Nottingham City Safeguarding Children Board

Serious Case Review

Child J

Report Author

Jane Wiffin
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1 INTRODUCTION

The reasons for this Serious Case Review

1.1 This Serious Case Review was initiated because of the sad death of a seven year old girl (known throughout this review as Child J). She was found dead at the home where she lived with her Aunt under a Special Guardianship Order (SGO). Her Aunt was subsequently arrested and stood trial for her murder. Her Paternal Grandmother (PGM) was also arrested. The Aunt was cleared of murder, but found guilty of child cruelty and sentenced to a period of imprisonment. Paternal Grandmother was also found guilty of child cruelty and sentenced to a period of imprisonment.

1.2 Statutory guidance\textsuperscript{1} requires that when a child has died and abuse or neglect is known or suspected, the Local Safeguarding Children Board must carry out a Serious Case Review.

Review Methodology

1.3 Careful consideration was given to the best method of conducting the review taking account of the principles set out in statutory guidance\textsuperscript{ii}. The review was undertaken using a hybrid systems methodology. A new chronology document was designed which required all the agencies involved with Child J and her family to outline their involvement, appraise the professional response and to provide information about the context in which that professional response had taken place. Over the period of the review further work was undertaken by some agencies to clarify information and provide more details as necessary. A number of case records were also analysed. Information about the agencies who were asked to submit a chronology and appraisal are outlined in appendix 1. These agencies have subsequently completed action plans to address lessons regarding practice raised by the review.

1.4 A review panel consisting of senior managers from key agencies was convened and chaired by an Independent person, Jane Wonnacott. The panel used the chronology and appraisal documents provided by all agencies as the starting point for their analysis. This report is a product of the work of this panel alongside the practitioner interviews and events.

<table>
<thead>
<tr>
<th>The Panel</th>
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<tbody>
<tr>
<td>Designated Nurse Safeguarding</td>
<td>NHS Nottingham City CCG</td>
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<tr>
<td>Named Nurse Safeguarding</td>
<td>Nottingham CityCare Partnership</td>
</tr>
<tr>
<td>Named Nurse Safeguarding</td>
<td>Nottingham University Hospitals NHS Trust</td>
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<tr>
<td>Director of Children’s Integrated Services</td>
<td>Nottingham City Council</td>
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<tr>
<td>Associate Director for Safeguarding</td>
<td>Nottinghamshire Healthcare NHS Foundation Trust</td>
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<td>Position</td>
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<tr>
<td>Assistant Director and Head of Service</td>
<td>Cafcass</td>
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<td>Service Manager</td>
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<td>Head of Service: Children’s Duty and Targeted Services</td>
<td>Nottingham City Council</td>
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<td>Area Manager</td>
<td>DLNR CRC</td>
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<td>DCI Public Protection</td>
<td>Nottinghamshire Police</td>
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<td>Head of Service Safeguarding and Quality assurance</td>
<td>Nottingham City Council</td>
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<td>Director Education</td>
<td>Nottingham City Council</td>
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<td>Legal Advisor</td>
<td>Nottingham City Council</td>
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<td>Children’s Officer</td>
<td>Nottingham City Safeguarding Children Board</td>
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1.5 Most of the key professionals involved with Child J and her family were interviewed by the Lead Reviewer and a panel representative; there were only a small number of people it was not possible to interview because they had left the organisation they worked for. This has not affected the final analysis. A number of practitioner events were held to check the developing analysis.

1.6 Jane Wonnacott is qualified as a social worker. She has published two books on supervision and co-wrote with Tony Morrison the national training programme for social work supervisors. Since 1994 she has been the author or chair of many Serious Case Reviews and in 2010 completed the Tavistock Clinic and Government Office London nine-day training programme for panel chairs and authors. She has also attended the 2012 Department for Education Serious Case Review training programme. She is completely independent of services in Nottingham City.

1.7 An experienced Independent Lead Reviewer, Jane Wiffin, was appointed to work with the review panel to carry out the review and produce the final report. Jane Wiffin is a freelance social care consultant and has a professional background as a social worker, with extensive experience of safeguarding practice, developing policy and delivering pre- and post-qualifying education. She is an experienced Serious Case Review author, having completed over 30 reviews. In 2010 she completed the Tavistock Clinic and Government Office London nine-day training programme for panel chairs and authors and she is an accredited SCIE Learning Together Reviewer. She is completely independent of services in Nottingham City.

**Family Involvement**

1.8 Family involvement is very important in any Serious Case Review process. For this review Mother and Father were both asked to contribute. It has not been possible to make contact with Father, despite the Board Staff making a number of attempts to do so. Mother met with the Author and the Chair; she was very open and helpful and her views are incorporated into the report. The Foster carer was also invited to contribute,
and she met with the author on two occasions; she provided useful information, on behalf of her family, and this is incorporated into the body of the report. Aunt and Paternal Grandmother were also asked if they could provide information that would help the review make progress, and both agreed to prison visits. PGM provided some background Family information.

1.9 Aunt was visited in prison, but decided she did not feel able to provide any information to the review.

1.10 This is the full overview report of the Serious Case Review. A decision has been made by the Review Panel and Nottingham City Safeguarding Children Board (NCSCB) that some detailed information about Child J’s siblings and Mother will be removed before publication due to the sensitive nature of the material and to reflect that this adult and children remain living in the same communities.

1.11 The overview report was completed before a full inquest took place. The inquest process provided new evidence and information and this has been incorporated into the body of the report. It became clear during the inquest that Aunt had recorded a number of phone calls and meetings and the information and knowledge that this provided is also incorporated into the body of the report and the analysis that follows.

1.12 The narrative conclusion of the Coroner was that Child J died whilst in the care of her Aunt who had been approved as her Special Guardian. The Coroner found that in the two years prior to death, Child J was the victim of sustained serious physical and emotional abuse. The Coroner also concluded that during the 48 hours before she died, Child J was subjected to horrific violence resulting in multiple internal and external injuries and Child J died as a result of an injury to her brain caused by blunt trauma which, on a balance of probabilities, was an inflicted non-accidental injury.

2 FAMILY MEMBERS

2.1

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Child J</th>
<th>Age at time of critical incident</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child J</td>
<td>Subject of the Review</td>
<td>Aged 7 when she died</td>
<td>Dual Heritage</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td>25</td>
<td>White</td>
</tr>
<tr>
<td>Sibling 1</td>
<td>Sister</td>
<td>Aged 5 when Child J died</td>
<td>Dual Heritage</td>
</tr>
<tr>
<td>Aunt</td>
<td></td>
<td>23</td>
<td>Ethnic Minority</td>
</tr>
<tr>
<td>Father of Child J</td>
<td></td>
<td>28</td>
<td>Ethnic Minority</td>
</tr>
<tr>
<td>PGM of Sibling 1</td>
<td></td>
<td>47</td>
<td>Ethnic Minority</td>
</tr>
<tr>
<td>PGM of Child J</td>
<td></td>
<td>53</td>
<td>Ethnic Minority</td>
</tr>
</tbody>
</table>
2.2 Child J’s family circumstances were complex. Information about her Mother is contained in the section below. Her Father has a number of different partners by whom he has a number of children. Child J had limited contact with these other family groups and for the purposes of anonymity these children are not included in the family details.

3 NARRATIVE CHRONOLOGY AND APPRAISAL OF THE PROFESSIONAL INVOLVEMENT WITH CHILD J

3.1 This section provides a narrative summary of the professional involvement with Child J focusing on an appraisal of the practice response at different points across the timeframe and comment on why practice was as it was where this is known. It starts with a brief overview of Child J’s family circumstances, which were well known to many, but not all professionals. Information has been anonymised as much as is possible, and dates removed in order to protect the privacy of children and family members. This forms a foundation for the subsequent section which analyses the practice response as a whole.

Family Background

3.2 When Child J was born she was diagnosed (antenatally) with a mild brain defect which caused her some developmental delay, mild learning disabilities and delayed motor skills and coordination. At birth she was also found to have damage to one of her kidneys for which she required four hospital admissions and operations in the first two and a half years of her life. The impact of this condition was that she was prone to urinary tract infections and her Mother was advised that she needed to drink large quantities of water. Mother received disability allowance for these health concerns.

3.3 Child J’s Mother experienced a difficult childhood and early adolescence. She met Child J’s Father when she was 16. He was already married, had a child and his wife was pregnant. Mother and Father separated whilst Mother was pregnant with Child J. She met a new partner and they had a child who was born when Child J was 3. Child J’s Father already had two other children by another partner.

3.4 Father has many other children by a number of different partners, some of whom were born at a similar time as Child J. Information was collected for this review about these children and their families and it was clear that there was minimal opportunity for contact between the professional networks.

Child J lives with her Mother and Sister: June 2009 – May 2011

3.5 The review period starts when Child J was almost 3 years old. Mother had experienced depression and anxiety from when Child J was born and she was concerned that this had an impact on her parenting and ability to cope with a young child with complex health needs. There were a number of instances where Mother said she had unwanted thoughts of harming Child J, and had described to professional’s harmful behaviours
towards her. As Child J got older Mother said she found her behaviour difficult to manage and that at times Child J had tried to hurt herself.

3.6 Over time there were CAF meetings, some professionals meetings and the family were provided with some family support services. At this time the health visitor noticed bruises to Child J and a referral was made to Children's Social Care (CSC). Mother said the injuries were inflicted by Father’s partner whilst Child J was staying with them for a three-week period. Mother said she had concerns that Paternal Grandmother was also harming other children in the family. A child protection inquiry was undertaken and it was agreed that family support was to be provided. An initial assessment was undertaken which involved Father and his partner which concluded there were no safeguarding concerns. It would have been expected that there would have been enquiries made about the allegations regarding PGM; it remains unclear why these did not happen, but the consequences were that important family information was not available to the subsequent assessment carried out regarding Aunt offering to care for Child J. During this time the school reported concerns about Child J’s poor progress and many absences.

3.7 When Child J was 4 years old, and her sibling 1 year old, there were escalating concerns about Mother’s poor mental wellbeing (she was never formally diagnosed with a mental health disorder). She had minimal support from either of the children’s Fathers. Child J’s Father was involved in criminal activity, for which he would receive a custodial sentence and therefore be unavailable to address the needs of his children (he was also Father to young children in other family units) or support Mother.

