessment of parental learning disability? What impact was there on the effectiveness of engagement with the family arising from communication issues and the specific dialect of Romany used by the family? How did that knowledge contribute to the outcome for the child?

8.10 There was no formal assessment of mother's learning ability and this was said to be due to her reluctance to participate in an assessment. During the early involvement with this family it would probably not have been feasible to provide an assessment of her learning ability or her parenting capacity by someone without appropriate language skills.

8.11 There appear to be differences of professional opinion as to whether mother had learning difficulties, lacked the capacity to parent effectively, did not understand or share the concerns raised by professionals, was dominated by her husband, or was influenced by her previous experience of a child being removed from her in Slovakia. At the practitioner's event, it was mentioned that some professionals thought her understanding of Slovak, as opposed to Romanes, was better than it appeared.

8.12 Effective engagement with the family was affected by their reluctance to share information about their history and the false information they provided, particularly in relation to the care they were giving Child 1 after he was burnt and his whereabouts. This cannot be fully attributable to language difficulties although this was a factor. The Romanes language includes several dialects, there are difficulties securing interpreting support from people with the appropriate skills despite the significant number of Roma families living in parts of the city. Although some Roma people speak Slovak their understanding may not be sufficient for them to fully understand.

8.13 As previously stated, practitioners felt that the decommissioning of the Specialist Health Visitor role, the Language Centre and the Roma Complex Case Meetings had collectively made the job of engagement with the Roma Community more difficult. There was reduced liaison between agencies and awareness of the difficulties within some very complex families. The lack of specialist services meant

that practitioners were less able to draw on expertise and help to ensure that the right services were getting to and were understood by the Roma community.

8.14 The valuable contribution of the New Communities Achievement Team attached to School A must be included in this section, they have excellent knowledge of Roma culture and families in Derby learn to trust them and value the advice and support they give to obtain benefits and find out about services. Whilst they understand the different child rearing practices in the UK and by Roma families they have pointed out that most Roma families do accept the practices in the UK and most do not neglect their children.

8.15 The number of children in the family and the capacity of the social worker made it difficult for the social worker to establish individual relationships with each child. It would have been helpful if the challenge had been raised with the social worker's manager or the assistance of other professionals had been enlisted by co-working and joint visits.

Were the child protection plan and subsequent child in need plan robust, and appropriate for that child, the family and their circumstances? Were all agencies effectively involved in the child protection plan?
Were the plans effectively implemented, monitored and reviewed? Did agencies contribute appropriately to the development and delivery of the multi-agency plans? How effective was the core group/network group?
What aspects of the plans worked well, what did not work well and why? How well were the plans understood by the children and parents and what evidence is there to demonstrate this? What oversight was there of the plans and how effectively were they reviewed? To what degree did agencies challenge each other regarding the effectiveness of the plans, including progress against agreed outcomes for the child? Was the protocol for professional disagreement invoked?

8.16 The initial child protection conference was held within timescales, on the 26th May 2016, and was attended by: the social worker, two Children's Social Care managers, a Police researcher, School A and School B, the school nurse, the assistant health visitor practitioner, mother, father and a Slovakian interpreter. Invitations were not sent to the GP, the community midwife or New Communities Achievement Team, and they did not receive the outcome or minutes of the meeting, although mother was pregnant and not accessing ante-natal care.

8.17 In their individual agency initial case summary and analysis report Children's Social Care highlight that a Graded Care Profile, which is required for neglectful families, was not completed so it could not be used to inform the discussion and decisions. Those professionals who did attend the meeting have confirmed that they felt they had effectively contributed information that informed the child protection plan.

8.18 The child protection plan included the main concerns and the need for continued support to the children and family, but the actions were confused with outcomes and there were no agreed timescales to ensure actions were completed on time.