3.8 Mother had continuing thoughts of harming Child J and she shared these with a number of professionals and consistently and urgently asked for help. Overall, there appears to have been a muddled approach with the CAF and Child in Need processes running alongside each other. There was no clear assessment of the nature of Mother’s difficulties or her lack of any family support, there was never a coordinated single plan and there was no review process to see if the help offered was making a difference to the outcomes and lives of these two young children or helping Mother with her significant difficulties. It is clear, given the level of concern, that Child J and Sibling 1 should have been subject to Child Protection enquiries and plans at this time as a way of addressing the very real concerns regarding Mother’s mental health and assertions

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1 The CAF is used when a child and family would benefit from co-ordinated support. An assessment tool often used by agencies such as education, health, or housing is the Common Assessment Framework. This is a standard way of looking at a child’s needs and is carried out by a ‘lead professional’ - someone from the agency working most closely with the child.

2 Children’s Services have a legal duty to look into a child’s situation if they have information that a child may be at risk of significant harm. This is called a child protection enquiry or investigation. Sometimes it is called a “Section 47 investigation” after the section of the Children Act 1989 which sets out this duty.

3 The initial assessment is a short assessment of each child referred to Children’s Services focusing on establishing whether the child is in need or whether there is reasonable cause to suspect that the child is suffering, or is likely to suffer significant harm. It may additionally determine the nature of any services required and if a more detailed Core Assessment should be undertaken.

4 Children’s Services decide if a child is in need by assessing their needs. If they decide the child is in need they will normally draw up a plan setting out what extra help they will provide to the child and their family. This is called a child in need plan. The plan should also say when and how the plan will be reviewed.
that she would harm Child J. During the early days of her difficulties Mother was not provided with the necessary level of support which might have enabled her to care for both children and there was a crisis which led to both children coming into care.

3.9 The lack of a clear support plan and the appropriate support services was caused by the arrangements for family support services which existed within the Local Authority at the time. A specialist team of agency staff was formed to provide extra capacity to support existing child in need processes, in recognition that this work often got overtaken by child protection processes when there was low capacity. This decision was taken to enhance the family support process, but had the opposite effect because the team became separate from mainstream work and planning. This approach to the provision of child in need services/family support has since ceased.

**Placement with Foster Family: May 2011 – July 2012**

3.10 Sibling 1 went to stay with her Paternal Grandmother (no biological relative of Child J) and Child J initially stayed with a family friend who was assessed as not being able to provide longer term care for Child J. Consequently Child J came to live with her foster family when she was four years old (Sibling 1 moved to live permanently with her own Paternal Grandmother) and Mother agreed for Child J to be accommodated\(^5\) (believing this would only be for a short period of time and that both her children would be returned to her care). Whilst in foster care Child J received good quality parenting, contact was facilitated with her Mother and Sibling 1 and Looked after Reviews\(^6\) were held regularly.

3.11 Child J came to the placement having experienced both a difficult early childhood and being away from her Mother and Sibling 1 unexpectedly at a very young age. This meant she was a traumatised young child and this trauma was manifest in her behaviour; she exhibited anger, aggression, harmed herself and constantly sought the attention of her foster family through means which they found inappropriate and distressing, but for which she had no alternative strategies.

3.12 The foster family were very loving, but inexperienced and were not sufficiently prepared (despite the training they received) for the behavioural manifestation of the significant early trauma to Child J. Consequently, they initially formed a view of Child J as a difficult child and they worried about whether they could be successful in meeting the needs of a child they very much cared about.

3.13 The foster family sought support and advice from CAMHS\(^7\) and Child J’s social worker and this helped. The psychological assessment of Mother provided good advice to the

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\(^5\) Accommodation is when a child or young person is cared for by Children’s Services because the person normally caring for them is unable to provide them with care (whether this is temporary or permanent), for whatever reason. This is also known as section 20.

\(^6\) When a child is accommodated, their situation is regularly reviewed at a meeting called a Looked After Child review.

\(^7\) CAMHS stands for Child and Adolescent Mental Health Services. CAMHS are specialist NHS services. They offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.
foster carers about the need to change their style of parenting, with a focus on a lack of control and confrontation, but with love and firm boundaries. This made a difference and Child J became more settled and the foster family more confident. This was a safe and caring time for Child J.

3.14 During the placement a plan was formulated regarding Child J’s health needs. The foster family ensured that all medical appointments were attended and plans to support her health needs carried out. The foster family also facilitated her attendance at school, promoted the development of friendships and after school activities such as dancing which she was said to enjoy.

3.15 Child J was confused about why she had come into care; she appears to have been initially told that it was because her Mother was unwell and she would return home when Mother was better; Mother also believed that the children would return home and told Child J this. Child J missed her Mother and she consistently said that she wanted to return home. These feelings of loss were not always sufficiently addressed; they were discussed in the Looked After Reviews, but no plan formulated to address them. Direct work was undertaken by the social worker and this helped, but the confusion and feelings of loss remained.

Making a decision about where Child J and Sibling 1 should live safely for the future

3.16 Mother initially opposed the children being accommodated/in care because she wanted them to return home, but agreed because she wanted to cooperate with professionals whilst further assessments were undertaken and rehabilitation to her care was considered.

3.17 The Local Authority gave serious thought to whether the children could be rehabilitated to their Mother’s care safely. A core assessment was completed to consider historical issues and assess Mother’s capacity to parent now and in the future. Father was in prison at this time and he was consulted as part of the assessment. He confirmed he would like to be involved in decision-making regarding Child J. The core assessment raised concerns about Mother’s poor mental health and her previous difficulties in parenting Child J.

3.18 Care proceedings were initiated and an independent psychological assessment was commissioned at the request of the Children’s Guardian and facilitated by Children’s Social Care.

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8 A core assessment is defined by the Department of Health as an in-depth assessment which addresses the central or most important aspects of the needs of a child and the capacity of his or her parents or care givers to respond appropriately to these needs within the wider family and community context. (DoH 2000, Framework for the Assessment of Children in Need and their Families)

9 A children’s guardian is an independent and experienced social worker who is an officer of the court. Their job is to make enquiries about the child’s circumstances and make a recommendation about what is best for the child in the future. Children’s Guardians are organised by a service known as Cafcass. This stands for the Children and Family Court Advisory and Support Service. This is an independent court based agency.
3.19 This assessment was thorough in its execution, but its conclusion did not match the available evidence. Mother was assessed as still finding the thought of parenting Child J very difficult believing that Child J placed significant demands on her. The assessment also suggested that Mother attributed the difficulties she had in parenting Child J to Child J’s personality and behavioural problems, rather than her own depression and anxiety which was of concern. The assessment also highlighted that there was an absence of emotional bonding between Mother and Child J which was reflected in a cold pattern of interactions from Mother. The assessment concluded that “Mother would be able to fulfil her children’s needs on a consistent basis if she receives psychological therapy for her anxiety and depressive symptoms and an intensive parenting course”.

3.20 The Children’s Guardian and the Social Worker both expressed concern about the conclusion of the report and additional work was undertaken by the psychologist. The recommendation of this second report was that Mother needed to undertake weekly Cognitive Behavioural Therapy (CBT)\(^\text{10}\) with a Clinical Psychologist for at least 6 months and to also attend an intensive parenting course. Mother actively tried to access CBT and found there were lengthy waiting lists. She sought a way to pay for private treatment (taking a loan from a family member) but this was not viable because of the cost and she also looked at parenting courses and sought advice about parenting on the internet.

3.21 Those professionals involved with Mother recognised that she had been open about her early difficulties and had worked to try and address the concerns. Ultimately, the professionals and court had to try and judge whether Mother could safely parent her children in the present and the future. There remained concerns regarding Mother’s difficult relationship with Child J which indicated that the significant changes needed would take too long to achieve and would be outside of the developmental time frame necessary for the wellbeing of both children. The difficult decision was made in November 2011 that it would not be safe to return the children to their Mother’s care and an alternative permanent placement needed to be sought.

**Assessment of Family Members:**

3.22 It was agreed that it was important to try and place both children with family members, which is a clear requirement of current public policy\(^\text{11}\). This was

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\(^{10}\) Cognitive behavioural therapy (CBT) is a talking therapy that can help you manage your problems by changing the way you think and behave. It is most commonly used to treat anxiety and depression, but can be useful for other mental and physical health problems.

\(^{11}\) Where children cannot remain with their parents, the first consideration must be a placement within the extended family. This is consistent with the Children Act 1989 (which requires local authorities to give preference to placing a child within the family network before considering a placement with unrelated carers) and Article 8 of the Human Rights Act 1998 (the right to a private and family life).
straightforward for Sibling 1 who was already living with her PGM (she had a different Father to Child J). Contact was made with Father who was in prison. Child J’s PGM and Father’s wife were approached and both declined to be assessed because of ill health on PGM’s part and overcrowding for Father’s wife. The fact that they both declined to be assessed meant that the historical allegations regarding PGM’s physical abuse of Child J and general concerns regarding Father’s wife care of her own children were not further explored.

Assessment of Aunt: January 2012

3.23 Father suggested that there might be members of his family who could care for Child J and he suggested his sister, who agreed to put herself forward to be assessed. Aunt did not know Child J at this point; they had only met once when Child J was much younger. A successful viability assessment was completed by the Social Worker and the court agreed that a Special Guardianship (SG) Assessment and parenting assessment would be undertaken.

3.24 The assessment conducted was largely in line with the national guidance regarding Special Guardianship Assessments. These do not require the same depth as fostering or adoption assessments, but do require a lot of work. The assessment did not sufficiently acknowledge that this was a completely new attachment relationship for Child J or explore the implications of this. Information was included in the assessment about Child J’s health and education needs but neither agency was specifically consulted during the Special Guardianship process regarding implications for future planning and services for Child J as outlined in the Special Guardianship regulations. There is no requirement within the Special Guardianship regulations to seek information from the police, but the social worker believed she had done so and there were no concerns, but there is no record of this request. The police did hold some personal information about Aunt including some details of Aunt’s experiences of being abused by a school teacher, PGM’s abusive treatment of her in her adolescence and some personal information. This information would not have been disclosed unless an “enhanced” disclosure and barring check (DBS) had been sought. This information would not have changed the final decision, but would have indicated that Aunt did not always provide a full account of her recent past and would highlight the need for a well-structured support package.

3.25 Child J’s views about this potential move were not included. The Special Guardianship Guidance makes clear the importance of children being offered the opportunity to express their view, dependant on their age and understanding. Consideration was

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12 The local authority must investigate and prepare a report to the court about the suitability of the applicants to be Special Guardians. The information to be included in the report to the court is set out in regulation 21 of the Special Guardianship Regulation 2005, (see Appendix 2: Schedule to the Special Guardianship Regulations 2005).

13 Regulation 12 requires that the local authority consults the relevant PCT (or LHB) or LEA during the course of the assessment, if needs identified relate to services provided by bodies other than social services, and it appears that there may be service implications for health or education services.

given to this and Child J was felt to be too young to understand the process. Child J had always made clear her desire to go home and had expressed confusion about where she would be living in the future; this indicated that a discussion with her was possible. The inclusion of this information could have led to a recommendation in the subsequent support plan that she might continue to need support regarding this confusion in the future.

3.26 The assessment focused too much on Aunt’s own self reporting of her circumstances and could have reflected more on the potential impact on parenting of Aunt’s experience of being abused as a child/young person; she had reported being beaten by PGM as a child and sexually abused in adolescence by a teacher; research\(^iv\) suggests that these early abusive experiences could cause difficulties in parenting, particularly during stressful times. Aunt’s view that she had reflected on those experiences and would never use physical chastisement was untested at this time. The assertion from Aunt that she provided care to her nieces and nephews, which made up for the deficits in their parents’ neglectful care, was discussed with Father’s wife, but not fully explored and it was never observed. This self-report was also accepted by the Children’s Guardian, who had initial reservations about Aunt’s young age, but in the final report for court praised her selflessness in looking after her nieces and nephews. Information was not sought from her employer, a provider of services to elderly people, though three references were sought and received from friends who were members of the church Aunt attended; these people were not interviewed in line with national special guardianship guidance. These references were all positive about Aunt and mentioned her work with children at the church, but more thought should have been given to the fact that these references all came from the same place.

3.27 The national special guardian guidance also makes clear that there should be a full exploration of the prospective special guardian’s family. Information was included, though largely provided from Aunt’s perspective. There was information available about concerns regarding Father’s wife and Mother had made it clear that she had concerns about physical abuse by PGM and some members of the wider family. These were not given sufficient weight and it is of concern that from this point onwards Mother’s view about Child J’s circumstances was not valued or acted upon. A genogram was drawn up for the court processes but focused on Mother’s family (about whom there were no known concerns), not paternal family. Given the complexity of the paternal family relationships a full picture of the whole family was necessary. It is unlikely that this information would have impacted on the final decision of the court, but could have and should have influenced the final support plan.

The Transition process from Foster Care to Permanent Placement with Aunt: April 2012

3.28 The Local Authority began working with Aunt to establish if she could care for Child J. As part of this process the Social Worker took Aunt through Child J’s medical report, her early experiences and her current behavioural difficulties. Aunt said that she
understood these early experiences were difficult and she felt able to meet Child J’s needs. Issues of attachment were discussed. At this point it would have been important to look more closely at the manifestation of Child J’s distress through her behaviour, and note the possibility that parents/carers when under stress can blame the child rather than the trauma. The strategies recommended by the Psychologist, which had been successfully implemented by the foster family should have been discussed at this point.

3.29 The need for careful preparation for Child J’s move to Aunt was discussed in two of the CAMHS consultations, but there were no plans agreed to address the issues raised; this was largely because the purpose of these meetings was to think about what needed to be done, with the expectation that any formal plan would be developed outside of the consultation process as part of normal casework process. The confusion about the decision making capacity of the CAMHS consultation meetings persisted across the whole period under review.

3.30 A brief transition plan was developed and consisted of a timetable of contact sessions over a four-month period; the first was supervised by the foster carer. From this point on the foster carer took on the task of facilitating the contact sessions. The Children’s Guardian expressed concern that there had been no overnight contacts, and these were organised and were successful. There were also no observed difficulties at this time and all the indications were that the relationship between Aunt and Child J was progressing well. The transition planning process for Child J should have been more detailed given that this was a completely new relationship and the needs of Child J were complex. However, there is no expectation of a fuller transition plan in the context of the Special Guardianship process.

3.31 It is unclear how much Child J was aware of the plans for her to live with her Aunt in the early stages of contact. She said she enjoyed the contact sessions but she did not appear to have understood that this was in preparation for moving permanently to her Aunt’s. The Social Worker talked to Child J about this potential transition on two occasions using some specialist books appropriate to her age and stage of development; Child J was said to be relaxed about this, but said she thought she might stay with her foster family and the Social Worker talked about staying with Aunt. A second session was organised, where the issues were once again raised with Child J. The work of social workers in these situations is limited by the nature of the court proceedings, where it is only possible to tell a child they will definitely be moving permanently when agreed by the courts/legal decision making.

**Care Planning and support for the Special Guardianship Placement**

3.32 The Children’s Guardian gave full support to the placement of Child J with her Aunt and recommended that an interim order should be sought in order to test out the success of the placement, that there be at least six months social work support for the placement
and Child J and her Aunt to be offered Theraplay\textsuperscript{14} by CAMHS when Child J was settled. This endorsement was based on only two visits and it is clear that the Children’s Guardian should have spent more time observing the relationship between Aunt and Child J. The social worker filed the Special Guardianship Support Plan. This proposed six months of social work support with a multi-agency meeting held every three months. The SGS plan outlined the expectations of Aunt which were:

- **Health needs**: to ensure that all health needs were met and that Child J attended appointments for urology services and continence services;
- **Education**: it was envisioned that Child J would remain at her present school and that the Aunt would support her full attendance and ensure her special educational needs were addressed;
- **Behavioural, social and emotional development**: Aunt was to provide Child J with consistent emotional warmth, structure and boundaries, with parenting that was flexible and warm in style.
- **Identity**: Aunt to promote direct contact with birth parents and siblings.

3.33 The Special Guardianship Order was granted to Sibling 1’s paternal grandmother. The final decision regarding the permanent carer for Child J was adjourned for three months to see how the placement with Aunt progressed. It was not made clear at this point how any information would be collected regarding this progress and there was no requirement from the court for a further social work or Children’s Guardian statement.

**Child J moved to live with Aunt: July 2012**

3.34 When Child J moved to live with Aunt there were weekly home visits by the Social Worker. Aunt talked about finding Child J difficult to manage, stealing, asking to be physically hit and screaming; Aunt reported that this had led to the neighbours coming to the flat to ask if everything was alright. These were all behaviours reminiscent of the early days of her foster care placement and were assessed as part of the likely difficulties of the transition. Aunt’s view was that these difficulties were caused by Child J’s contact with her mother. The Social Worker was aware from the contact supervisor that contact had been quite emotional and she asked Mother to be more thoughtful about what she said to Child J and to support the placement for her best interests; telephone contact between Mother and Child J was temporarily halted. The Children’s Guardian visited Child J who was seen alone and said she was happy living with Aunt; Aunt reported difficulties managing Child J’s behaviour and that Child J had been verbally abusive to her.

**Child J permanently placed with Aunt: September 2012**

3.35 At the final Court hearing the social worker reported that overall the transition period had gone well. The court did not require further details to be provided, and the early

\textsuperscript{14} Theraplay is a child and family therapy for building and enhancing attachment, self-esteem, trust, and engagement. It is based on the patterns of playful, healthy interaction between parent and child and is intended to be personal, physical, and fun.
difficulties were seen as part of Child J’s existing complex needs and the transition to a new carer. Child J had expressed a positive view to both the Social Worker and the Children’s Guardian about living with Aunt, and positive interactions between them had been observed. The SGO was granted and the Children’s Guardian recommended on-going support because of Child J’s complex needs; the court agreed that there would be a Family Assistance Order (FAO) for one year. This named the family support worker (FSW) as the “appropriate officer”. There is no requirement for there to be a formal plan of how support is provided under a FAO, and it is intended as a “light touch” arrangement with the support being agreed by all parties. At this point the support plan consisted of the Children’s Guardian recommendations and the Special Guardianship Support Plan. The impact of the FAO was that neither of these were implemented and no other plan was formulated. There were no multi-agency meetings held, despite Child J’s complex needs and no planned opportunities for the many professionals involved in her life to come together. Although there was no formal requirement to do this under the FAO, it would have been an important opportunity to think in a multi-agency context about what support was needed, how Child J’s emotional needs, her health needs and educational needs were to be met. The impact of the lack of a plan or meeting made the subsequent professional response to Child J and her Aunt more fragmented and led to a lack of a joined up approach.

3.36 There was a CAMHS consultation meeting a month after the Special Guardianship Order was granted, attended by Aunt, specialist CAMHS professionals and the Social Worker. It was agreed that CAMHS would remain involved and although this service would not usually provide support for children placed with Special Guardians, who would more routinely be seen by CAMHS community services (who would themselves assess what support was required) it was agreed that the continued involvement would provide continuity of support.

3.37 The purpose of the first meeting was an opportunity to review CAMHS involvement with the family and to consider when any therapeutic input (Theraplay) could commence. The meeting was designed to discuss the needs of a child and provide support to the network of carers and professionals; it was not a case work planning or decision making meeting and this was made clear within the minutes of the meeting. The meeting provided Aunt with an opportunity to explore how Child J’s move to live with her was going. Aunt reported difficulties managing Child J’s behaviour and Aunt said this was caused by contact with Mother, particularly walking past her house on the way to school. Actions were agreed to address this and it was also agreed that a change of school would be helpful.

3.38 There was confusion from the start about the CAMHS consultation process, despite the minutes making their status clear. Professionals came to see the meetings as the multi-agency decision making process for Child J. This was not surprising given that they

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15 The legal definition of a Family Assistance Order is set out in s16 of the Children Act 1989, which enables a court to make an order requiring a Cafcass officer or an officer from a local authority to advise, assist (and where appropriate) befriend any person named in the order.
were the only place (with the exception of two school meetings attended by the family support worker) where professionals came together to discuss Child J.