8.19 The child protection plan was ineffectively implemented due to the core groups not taking place as required i.e. the lack of an interpreter at the first core group meant it could not go ahead; the second core group was cancelled as the social worker did not attend (due to competing priorities) and the parents were not able to attend the last core group before the review child protection conference.

8.20 At the review child protection conference on the 17th August 2016, there were views expressed by attendees, although not by the school who had submitted a report, that the child protection plan was working; the children were attending school; the family had moved to a different house and home conditions were improving; there had been no recorded incidents of the children being left unattended; the family had registered with a GP; and mother was receiving ante-natal care. Nevertheless, the situation deteriorated in the school summer holidays; seven days after the review child protection conference. Child 5 was seen alone on the street and a further week later, the Police were involved with the family as the older children had been stealing bicycles and Child 1 was seen urinating in the street, so the impact of the child protection plan had not been sustained nor had it remained in place long enough to monitor the impact on the family following the birth of the new baby Child 6. This indicates an over-optimism about improvements and an acceptance that the children's care was part of their culture.

8.21 The effectiveness of a child protection plan is dependent on the engagement and commitment of the family however, the language used in the plan was inaccessible, it used professional jargon (e.g. "parents to engage with advice from professionals") and was inappropriate for someone whose first language was not English, caring for a family of five children and the possibility of insufficient parenting skills and a learning difficulty. The individual agency initial case summary and analysis reports do not state whether it included the consequences of not complying with the plan or whether it included the views of the children.

8.22 The Police have reflected, appropriately in my view, that a written agreement was not an appropriate way to ensure the parents complied with the plan and this would have been more appropriately addressed and enforced by considering a criminal investigation of neglect.

How effectively were agencies able to contribute to the analysis of risk and safeguarding concerns both at the point of the decision and in the period following the de-escalation from child protection plan to child in need status?

8.23 The pre-birth assessment was completed on the 27th July 2016, one month after all the children had been made subject to child protection plans due to neglect, it is unclear who contributed to the assessment. The community midwife was not informed of child in need or child protection processes and when she asked how the issues identified in the child protection plan might affect the care of a new-born baby she was informed the concerns were about the older children and school attendance despite the known issues of the youngest children being left alone; one child being found wandering in the street and mother's limited engagement in ante-natal care, It would, in my view, have been more appropriate for the plans for the unborn baby to

have been included in the child protection plan and an ongoing assessment being made by health professionals as part of the plan.

8.24 The individual agency initial case summary and analysis reports do not provide much detail on the review child protection conference, what was discussed and how the risks were weighed but given the above; the decision to remove the children's names from the child protection plan was premature, in my opinion.

The child in need plan

8.25 A Children's Social Care manager completed an audit of the child in need plan; she believed the threshold for child in need support was met and the family needed close monitoring, she concluded that the child in need plan was too general and contained no timescales for the completion of tasks. This was not escalated to more senior management.

8.26 From 31st August 2016 until the 18th November 2016, several concerns emerged in relation to the care, neglect and supervision of the children. Network meetings took place on two occasions, but the concerns continued, Derby City's principal solicitor has subsequently confirmed that the thresholds for another initial child protection conference were met.

Were the respective statutory duties of all agencies working with the child and family fulfilled?
Were there obstacles or difficulties in this case that prevented agencies from fulfilling their duties? This will include consideration of both organisational issues and other contextual issues? This will include analysis of responses by all agencies to safeguarding concerns and the effectiveness of communication?

8.27 The agencies who contributed to this review were robust in their analysis of this issue, some going further than simply evaluating whether they had complied with statutory duties by exploring whether good professional practice was adhered to.

8.28 Children's Social Care set out the duties of local authorities in respect of children under the Children Acts of 1989 and 2004. They comment that the team manager appropriately allocated the case for single assessment on the third occasion the children were left unsupervised and on the fourth occasion the team manager acted appropriately by convening a Section 47 strategy meeting with the Police and the child protection manager, although I note that health were not involved as required and schools were not included, which was significant given their daily contact with the children. They state that there was a lack of liaison with other local authorities and the Slovakian Authorities but explain that this would not be feasible unless clear safeguarding issues were identified.

8.29 They also state that on some occasions, there were safeguarding concerns which the locality manager did not discuss with the child protection manager to determine whether thresholds for child protection enquiries had been met:

- Following the review child protection conference, when the school nurse found Child 5 inappropriately unsupervised in the street, it is accepted by

Children's Social Care that a Section 47 enquiry should have been undertaken and in all probability, would have led to an updated Single Assessment and an initial child protection conference.

- In September 2016, there were two further occasions when the social worker found Child 6 to be covered by a blanket with a pillow under his head and although this had been addressed by the health visitor and the social worker as being unsafe sleeping practice, it was being disregarded by mother who did not understand the risks; but no further action was taken.
- Child 1 was not seen by professionals from the 7th November 2016 until the 18th November 2016, despite concerns that he had burns to his feet and was not in school. The social worker should have seen Child 1 on the 17th November 2016 or asked the team manager to send a colleague and if necessary secured the support of the Police in so doing.

8.30 It must be recognised and commended that when the social worker did see the child she acted appropriately and took emergency action by taking the child to hospital and may have saved his life.

8.31 Derbyshire Healthcare Foundation Trust stated in their individual agency initial case summary and analysis report that their statutory duties were not completely fulfilled as although two safeguarding referrals were made when Child 5 was deemed to be at harm, these were not followed up with a written referral in accordance with procedures, they are of the view that staff believed that because the case was already open to Children's Social Care this was not necessary, despite this being a requirement in Derby and Derbyshire Safeguarding Children Board procedures and covered in training.

8.32 They also state that the team did not consider using the Derby and Derbyshire Safeguarding Children Board Escalation Policy when on the second occasion Child 5 was unsupervised and Children's Social Care took no action and there was no consideration of completing a graded care profile or an early help assessment despite this being covered in training.

8.33 The Police were fully engaged with the initial child protection conference and acted appropriately when Child 1 was found with injuries and the siblings were removed under Police Powers of Protection. However, as previously stated, they did recognise that earlier consideration of investigating the parents for neglect should have been undertaken.

8.34 School A and School B both made considerable efforts to meet the educational needs of the children, they describe how unprepared Child 1 was for school and spent the first few days crying inconsolably, they changed his timetable and provided him with nurturing support, they provided daily contact with the family through New Communities Achievement Team and support with a range of non-educational welfare issues, housing and benefit concerns and advice and support regarding the payment from the hospital for the bill for the delivery of Child 6.

8.35 They reported when the children were absent or had left school without permission, they ensured the EWO followed up continued absences and challenged the parents about the children's behaviour and being left alone. They shared

information regularly and have maintained a comprehensive file of safeguarding actions.

8.36 They have reflected that although they made every effort to meet the needs of Child 1, based on their extensive experience of working with Roma children, they needed to revise their induction policy. They also reflected that they could have measured the impact and effectiveness of the plans for the children and stood back and considered what life was actually like for them.

8.37 Derby Teaching Hospitals Foundation Trust provided ante and post-natal services appropriately but they did not have any involvement in the child protection and child in need processes because they were not invited to them. They were fully compliant with procedures when Child 6 was admitted to hospital with neglect.

8.38 The practice of the health visitor was good. Following the birth of Child 6 a primary birth visit was undertaken in accordance with the Healthy Child Programme (2009). Concerns were raised by the health visitor about mother's ability to read.

8.39 A visit was arranged a month later to complete Child 6's six-eight-week review. Following this visit the family were offered a higher level of support and regular visits were made to the family and missed visits, when there was no response to the door, were promptly followed up.