3.39 At the beginning of the new school term, the school that Child J had attended was informed that Child J was placed with her Aunt as a Special Guardian and that the plan was for Child J to change school. The existing Head Teacher expressed reservations to the Social Worker about the move and the disruption to Child J, but also agreed that walking past Mother’s house might be difficult. The process of the move was started.

3.40 During this time the specialist nurse for continence struggled to make contact with Aunt about an overdue appointment for Child J and telephone contact was attempted, but not achieved until two months later, when Aunt reported her concerns about what she described as Child J’s difficult behaviour and her belief that she wet the bed deliberately. The specialist nurse for continence gave advice and reinforced the need to take a gentle approach, without punishment or blame, in line with existing guidance\(^\text{16}\); Aunt agreed to this. However, despite Aunt’s concerns she did not bring Child J to the next appointment, but continued to seek support over the telephone. The specialist nurse for continence tried to encourage Aunt to attend appointments. Telephone advice was given once a month for the next three months. During these calls Aunt reported her belief that Child J deliberately wet the bed, had behavioural issues, “self-harmed” and said because of this Child J was being referred to CAMHS for support. The continence service is entirely voluntary and adults’ not bringing children to appointments is not uncommon. The specialist nurse for continence had a plan of action, but the absence of a social, emotional and health care plan for Child J (because it was not required by the FAO) meant that there were no forums at this time to share these issues and therefore the meaning of the contradiction that Aunt was complaining that the continence issues were not improving, but not attending appointments was not known by professionals. It meant that this early evidence that Aunt might not be prioritising Child J’s needs was not known.

3.41 Aunt also cancelled Child J’s appointment at the child development centre. A further appointment was made, there was confusion about addresses and after another failed appointment Child J was discharged from the service. CAMHS contacted the FSW to say that the planned meeting in November had been cancelled by Aunt. These were all important appointments for Child J, but the lack of a mechanism to develop a health plan to coordinate services to address Child J’s health needs meant these separate incidents were seen in isolation from each, and the meaning for Child J not analysed.

3.42 The Social Worker undertook a final home visit with the family support worker two weeks after the FAO was granted, and the FSW took over case management responsibility. The next home visit by the FSW was 8 weeks later and Aunt said she had concerns about Child J’s poor behaviour, reported that she had been swearing, was “self-harming” by scratching, was smearing faeces and she believed that Child J wanted

\(^{16}\) NOCTURNAL ENURESIS: the management of bedwetting in children and young people – FINAL VERSION
https://www.nice.org.uk/Guidance/QS70
to be naughty on purpose. Aunt said she had restricted Child J’s use of the bathroom so she could not drink water, in the hope that this would help with continence issues. It would have been helpful if the FSW had made contact with the specialist nurse for continence at this point to establish an agreed plan of action to address these concerns. If this had been done the FSW would have become aware of the missed appointments and therefore clearer that this was an issue of Aunt not accessing the right support services, rather than Child J having difficulties. This pattern of Aunt being able to deflect concerns from herself, and her lack of accepting the support offered to Child J, was a pattern that firmly established itself and was not noticed. This is addressed in the analysis section.

3.43 A few weeks later Child J’s school noted that she had bruises under her eye and down the left side of her cheek. The school spoke to Aunt about this and she told them that Child J had deliberately harmed herself. School staff were concerned that Child J looked uncomfortable and unhappy whilst this issue was discussed, but this information was not shared with any professional and only became clear during the trial and inquest after Child J died. Over the next two years there were concerns regarding the demeanour of Child J in the presence of her Aunt in a number of different contexts, which were not recorded or shared and this is addressed in the analysis section.

3.44 Aunt told the FSW by phone that Child J had intentionally hit her head on the bed and a visit was organised during the following week. The FSW spoke to the school admin team who confirmed what Aunt had told them. This was not considered to be a safeguarding issue, and information regarding this incident was therefore not passed on to the next school. At the home visit a week later Aunt said the bruises were caused by Child J “self-harming” and that this was caused by contact with Mother; the FSW agreed to address this. Aunt also said that she was concerned about continence issues and was restricting access to the bathroom so Child J did not drink water. The FSW suggested some positive reinforcement strategies including rewards for dry nights. Aunt reported that she had not attended the recent CAMHS appointment.

3.45 The next day the FSW received a letter regarding Aunt’s non-attendance at the continence service for Child J. This was 6 months after the move to live with Aunt, and alongside the non-attendance at the CAMHS appointment these issues should have prompted a review of progress, despite the FAO not requiring this; Aunt had said she was finding Child J difficult to cope with, there were consistent allegations from Aunt that Child J was self-harming and Aunt described Child J’s behaviour as difficult, but Aunt did not attend the services designed to address the needs of Child J and to provide Aunt with advice. This contradiction or discrepancy suggested that review was necessary. There is no evidence that this case was discussed in supervision at this time, and so there was no recorded management oversight of progress; the team manager and FSW reported as part of the Serious Case Review process that they often discussed Child J and her circumstances. The lack of records makes the content of these discussions hard to evaluate.
Child J moves schools – six months after moving to live with Aunt: January 2013

3.46 At this time Child J moved schools. Information was shared by the previous school regarding Child J being placed with Aunt on a Special Guardianship Order and incorrectly that there was a “social worker” when in fact it was a FSW; contact details were provided. However, the transfer of records was delayed and the new school were not aware of Child J’s past history, her health needs or the involvement of CAMHS.

3.47 The terms of the FAO meant that there was no automatic meeting process and the FSW did not organise a meeting with the school. However, this was an important transition in the early days of a new home and relationship for Child J and a meeting would have been an opportunity to consider how this transition would be managed given the discussions between the FSW and Aunt regarding the challenges this new school move might pose for Child J and Aunt’s reported concerns regarding difficult behaviours and “self-harm”; the absence of a meeting meant that there was no working relationship established between the school and Children’s Social Care. There was no handover from the school nurse and it is unclear how much the new school nurse knew about Child J’s past. The school nurse saw Child J eight weeks after she had started at this new school and routine health procedures were undertaken in isolation from other activities to address Child J’s health needs. This was not helpful multi-agency practice.

3.48 At the next home visit by the FSW Aunt reported again that Child J had “harmed herself” and Child J showed her the injuries. The FSW spoke to Child J about this and it was recorded that she said she wanted to be naughty. She also said that she was happy at school and living with Aunt. The contradictions between happiness and self-harm were understood to be caused by Child J’s ongoing difficulties and were reminiscent of the behaviour seen whilst Child J was settling into her foster family.

3.49 The next home visit by the FSW was mid-March 2013 and Aunt reported that she was upset because she felt that school were criticising her and she had been told that Child J was stealing. Aunt told the FSW that there was a meeting planned to discuss these concerns but there is no record of this held by the school or no contact between the FSW and the school. Aunt discussed her continued concerns about continence issues and that she remained concerned about the impact of contact with Mother. The FSW said that contact was important, but agreed to talk to Mother, which she did the next day. The concerns regarding Child J’s behaviour, continence issues and the importance of Mother supporting the placement with Aunt were discussed. Mother was provided with no agreed way to share any thoughts she had about the placement and the emphasis on supporting Aunt, which was absolutely appropriate at this point, did not change despite Mother expressing concerns regarding Child J during contact over time.

3.50 The FSW subsequently discussed Child J in supervision and reported that Aunt was being supported by her family and the Church and she was implementing a strict parenting style to address Child J’s behavioural needs; no further detail is recorded. There was no discussion regarding the current issues at school.
3.51 Four weeks later Aunt took Child J to hospital with a burn to her leg and some bruising to her thigh. On examination the Doctor found further scratches and bruises that Aunt said were due to “deliberate self-harm” for which Child J was going to receive support from CAMHS. Aunt said Child J deliberately stood in front of the heater and this had caused the burn. The hospital reported that Aunt had behaved appropriately and Child J was not observed to be distressed; she was, however, not seen alone or asked what had happened and there was no reflection on the part of the medical team regarding either the likelihood of a child aged 6 engaging in this type of behaviour; if this seemed a likely explanation or the seriousness of such an action by a child of this age. This required further reflection; either to consider a differential diagnosis of safeguarding, in which case advice should have been sought from the safeguarding team or to consider why a child this young was behaving in this way/possibly self-harming and to consider whether appropriate support was in place. The reported involvement of the CAMHS team seemed to have provided reassurance that it was. There was an acceptance of Aunt’s self-report and an uncritical acceptance of self-harm as an explanation for an injury to a young child and this is addressed in the health action plan.

3.52 The attendance at A&E was shared with the emergency duty team at CSC, and a notification passed to the FSW, including that the hospital had no concerns regarding the incident.

3.53 Aunt provided information about the visit to the hospital to school. The Designated Safeguarding Lead (DSL1) reported keeping handwritten notes regarding this incident though it is unclear where these records were kept at this time. DSL1 states that she became aware that she needed to record incidents of concern on a form later that year when she attended safeguarding training and said that she transferred all her handwritten notes onto a concern form she designed in September 2013, and at this time reported that she destroyed all her handwritten notes. This means it is not possible to know what was recorded at the time that each incident took place or what action was taken at the time). It was reported that the FSW was contacted and to have confirmed the detail regarding the burn; there is no corresponding record in CSC files.

3.54 The school nurse was informed of the hospital visit by the liaison health visitor, who asked that the incident was reviewed. The school nurse did contact school, but focused on issues regarding attendance, and the burn was not discussed. It would have been expected that the school nurse would have some oversight of Child J’s circumstances and complex health needs, but although she was never invited to any of the meetings held, the safeguarding concerns were not shared with her by school staff and she never sought to meet with either the DSL or the FSW. This is unusual. The school nurse has a central role to play when there are both safeguarding concerns and complex health needs.
3.55 No one agency explored this incident in sufficient detail and all seemed reassured by what they saw as Aunt’s caring demeanour and confident assertion that this was a deliberate act by Child J and they were reassured by Child J’s lack of distress.