8.40 The health visitor had noted nappy rash, she prescribed Clotrimazole cream but was not overly concerned and another visit was planned in two weeks' time to review. At the next visit the health visitor reported that the nappy rash looked better, but she was concerned about some areas of the baby's skin and an appointment was made with the GP which the parents did not take the baby to; mother later stated she did not know about the appointment even though the health visitor was with her when it was arranged.

8.41 The health visitor was concerned about the parents' apparent lack of understanding and inability to act on advice; she therefore shared her concerns with the social worker and with the GP and attended relevant multi-agency meetings about the family.

8.42 The GP practice commented that insufficient information was shared with them. They did hold safeguarding practice meetings and the family was discussed and agreed plans were recorded and open sharing of information was agreed with the 0-19 family health services to ensure electronic records could be equally accessed.

Were there obstacles or difficulties in this case that prevented agencies from fulfilling their duties? This will include consideration of both organisational issues and other contextual issues? This will include analysis of responses by all agencies to safeguarding concerns and the effectiveness of communication?

8.43 Much of this question is covered within the other key questions and is not repeated here in full, the impact of working with Roma families with complex needs and challenges around communication have been highlighted by agencies

throughout this review, as has the impact of the withdrawal of some specialist support which made a real difference for example; The Derby City Language Centre which Child 2 and Child 3 attended before joining School B, was established to help develop student's language acquisition to enable them to function in mainstream schools, although a review of the service concluded that it did not meet the needs of young people, nor did it promote their inclusion in schools or wider society and as a result, the service was closed.

8.44 Overall, although professionals were carrying complex cases and found that the need to secure interpreters made working with them took longer, organisations did not raise issues of difficulties in staff shortages or in recruiting and retaining staff, (except for health visiting and school nursing services in the locality area, this was raised as a significant issue by the health visitor with her manager on 20th July 2016 and was formally recorded as a risk for the Derbyshire Healthcare Foundation Trust) they appeared to be reasonably resourced and have considerable professional experience. However, the additional demands of working with Roma families and the loss of some specialist Roma services, particularly the specialist health visitor for Roma families, which not only provided support directly but were a source of advice for professional, was repeatedly mentioned in reports and discussions, as being of significant concern.

Were the practitioners involved in the case have appropriate safeguarding training and management supervision/support specific to their role?

8.45 It is evident from the information provided that staff in all agencies have been provided with a range of safeguarding training, both their own agency training and that provided by the Derby Safeguarding Children Board, with the exception of Children's Social Care who state that although the social worker, team manager and deputy head of service had received mandatory training the social worker and team manager had not received training on completing effective plans and the use of the Graded Care Profile which was being rolled out at the time they were involved in this case; this has been subsequently addressed.

8.46 Supervision processes, both individual and in groups and access to safeguarding advice from lead professionals in all agencies has been effectively established.

8.47 In relation to supervision, Children's Social Care have reflected that during the summer of 2016 it took time for the new team manager to gain oversight of the 160 cases held by the team and given the complexity of this case, more frequent supervision would have been helpful, although this would have had to have been balanced with the need to closely supervise several more complex cases.

8.48 There is little evidence of use of effective professional challenge or Derby and Derbyshire Safeguarding Children Board's escalation policy to resolve professional disagreements, apart from the schools who on returning from the summer holiday and discovering that the children had been removed from child protection plans, raised this with the social worker at the network meeting.

8.49 Practitioners who contributed to the review reflected that they had been unclear about when, and to whom concerns should be raised or escalated but the review had enabled them to understand this better.

9.0 Conclusion

9.1 This was a complex and challenging case; a family with many children, parents who came from a Roma heritage and culture, who were not always open and honest with professionals in sharing information and may not have understood or agreed with the concerns raised with them.

9.2 Not only was it difficult to obtain information from the family, there was no contact made with the Slovakian Authorities for information about the family, had they been it would have become known that Child 7 had been removed from the care of their parents and that Child 3 had fallen into a fire and suffered significant burns to his body and enabled practitioners to identify potential risk at an earlier stage.

9.3 Communication between the family and agencies was challenging as the family speak a Romanes dialect and interpreting services for this language were insufficiently available and there has been a loss of some significant support arrangements to help professionals understand and meet the needs of Roma families in the city**.**

9.4 Overall, the information gathered for this review evidences strenuous efforts by professionals to respect the heritage of the family, to work with them in meeting their needs and to respond to the plethora of daily events that required a response.

9.5 There was not a shared view as to whether mother had learning difficulties, was illiterate or was reluctant to accept the need to care for the children in accordance with the culture in which they lived. Father was the main point of contact with several agencies as he had some command of English and the Slovakian language for which interpreters were available, it was unclear whether he dominated his wife or was simply the more articulate and responsive parent or whether he appeared to comply but in practice did not. It should be noted that the children always appeared happy in the care of their parents until the events that triggered this review.

9.6 There was a lack of consensus on what the focus of concerns was, was it about; non-school attendance; the children's challenging and anti-social behaviour; the children being left alone at home and being unsupervised and allowed to wander outside in the street or; the care given to them at home? The decision to remove the children's names from the child protection plan undoubtedly had an impact on the focus of concerns which were no longer on neglect and led some professionals to believe they had reduced. This lack of clarity and lack of appropriate focus is not uncommon in cases of neglect where the demands of the family are responded to by professionals but divert them from monitoring what is actually happening and stepping back and reflecting on what the real issues are, i.e. is the care given to this child 'good enough'?

9.7 Some of the characteristics and challenges of neglect contained in the DfE Research report of 2014, *'Missed opportunities; indicators of neglect, what is*

ignored, why and what can be done' are paraphrased below as they are relevant to this case:

- neglect can, in some cases, be challenging to identify because of the need to look beyond individual parenting episodes and consider the persistence, frequency, enormity and pervasiveness of parenting behaviour which may make them harmful and abusive;
- there is a reluctance to pass judgement on patterns of parental behaviour particularly when deemed to be culturally embedded (e.g. the Traveller community) or when associated with social disadvantages such as poverty.

9.8 Although agencies responded well to events on an almost daily basis and communicated reasonably well with each other, there were some exceptions, for example, there were missed opportunities to gather all the information which was held by different agencies and produce effective plans that were clearly understood by everyone, rigorously monitored and revised as new information became known and challenged when agencies had concerns.

9.9 Practitioners were very sensitive to the fact that the family were from a different culture but they, the social worker, the school and the health visitor did challenge the parents' care and supervision of their children.

9.10 After the injuries to Child 1 a medical examination of Child 6 was undertaken and identified some significant concerns and indicators of neglect for which the parents were prosecuted and admitted their guilt. Since birth, most contact with Child 6 was by the health visitor, who made regular assessment visits, identified and addressed concerns but also emotional warmth and that the baby was thriving and active, they liaised with professionals from other agencies. The health visitor's last contact with Child 6 was on the 31st October 2016 by the 18th November 2016 medical examination, the baby's condition had deteriorated.

9.11 Communication between professionals was in person, by 'phone, by leaving 'phone messages and by email. All verbal concerns should be followed up in writing immediately, responded to in writing and if the sender does not receive a response they should pro-actively contact the addressee's manager. In this case the reliance on communication by email had a significant impact on how quickly the social worker was made aware of Child 1's burns. It was not appreciated that social workers do not have mobile 'phones on which they can access emails, when they are out of the office.

10.0 Recommendations

10.1 The following recommendations are predominantly directed at Derby Safeguarding Children Board, they do not include those identified by agencies in their individual agency initial case summary and analysis reports and provided for this review. However, two additional recommendation for Children's Social Care are made and one for all agencies.

1. Derby Safeguarding Children Board should ensure that a strategic multi-agency needs assessment in relation to Slovak families and families from new, emerging communities in Derby City is undertaken to ensure there is a

sufficient range of services to meet identified need. This should include consideration of the reinstatement of the complex case meetings for Roma and new, emerging communities and other previous arrangements.