3.56 Follow up appointments were organised with the practice nurse at the GP surgery to change dressings and to check the injury. Aunt took Child J for these appointments and the practice nurse observed what she described as a warm and caring relationship.

3.57 Two days after the visit to the hospital Child J’s Class Teacher noticed bruising to her face and some older bruises. Child J was spoken to and gave different and contradictory versions of the cause, including that she deliberately banged her head against her bed (this is the same explanation provided for concerns of bruising some three months earlier to the previous school). Child J reported that she was punished at home by being made to hold her hands out and facing the wall, being made to strip and go in the bath because of conflicts with Aunt during teeth brushing.

3.58 The Class Teacher recorded this and she passed her notes to DSL1. DSL1 phoned Aunt who reported that Child J self-harmed. This was recorded on a handwritten note and put onto a safeguarding form in September 2013 (the original record was destroyed so it is no known what was recorded at the time or what action was taken). This form, completed some months later, says a message was left for the FSW; there is no corresponding entry in CSC records. If a message was left, it was not appropriate to do so given the seriousness of the incident and without ensuring that the information had been received and next steps agreed. The details of concerns regarding the disclosure made by Child J were subsequently shared verbally (so it is not known how much detail was provided) at a meeting in school attended by the FSW five weeks later. The information about the bruising which led to the original discussion was not. Once again there was no feedback loop. The classroom teacher had shared her concerns, and these had been shared appropriately with DSL1 – but the lack of contemporaneous recording or any action or clarity regarding whether FSW had received the message meant that this concern was not fully addressed.

Nine months after moving to live with Aunt

3.59 The next CAMHS meeting took place a week after the burn incident and was attended only by Aunt and CAMHS professionals; the FSW had previously made it clear that she could not attend. Aunt reported her concerns about Child J’s behaviour and continence issues which Aunt believed were deliberate and connected to “self-harming behaviour” (the specialist nurse for continence was not involved in this meeting and so no specialist advice was available). Aunt also reported the incident of the burn was also an incident of “self-harm”. Aunt said she needed to implement punishment such as making Child J stand against the wall with arms outstretched, because Child J was “difficult, defiant and lacked remorse”. The CAMHS professionals were concerned regarding this, and reported expressing these concerns directly to Aunt, but this is not recorded in the minutes. The CAMHS professionals tried to get Aunt to focus on Child J’s difficult early...
experiences. Aunt focused this discussion on contact with Mother as an explanatory factor. The issue of Child J’s potential self-harming behaviour was not questioned, and more thought should have been given to either reflecting on the likelihood of this level of self-harm in a six year old and therefore concern about her wellbeing. The professionals at the meeting were persuaded by Aunt’s confident articulation of her concerns regarding these issues.

3.60 After the meeting the CAMHS professionals appropriately agreed that a meeting was needed with the FSW to discuss concerns regarding what they saw as harsh and critical parenting approaches and this was organised for eight weeks’ later. However, the focus at this time was on Aunt’s struggles to manage her own reports of Child J’s difficult behaviour, rather than as a potential safeguarding concern; this was not an appropriate analysis. It would have been the responsibility of the FSW to invite the school to attend the CAMHS consultation sessions, and it is not clear why this did not happen until October 2013.

3.61 In mid-April Aunt told the school that Child J’s burn was infected and that she could not do PE or go swimming. This information was not shared with any agency, and the information not checked or clarified.

3.62 There was a meeting at school at the end of April 2013. This was attended by the FSW, Aunt, DSL1, the school nurse and the Head Teacher. Concerns about “abusive” parenting practices were discussed, which Aunt denied. It is unclear whether Aunt was challenged regarding this disclosure from Child J, Aunt had told the CAMHS professionals a month earlier about adopting this approach, and although the FSW had not been present, minutes had been sent out and a meeting organised to discuss the concerns. There is no action recorded regarding this. The meeting notes also record that the school were made aware of Child J’s continence issues, self-harm and CAMHS involvement. The agreed plan was that the school nurse would liaise with the specialist nurse for continence and the school to inform all professionals, and Aunt, if Child J displayed challenging behaviour. There was no review of this plan and there was no further school meeting with the FSW until 14 months later.

3.63 The CAMHS consultation organised to discuss concerns about Aunt’s punitive parenting practices took place two weeks later in May 2013; it was attended by CAMHS professionals and the FSW, the school were not invited, despite having similar concerns and having spoken directly to Child J about this from her perspective. It is unclear why this was the case, but the meeting lacked a focus on Child J and her experiences. The meeting concluded that Aunt was implementing harsh “discipline” and this was because she was struggling to cope with Child J’s complex behaviours. There was agreement that the observation/attachment session planned for that afternoon would help make sense of Child J’s circumstances, that parenting support would be provided by the CAMHS intensive support team and that Theraplay would be considered to improve the relationship between Aunt and Child J. Although there was recognition that Child J had experienced early trauma, there was insufficient analysis
regarding whether Aunt understood this and was addressing this appropriately, rather than blaming Child J for her difficulties, something which was evident. There was also insufficient attention paid to what impact the current circumstances were having on Child J’s behaviour and what life was like for her given Aunt’s disclosure of harsh and abusive parenting.

3.64 On the same day an observation of Aunt and Child J was undertaken by CAMHS (MIMS assessment\textsuperscript{17}). Aunt provided a lot of background history and outlined her current concerns about Child J’s behaviour. The analysis of the observation itself was that Child J did seek reassurance and comfort from Aunt, but she was not relaxed. The CAMHS professional reflected on this a week later where they noted that there had been positive interactions but that there was also discipline and fear. This information was shared with Aunt, who said the observation had been artificial, but she agreed to accept support from the CAMHS intensive support team which would focus on positive behaviour management.

3.65 In mid-May 2013 the Class Teacher noticed that Child J had a bruised eye. DSL1 was informed of this incident, and she telephoned Aunt who said this was caused by her itching chicken pox scabs, something the school also observed her to do. This was recorded on the DSL1’s handwritten notes and transferred onto a concern form some months later. This form says that Aunt was told that the FSW would need to be informed but there is no corresponding record held by CSC and it appears this incident was not shared at this time.

3.66 The work with the CAMHS intensive intervention service started a month later and a Health Care Assistant (HCA)\textsuperscript{18}, overseen by a manager, was allocated. There were to be six sessions focused on issues of positive disciplinary strategies and addressing Child J’s continence issues. The HCA liaised with the specialist nurse for continence regarding this, but there does not appear to have been discussion about a consistent approach in line with the NICE guidelines\textsuperscript{19}; for example the HCA implemented a reward programme, something which was considered unhelpful in the Guidance. Aunt told the HCA that she was now more responsive to adopting more positive disciplinary approaches. The HCA saw Child J at school and home and noted a good relationship with Aunt, who joined in games and positive activities.

3.67 The continence nurse met Aunt at this time and they discussed Child J’s behaviour and continence. The school nurse sought advice and supervision from the specialist nurse for safeguarding regarding Child J. Concerns were said to be bruises for which Aunt always had an explanation, Child J’s stealing and self-harm for which CAMHS were involved. It does not appear that there was a discussion about what other agencies

\textsuperscript{17} The Marschak Interaction Method (MIM) is a structured technique for observing and assessing the overall quality and nature of relationships between caregivers and child. The MIM provides a unique opportunity for observing the strengths of both adult and child and of their relationship. It is, therefore, a valuable tool in planning for treatment and in determining how to help families strengthen their relationships. http://www.theraplay.org/index.php/what-is-theraplay-3/the-mim-assessment

\textsuperscript{18} Healthcare assistants (HCAs) work in hospital or community settings under the guidance of a qualified healthcare professional.
were doing, whether they shared the concerns and therefore whether a multi-agency discussion was necessary. No action plan was agreed and no contact made with the school nurse or family support worker.

3.68 At the beginning of June 2013 the HCA spoke to DSL1 who reported that she had noticed bruising on Child J’s cheeks, and it was also reported that Child J had reported harsh discipline approaches. The HCA shared these issues with one of the CAMHS professionals who spoke to speak to the FSW.

3.69 At this time the Class Teacher noticed that Child J had bruising to the inner sides of her legs and knees and a mark on the bridge of her nose. When Child J was asked about this, she said she had fallen down the stairs. The Class Teacher shared these concerns with DSL1 who reports she recorded them in her handwritten records. A concern form was written some months later, which said that the bruises were not discussed with Aunt, but shared with the FSW. There is no corresponding entry in CSC records and the contemporaneous notes held by DS1 were reported to having been destroyed by herself.

3.70 The next day the Class Teacher noticed big bruises all down the shin on both legs when Child J got changed for PE. She also noticed a lump on her forehead. This was shared with DSL1 and recorded some months later on the newly designed cause for concern form. It was again recorded that the FSW was informed, but there is no corresponding entry in CSC records and it seems likely this was not shared as it should have been.

3.71 The next day the FSW rang the school and spoke to DSL1 because she had become aware of school concerns regarding bruising. DSL1 shared information regarding bruising on her legs, nose and knees. The FSW was concerned that this had not been discussed with Aunt and it was agreed that a school/home liaison book would be started.

3.72 The FSW shared background information regarding the SGO, bed wetting and self-harming behaviour. These issues were recorded in the DSL1 handwritten records and there is no evidence that the Class Teacher was informed about this conversation or provided with any feedback regarding her concerns. She also did not seek any feedback.

3.73 The FSW asked that all injuries noted by school were shared with her. The DSL1 said that this “would be a daily occurrence”, but the meaning of this was not explored and the FSW did not ask about what records were held. It is clear that the FSW did not have an accurate chronology or any written details of the many concerns held by the teacher and teaching assistants, as one did not exist. It is of concern that both the FSW and DSL1 were happy to discuss the bruises in a general way, rather than discussing the detail.

3.74 This was an opportunity for the school, the FSW and the CAMHS intensive intervention worker to arrange a meeting to discuss concerns about bruising and injuries face to
Neither the FSW or DSL1 recognised the critical importance of recording accurately what was said by a child and their parents/caregivers about injuries so the explanations can be explored and concerns about possible non-accidental injuries accurately assessed. This recording is essential and something explored further in Finding 6.

3.75 Aunt spoke to the specialist nurse for continence at this time and reported continued concern; she said she had restricted Child J’s access to the bathroom, but this had led to her drinking urine from the potty. The specialist nurse for continence sought advice regarding this from CAMHS, and was told that this behaviour was likely to be attention seeking and she was encouraged to attend the next CAMHS consultation meeting, which she did. It is unclear why she did not seek contact with the FSW as the case holder, but it seems that she might have been unaware of her role at this point. Again, the lack of either a health plan, or care plan was influential in the lack of an analysis of the available information. The specialist nurse for continence could have sought her own safeguarding supervision, given Aunts punitive and blaming approach. It appears that she was reassured by the involvement of CAMHS.

12 months after moving to live with Aunt: September 2013

3.76 The FAO was granted for one year and when this year was up the FSW appropriately sought advice from her manager about her concerns that Aunt was adopting what she believed to be a harsh and punitive approach to parenting and it was agreed there needed to be social worker input, without the purpose of this being made clear. It also remains unclear why there was not a multi-disciplinary meeting to review the placement at this point. This was not a requirement of the FAO, but was necessary because of the on-going concerns, which were not analysed as being of a safeguarding nature, but were recognised as a need for further support.

3.77 Aunt informed the FSW that she would be away and that Child J was going to stay with a family friend (known as Auntie) who attended the same church as her. The FSW appropriately visited Auntie to ensure that the carer and the accommodation was suitable. This was approved by the team manager.

3.78 The following week the Class Teacher noted bruising to Child J’s cheeks and ears and a cut to her lip. Child J told DSL1 that she had been beaten with a belt and a spoon by the Auntie with whom she had stayed whilst Aunt was away. The Class Teacher wrote a cause for concern form and body map and this was passed to DSL1 who shared it with FSW. The FSW rang Aunt who said that Child J had fallen against a pushchair after she had been sent to her room. There was no feedback to the Class Teacher about action taken, or what the FSW proposed to do to address the concerns. This continued lack of a feedback loop, and the lack of perceived action was not discussed at school, despite the Class Teacher being concerned about it.

3.79 The FSW and the Duty Social Worker visited Child J at home and noted that she had visible bruises, but when asked about them said she had lied about being beaten by
Auntie and had harmed herself by banging against her toys in the bedroom – a slightly different story than that given by Aunt on the phone. The discrepant explanation was not noted, and Child J was not asked about why she might give a different account. Child J said Aunt was still punishing Child J by making her stand in the corner with her arms out, because she was “thieving” water. This does not appear to have been questioned or challenged. There is no evidence that the FSW or the Social Worker provided any feedback regarding the outcome of their visit to DSL1 or that this information was sought.

3.80 The FSW then saw Aunt at home alone where she was described as distressed and she reported finding it difficult to manage Child J’s complex behaviour; evidence of this behaviour was provided by two church members who were with Aunt; one of whom was the family friend about whom Child J had made allegations of physical abuse. This meant that the continued evidence of “harsh parenting” was contextualised again as a response to Child J’s reported difficult behaviour.

3.81 The agreed plan was to speak to CAMHS and discuss what further support could be provided. This was done by telephone contact with a CAMHS professional and it was agreed that there would be further discussion at the next CAMHS consultation, but that the school needed to clearly record bruises and to report them to the FSW. This process highlighted again the confusion about who were the main decision makers in this case. The analysis remained that although there were concerns regarding Aunt, the problem was Child J’s behaviour, rather than Aunt’s response to it, and that CAMHS support was needed. There was no discussion about whether there was a need for a separate multi-agency meeting or a safeguarding response.

3.82 In October 2013 the Class Teacher noticed a small bump and graze on the left of Child J’s forehead. She tried to speak to Child J about this, who seemed upset and nervous. She said she had hit her head at school. It was recorded that this information was shared with the FSW, but there is no corresponding entry in CSC records. It was recorded on an incident form. A week later Child J came to school with bruised finger, which Aunt explained had been caused by jumping on the bed. Child J was also asked about what had happened, and gave the same story. The Class Teacher recorded that she was concerned about Child J’s demeanour, particularly that she made no eye contact. The Class Teacher and the DSL1 were satisfied with the explanation provided by Aunt, and reassured that Child J also provided the same explanation, and so they did not consider that this was a safeguarding issue, but an accident, which did not need to be shared. They were concerned about Child J’s demeanour, but this was not something they usually shared because it was not factual information. This issue is addressed in the analysis section.

3.83 CAMHS and the GP received a letter from a Consultant Clinical geneticist. The letter said that Child J had a disorder associated with renal cysts, risk of maturity onset diabetes, mild learning disabilities and behaviour problems – although it acknowledged that behaviour problems could be caused by a number of issues. The
letter ended with a concern that further kidney problems and diabetes could be a problem in the future.

3.84 There was a CAMHS consultation this same month attended by all the professionals currently in contact with Child J, including for the first time DSL1; Aunt attended with two supporters who she described as spiritual guardians for Child J and who were friends from her church (it is now clear that they were not representing the church in any capacity and their exact status and role was not discussed). One of these adults appears to have been Auntie about whom Child J made allegations of physical abuse but her role was not challenged (it is not clear who was aware of this and the concerns had not been substantiated – this clearly influenced the lack of challenge). There was no discussion about whether it was appropriate or helpful to have these adults present.

3.85 This was the first CAMHS meeting attended by DSL1 from the school and the specialist nurse for continence. Aunt shared a number of concerns about what she described as Child J’s “extreme and shocking and provoking behaviour” connected with continence issues and allegations that she was defecating in the flat and eating faeces. The detail was backed up the spiritual guardians (one of whom was the adult about whom Child J had made previous allegations of abuse). Given the continence nurse was present at this meeting, it is surprising that no plan was formulated to address these issues of continence. The recent allegations regarding bruising were discussed; it was noted that Child J had made some false allegations and that she continued to “harm herself” by biting her lips and scratching.

3.86 Despite all the worrying incidents the meeting concluded that the work of the Intensive Support Health Care Assistant had been positive, but that Child J was “finding it difficult to stick to the agreed plan” and her behaviour remained concerning. Aunt described Child J as “very calculating and manipulative”. The records do not make it clear if this view was challenged or explored in the meeting – or whether she was asked to consider what Child J’s positive qualities were, or what this harsh criticism might mean for a young child. The FSW said she had previously discussed Aunt’s “abusive” parenting approach with her and that Aunt understood this was a safeguarding matter, but there were no actions arising from this. The conclusion was that Child J was a challenging child because of her earlier parenting experiences and the recent geneticists report reinforced professional thinking at this time. These were serious issues regarding a young child, and although professionals were reassured that Theraplay was designed to address these issues it is the view of the Serious Case Review that more thought should have been given to responding to the distress and unsettledness of Child J reported by Aunt. This continued focus on the adults, rather than the child is discussed in Finding 12. This meeting was recorded covertly by Aunt, and this recording was heard as part of the inquest. This record makes clear the way that Aunt dominated the meeting, and was supported in her views regarding Child J as the problem by the two adults who attended with her. The professionals present genuinely believed that they were providing Aunt with a forum to discuss her experiences of parenting Child J, and it was only on reflection when hearing the tape
recording that the dominance and manipulation of the focus of the meeting became clear. This dominance and manipulation meant that Aunt was able to deflect professional attention from the need for a plan of action to address the many concerns, including serious issues regarding continence and self-harm. This is addressed in the analysis section.

3.87 The next month there was an anonymous referral from the NSPCC about two girls being locked in a car at a church car park. It became clear that this related to Aunt, Child J and a niece. The FSW and the Social Worker took this referral seriously and started the process of exploring what had happened. The SW telephoned the safeguarding lead for the church who provided a confused account of what happened. There had been an argument, Aunt had “gone crazy and hit the woman”. The church safeguarding lead shared concerns about previous incidents where Aunt had put Child J in the corner for misbehaving, but had not considered them serious enough to make a referral; the SW made it clear that the safeguarding lead for the church should have been in contact with Children’s Social Care if she had any concerns. 

3.88 The Social Worker undertook a home visit. It was recorded that Child J looked terrified, and Aunt said this was because she had been caught stealing at school, it is not clear if this version of events was checked with Child J or school. Aunt refuted the allegations. Two witnesses from the church supported Aunt’s version of events. The FSW discussed the NSPCC referral with her manager and because witnesses had supported Aunt’s version of events and Child J had not raised any concerns when seen alone at school, it was agreed there was no need for further action. This incident was seen in isolation from the previous concerns without stopping to think about the cumulative impact on Child J; a chronology of events had never been started and at this point it would have helped with the analysis of recent events. The fixed analysis remained, supported by information from others, but without any professional stepping back and appraising the available cumulative evidence.

3.89 At the end of this month the Class Teacher noted bruising under Child J’s chin, one bruise on top of another, and there was a small bruise on her left ear. She asked Child J about these marks and it was recorded that she said she had caused them by harming herself. This information was recorded on a cause for concern form and a body map of the injuries was completed at the end of the school day. The next day Child J was seen by a Paediatrician for an existing appointment regarding brittle hair and hair loss which was unexplained. This appointment was held after two previous ones had not been attended. The Paediatrician also noted the bruising and was concerned and was to ring CSC the next day.

3.90 DSL1 contacted the FSW to inform her of the concerns and faxed through the written information. The Team Manager and Social Worker discussed the concerns and agreed

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19 This incident led to later concerns regarding the safeguarding processes in place within the Church. This was addressed by the Local Authority Designated Officer (LADO) who had several meetings with the church leaders and the church safeguarding team. Work has been undertaken to ensure that the church currently have robust safeguarding processes in place.
to undertake child protection enquiries. The SW rang Aunt who reported that Child J had scratched herself and they had seen a Paediatrician that day who Aunt reported had not been concerned.

3.91 Appropriately the Social Worker spoke to the Paediatrician, who said that she was concerned about the mark behind the ear and a child protection medical was organised; it was agreed the need for parallel child protection enquiries would be decided once the medical was completed. The rationale for this is not entirely clear. Given the complexity of Child J’s circumstances and recent concerns regarding Aunt’s behaviour at church (which were unsubstantiated) it would have been expected that a full child protection enquiry, in the form of a holistic assessment would have been carried out. The child protection medical assessment was part of this process.