2. Derby Safeguarding Children Board should assure itself that single assessments are always shared with other agencies and the family. They should always include checks with previous local authorities in the UK and with authorities abroad.

3. Derby Safeguarding Children Board should satisfy itself that where cognitive and parenting assessments are part of a plan, they are completed at an early stage to assist in effective planning.

4. Derby Safeguarding Children Board should satisfy itself that reports to child protection conferences, at which the agency is not represented, should be referred to at the meeting, to inform decision making.

5. Derby Safeguarding Children Board should satisfy itself that plans, whether child protection or children in need should be translated for families where appropriate and be explicit about who will do what by when and what must be evidenced to demonstrate that things have improved, invitations should always include all agencies involved with the child including GPs and midwives. If the plans are not being implemented or there are other professional concerns, these must be escalated, using the Derby Safeguarding Children Board's Escalation Process.

   In January 2015, similar recommendation was made in another Derby Safeguarding Children Board review - *"Derby and Derbyshire LSCBs should ensure partner agencies remind all frontline staff of the Escalation Process which is there to support them in cases where there is difference of professional opinion".*

6. Derby Safeguarding Children Board should satisfy itself that agencies have assured themselves that their staff follow up verbal referrals in writing and if no response is received, have escalated this to the relevant manager in accordance with the Derby and Derbyshire Safeguarding Children Board Escalation Policy.

7. All agencies should ensure that their staff understand the impact of culture, race and heritage, when identifying neglect and significant harm and ensure that assumptions are not made about the practice and beliefs of newly emerging communities, nor should they condone these if they are not in accordance with practice in England

8. Children's Social Care should remind social workers of the memorandum of understanding that Derby City Council has with Slovakian Authorities in terms of obtaining and sharing information and ensure staff do so at an early stage of their assessments.

9. Derby Safeguarding Children Board should monitor the implementation of these recommendations and those identified by individual agencies.

10. Derby Safeguarding Children Board should offer the Slovakian Authorities, where the family and the children live, a copy of this report and they accept the offer, they should be asked to share it with the family on behalf of Derby Safeguarding Children Board.

Appendix 1

The purpose of the review is to

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Local Safeguarding Children Board.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were child focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources.

The extended child practice review will have regard to the following:

- Was previous relevant information or history about the child and/or family members known and considered in professionals' assessment, planning and decision-making in respect of the child the family and their circumstances; How effective was the assessment of parental learning disability? What impact was there on the effectiveness of engagement with the family arising from communication issues and the specific dialect of Romany used by the family? How did that knowledge contribute to the outcome for the child?
- Was the child protection plan and subsequent child in need plan robust, and appropriate for that child, the family and their circumstances? Were all agencies effectively involved in the child protection plan?
- Were the plans effectively implemented, monitored and reviewed? Did agencies contribute appropriately to the development and delivery of the multi-agency plans? How effective was the core group/network group?
- What aspects of the plans worked well, what did not work well and why? How well were the plans understood by the children and parents and what evidence is there to demonstrate this? What oversight was there of the plans and how effectively were they reviewed? To what degree did agencies challenge each other regarding the effectiveness of the plans, including progress against agreed outcomes for the child? Was the protocol for professional disagreement invoked?
- How effectively were agencies able to contribute to the analysis of risk and safeguarding concerns both at the point of the decision and in the period following the de-escalation from child protection plan to child in need status?
- Were the respective statutory duties of all agencies working with the child and family fulfilled?
- Were there obstacles or difficulties in this case that prevented agencies from fulfilling their duties? This will include consideration of both organisational issues and other contextual issues? This will include analysis of responses by all agencies to safeguarding concerns and the effectiveness of communication?
- Were the practitioners involved in the case have appropriate safeguarding training and management supervision/support specific to their role?