3.92 Child J was brought for the child protection medical by her Aunt and her Father; he reported that Child J had spent the weekend with her half siblings, children from his other families. The Social Worker also attended and gave a history of the most recent concerns about bruising and harsh punishments. The Social Worker reported there were problems with Child J’s behaviour, which was caused either by her past experiences or a mild brain defect; she also reported that Child J self-harmed. This verbal information would have been enhanced by written information or a chronology, something the Paediatricians now routinely seek. A comprehensive child protection medical was undertaken and multiple marks were noted and histories given for all but two of them. The concerns regarding these marks were followed up the next day by a Consultant Paediatrician. He considered that the two marks were unusual, but not bruises and the Consultant Paediatrician agreed to consult a dermatologist about them; this did not happen. Child J was offered an appointment with a dermatologist in February and April of the following year, and she was eventually seen in June 2014 but not in the context of a safeguarding concern and the unusual marks were never evaluated further.

3.93 The Team Manager recorded that she spoke to the Consultant Paediatrician by phone. There is no corresponding entry in the hospital records and the Consultant Paediatrician recorded that he had tried to talk to the Team Manager. A written report was provided three weeks later.

3.94 This reported that Child J had been happy and cooperative. There were two marks that were in areas that did not normally bruise accidentally and were unusual and he had asked for these to be reviewed by a dermatologist. Pictures had been taken. The Consultant Paediatrician reported that Aunt had indicated that there was evidence that Child J bruised easily, and blood tests were organised to rule this out. It is not clear when these tests were undertaken as a confused picture emerged over the following months of Aunt not bringing Child J to agreed health appointments. It was confirmed at some point that Child J did not have a medical condition which caused easy bruising. The actions agreed from the child protection medical did not take place immediately, and were not followed up as would be expected.
3.95 This was another incident which was investigated, but not contextualised alongside the history of incidents, concerns and possible injuries. The child protection medical suggested that no safeguarding action was seen as necessary, but what was needed was a broader and more holistic assessment.

3.96 Aunt had said that a number of the injuries were caused by self-harm and there should have been more concern about this; however, professionals were reassured that these issues were being addressed through contact with CAMHS and did not question exactly what support was being provided.

3.97 There were a large number of marks/bruises and this in itself should have caused all involved more concern; either there was a significant lack of supervision, deteriorating problems with balance (something noted in the past medical history), serious neglect or safeguarding concerns. This required a full assessment.

3.98 In December 2013 there was a CAMHS consultation attended by all currently involved agencies. Aunt reported that Child J was still attempting to "hurt herself" which had led to an examination by a Paediatrician who had concluded that there were no injuries of concern and Aunt reported that Child J “bruises easily”. Aunt reported that she remained concerned about the poor communication from the Class Teacher and it was agreed that it was important that the home-school liaison book was used appropriately. The conclusion was that Child J continued to present with a number of challenges. The recent NSPCC referral and the incident at the Church were not discussed, and it seems clear that CAMHS did not know about these. Aunt covertly recorded this meeting, and again dominated the discussion, supported in this activity by the spiritual guardians.

18 months after moving to live with Aunt

3.99 Over the next six months Child J and Aunt had regular contact with professionals. There was a sense that circumstances had become more settled and the FSW agreed that CSC would cease their involvement when therapeutic support had been started. The need for a multi-agency meeting was acknowledged before this happened but did not take place.

3.100 The specialist nurse for continence sought safeguarding supervision from the specialist nurse for safeguarding where she reflected on the recent non-attendance of Aunt and Child J at planned appointments and Aunt’s critical approach to Child J. The specialist nurse for continence was asked to liaise with the FSW regarding Aunt’s belief that Child J’s continence issues were deliberate and behavioural, when it might be connected to her medical issues. This was an appropriate response, but did not happen. This was the first discussion about whether Child J’s chronic wetting/enuresis was psychological, behavioural, had a medical cause or was a mix of all three. The specialist nurse for continence had telephone contact with Aunt during this time and she reported that Child J had been discharged from paediatric care (she did not say it was
because of non-attendance), that she was due to see the dermatologist and continence had improved.

3.101 There was a CAMHS consultation in February 2014 and all agreed that progress had been made and that Theraplay would commence; given the concerns about self-harm, a dominant theme at this time, it is hard to know why this conclusion was formed.

3.102 In February 2014 safeguarding arrangements changed at the school. The existing DSL1 was joined by a learning mentor – who became DSL2 and the Head Teacher was also part of what was described as the school safeguarding team. It has become clear through the inquest process that DSL2 had little experience of safeguarding and that the Head Teacher did not make clear that he was not just part of the team but had leadership and management responsibility. There were regular meetings to discuss all the children about whom there were concerns, and Child J was regularly discussed. At no point was there any discussion of the concerns held by teaching staff regarding bruising and no chronology was completed for this meeting. There were considerable tensions amongst the school safeguarding team, and from this point onwards school staff reported feeling confused about internal safeguarding arrangements. This is discussed in Finding 8.

3.103 At the beginning of March 2014 school noticed that Child J had bruising on her hands said to have been caused by her brother whilst playing at her PGM house. This was not shared with the FSW because DSL1 believed that the explanation given was consistent with the injury; a safeguarding concern form was completed by the Class Teacher. At the end of March 2014 Child J had further bruises on her hands and two days later she was noted to have a bruise and bump to her head that Aunt said was caused by her banging her head on the car door. There is no evidence that this was shared with FSW or any action taken. It was recorded in the notebook of the Class Teacher.

3.104 The FSW had a case discussion with the Social Worker. She told her that Child J was reported to be stealing food and manipulating her friends at school (unclear where this last issue came from or who reported it). They acknowledged that Child J had had bruises, but these were caused by self-harm and appropriate explanations had been provided by Aunt who had cooperated with all inquiries.

3.105 The FSW saw Child J at school at the beginning of April and she observed her to be happy, but the Class Teacher reported concerns regarding her behaviour.

3.106 A letter was sent to the GP, the social worker and the school nurse by the Community Paediatrician to report that she had seen Child J regarding hair loss and thinning hair. This letter also noted that that Child J had missed two appointments with paediatrics regarding her thinning hair a, giving family emergency as the reason. Child J had also missed two appointments with the dermatologist, and a blood test requested at the Child Protection medical had not taken place. This was evidence of Aunt not addressing Child J’s health needs, that was not responded to or addressed in the professional network
3.107 There was also a visit by the FSW at the end of April where Child J was described as positive and happy, but the Class Teacher said she remained concerned regarding her behaviour and some bruising. The FSW does not appear to have asked for any specific details, and the Class Teacher did not provide any. The Class Teacher was reminded to continue to share any concerns and the FSW gave the Class Teacher her direct number to enable her to do so.

3.108 On the same day as the visit to the school the FSW undertook a home visit where Aunt reported that Child J was still bed wetting, stealing food from school and blaming other children for it. Aunt said they had missed the Theraplay appointment, another example of Aunt raising concerns but not attending appointments intended to provide support to the placement. Aunt continued to say that contact with Mother impacted negatively upon Child J. This was not discussed with Mother or her views sought; Mother was also concerned about how Child J appeared during contact, but was unclear who to share this information with.

3.109 A few days later Aunt told the Teaching Assistant (TA) in Child J’s class of a bruise on Child J which she said had been caused by a child pushing her off a bench. The TA also noted this and a scratch under the eye, which Aunt said Child J had caused herself. This was shared with the Class Teacher, DSL1 and DSL2. It is not clear what the DSL response was, but the Class Teacher was so concerned that she faxed a concern form and body map to the FSW as she had been asked to share any concerns regarding bruising five days earlier. The FSW phoned Aunt who reported that Child J had said that another child had pushed her. Aunt was angry because she believed the school were accusing her of abuse and wanted this addressed with the school.

3.110 The FSW went into school to discuss the safeguarding concern and possible confusion regarding the nature of the injury. She met with the Head Teacher and DSL2. It is unclear why DSL1 was not invited. The Class Teacher and DSL1 were inappropriately not invited so could not explain their overall concerns for Child J or their specific worry about the scratch to the eye which was different to the bruise to the arm. It was agreed that it was of concern that the Class Teacher had faxed a safeguarding form and body map to the FSW, without anyone else in the school being aware of this. It was not acknowledged that this is precisely what she had been asked to do some days earlier. The Safeguarding in Education Guidance makes clear that it is best practice to share safeguarding concerns in school with the designated safeguarding lead (DSL) but that there will be times when a member of the school staff will need to share information directly in order to safeguard a child. The Class Teacher in this case had been told by the FSW to contact her directly a few days earlier, but also overall she felt her concerns regarding the safety and wellbeing of Child J were not being listened to and that is why she faxed the form. She was never asked why she had done this.

3.111 DSL2 said she had seen the injury to the eye and had considered that the explanation provided had been consistent with the injury; this did not account for the two different injuries. The issue of Child J being pushed by a child was also acknowledged and it was
agreed this was not a safeguarding issue. The concerns of the Class Teacher and the TA was effectively dismissed.

3.112 During this discussion the FSW shared information about Child J’s complex needs and the importance of taking account of these when considering injuries because Child J bruised easily (self-reported by Aunt and shown not to be true), as well as a history of self-harm, also self-reported by Aunt. DSL2 felt concerned that the school were not fully aware of this background information and had therefore not been able to contextualise their concerns. No actions are recorded as a result of this meeting, but it appears to have cemented the notion that all school staff needed to be sensitive and placatory to Aunt, rather than focusing on the safeguarding of Child J. This position remained and influenced decision making over the last six weeks of the school term.

3.113 The FSW phoned Aunt and shared the content of this meeting with her, Aunt was said to be angry because she felt the Class Teacher was “targeting” her. The FSW sought to reassure Aunt that she was coping well and that the FSW would be ensuring that the school dealt fairly with her and would challenge any actions regarding false allegations. DSL2 also telephoned Aunt; she apologised for the behaviour of school staff and reassured Aunt that she was a good parent, that she was coping in difficult circumstances and the DSL2 would ensure that concerns held by school would be addressed and she would also ensure that the FSW understood the difficulties she was facing.

3.114 Aunt covertly recorded both these conversations, and they were heard during the inquest. They make clear that both professionals sought to placate Aunt, rather than focus on the needs of Child J. It is clear that the telephone calls also undermined a collective view of the needs of Child J, with FSW and DSL2 taking the side of Aunt against other school staff. This was a serious issue and is addressed in the analysis section.

3.115 On the same day as the meeting between the FSW and DSL2/Head Teacher there was a concern logged by playground staff that Child J may have lifted her skirt up in a school queue and she had no underwear on. This was shared with the school safeguarding team, but not passed on to the FSW.

3.116 Aunt asked for there to be a meeting in school because of her concerns about false allegations and the Class Teacher questioning of Child J. This was attended by Aunt and a friend, the Class Teacher, DSL1 and DSL2 and the Head Teacher. Child J’s complex needs were discussed and Aunt drew attention to Child J’s stealing and bed-wetting. The focus was on poor communication by the Class Teacher and TA to Aunt and the conclusion was that there would be efforts made to improve communication through a communications book. The focus on communication, supporting Aunt and being sensitive to Aunt’s needs was inappropriate and led to any concerns about bruising and Aunt’s behaviour to Child J being dismissed. The fixed view held by some professionals
that this was about Child J being a difficult and complex child and Aunt responding to those difficulties became further entrenched. This is discussed in the analysis section.

3.117 The Class Teacher was unable to express her concerns in the meeting; this was influenced by the fixed view held by others that the concerns were false allegations, partly because she was being told off for sending in the concern form to the FSW, and also because Aunt was present and had dominated the meeting. There was clear confusion here regarding the purpose and focus of the meeting. There should have been two meetings. One internal management meeting to discuss the issue of the Class Teacher not informing the school safeguarding team of her actions. This would have been an opportunity to discuss her reasons for doing so- something the Class Teacher could not do with Aunt and a friend present. This could have exposed both the confusion about safeguarding processes in the school and offered a forum for discussing the differences of opinion held across the staff group. The Head Teacher took no leadership role within this. The second meeting should have been a discussion with Aunt where the school robustly supported teachers’ rights to raise concerns about children in the interest in safeguarding. Communication and respect could have been part of this conversation.

3.118 School held two of their now routine school safeguarding meetings in May 2014, but Child J was not discussed at either, despite the concerns shared and many incidents of bruising. This appears to be because there was a view that there were no safeguarding concerns. In May 2014 DSL2 sent an email to all members of staff in the school involved with Child J and asked that any concern forms were either passed to her directly or placed in a box file which was held behind the reception. It is unclear how this was decided upon as there is no record of this decision in the school safeguarding meetings, and leaving concern forms in a public area of the school was not an appropriate decision.

3.119 In mid-May 2014 the FSW carried out a home visit; Child J was reported to be in the car ready to go out. Aunt said Child J was “testing her again” and Child J told the FSW that she was sorry for not telling the truth, there was no further discussion of this as they drove away and this was not followed up.

3.120 In mid-May 2014 there was a meeting with Aunt and CAMHS professionals regarding the start of Theraplay, which had been rescheduled from April. Aunt said that Child J was still self-harming, her continence issues had deteriorated and she described Child J as no longer motivated to make any changes. Issues of stealing were also discussed. Aunt did not bring Child J to the first Theraplay appointment. This was a further example where Aunt complained of struggling, but then did not attend the appointment aimed at supporting her and helping Child J. She was never challenged regarding this.
3.121 At the beginning of May 2014 Child J was discussed at the regular school safeguarding meetings, where no information was recorded beyond DSL2 continuing to provide support.

3.122 The first and second Theraplay sessions took place in June 2014 and were considered to have gone well, with a warm relationship noted and Aunt engaging in play. Child J was said to be controlling at times but Aunt was observed to manage this appropriately. The school contacted the FSW two weeks later to report concerns that Aunt was still using “inappropriate disciplinary approaches”. This was noted, and believed to be being addressed through the Theraplay sessions.

3.123 At the end of June 2014 DSL2 telephoned the FSW to report continued concerns regarding Aunt implementing harsh and critical parenting approaches. DSL2 was informed that CSC would be closing the case because there were no safeguarding concerns after the meeting planned for the following week.

3.124 There was an incident in June (although the date is not clear because no record was produced) that Child J reported that she had been hit by her PGM on the way to school. This was reported to DSL2 who later spoke to Child J in the presence of Aunt and PGM and Child J said that she had hit herself. This was accepted by DSL2 as an explanation, and not reported to CSC. It was completely inappropriate that Child J was asked about this incident in front of the person she had alleged had hit her, and this should have been reported as a safeguarding concern.

3.125 At the beginning of July there was a meeting at school attended by Aunt, the “spiritual guardians” (about who there had been concerns regarding physical abuse), DSL2, the Head Teacher and the FSW. This meeting highlighted that there was feedback from CAMHS that a close relationship was developing between Aunt and Child J; she was described as happier than she had ever been at school and she was helping out at lunchtime supervision. There remained some concerns about Child J’s behaviour which the school were addressing. The FSW said she was closing the case because there was support in place and there were no safeguarding concerns. At this stage there were differences of opinion between school staff. Some felt concerned about Child J and Aunt’s attitude to her, whilst others felt that recent information regarding difficult behaviour and self-harming had helped to make sense of a complex situation, and that Child J’s need would be addressed through continued CAMHS support. There were no concerns expressed by the school that Children’s Social Care were due to cease involvement.

3.126 There was a telephone exchange between the FSW and CAMHS professionals. The FSW informed them of the proposed case closure. The meeting at school was discussed along with the view expressed by Aunt that she remained concerned about Child J’s behaviour and “lack of remorse, being defiant”. The FSW reported that there had been poor communication within school, and that DSL1 had not sufficiently shared Child J’s background and consequently there was a new DSL2 who would be attending the next
meeting. The CAMHS professional thought these were all issues related to Child J’s poor early experiences. The conclusion was that Child J had made progress and a warm and loving relationship had been observed between Aunt and Child J.

3.127 The third Theraplay session took place at the beginning of the next month. Child J was described as subdued and Aunt said something had happened at school. There was no eye contact between Child J and Aunt who “rolled her eyes” when Child J was given a biscuit; this was not explored with her, which is surprising given that the sessions were intended to improve the attachment relationship. Aunt phoned CAMHS after the session to report that Child J had been stealing from school, the church and a shop and she was advised to respond in a non-shaming way. There was a discussion between the CAMHS professionals and it was agreed that peer supervision would be sought to discuss the issues raised.

3.128 During the second week of July there was a CAMHS consultation meeting attended by CAMHS professionals, Aunt, the two spiritual guardians (friends of Aunt’s), and DSL2. Aunt’s concerns about Child J’s behaviour and stealing were discussed alongside ways of managing this sensitively. The relationship with the school was said to be better and DSL2 noted that there had been some incorrect concerns regarding safeguarding which had had an emotional impact on Aunt and these were now resolved by improved communication. DSL2 said Child J was much more settled at school; this was not the conclusion of those who knew her best, the Class Teacher and the TA. Aunt explained that she had a letter from the Paediatrician about Child J’s easy bruising. Child J’s self-harming behaviour was also discussed, that Child J often came up with stories to explain bruising that were inconsistent and also made false allegations against people.

3.129 The CAMHS professionals discussed Child J in Theraplay supervision, and no concerns were raised.

3.130 In July 2014 at the next school safeguarding meeting five days later DSL2 said that she was concerned that DSL1 had not shared with the school safeguarding team Child J’s background; specifically, that Child J had been self-harming since the age of 2, had a medical issue of easy bruising and had made false allegations against adults close to her and other professionals. DSL2 was concerned that these issues had not been taken into account when evaluating whether bruises and injuries to Child J were a safeguarding matter and she reinforced her view that communication needed to be improved and injuries dealt with sensitively with regard to Aunt’s feelings.

3.131 There was an incident in July where the Class Teacher noticed that Child J had bruising to her face, and Child J also drew attention to this. The Class Teacher gave evidence at the inquest that a safeguarding form had been completed and placed in the box in reception, with a copy being kept on the Class Teacher’s own file for Child J. Neither the original nor the copy of this form can be found. It is unclear what action was taken, but DSL2 recorded on a safeguarding form created after Child J’s death that she met with Child J that morning and observed no bruises. DSL2 also recorded on the form
completed post-death that she spoke to Aunt after school who showed her a video on her phone of Child J throwing a doll into the air and Aunt explained this is how the bruises were caused. Also on the form completed retrospectively was mention that Child J also said she had harmed herself and had an ice pack, although no corresponding entry exists on the accident book. This incident was not shared with the FSW; it clearly should have been. It is of concern that this serious incident was recorded after Child J died, and the contents are completely inaccurate, something not known by the Serious Case Review until after the inquest.

3.132 At the next school safeguarding meeting (just before the end of the school term) it was noted that Aunt remained concerned that staff were still judging her and drawing incorrect conclusions given the complexity of Child J’s needs. The conclusion regarding this is unclear, but it appears there was some discussion about ensuring that these issues were addressed effectively through better communication. Once again the needs of Child J were lost through these entrenched, adult focussed views. This is addressed in the analysis section.

3.133 CSC closed the case in July 2014.


3.135 When the new term started a meeting was organised for all school staff with an education psychologist to discuss what had happened. Some of the Class Teachers and the TA asked to see her afterwards and they individually shared a number of concerns including:
- Confusion about safeguarding process within the school
- Concern that school staff had been told by some members of the school community they should not raise safeguarding concerns directly with Children’s Social Care – and that if you did you would be subject to some criticism
- Leadership around safeguarding at the school was not robust and was based on personal relationships and disputes
- Teaching Assistants’ concerns regarding children were not always listened to and they had no opportunity to share their concerns
- There were concerns regarding the assessment of injuries to Child J.

3.136 There were also concerns expressed about Child J that had not previously been reported or recorded at the school and not shared with other professionals. These included:
- Child J was terrified of her Aunt and did not want her to know when she was ill
- Aunt would not allow Child J to go on school trips or join the choir because she said “she did not deserve it”
- Aunt told Class Teachers and the TA that she should be excluded from school because of what she had done
- The bruising was of concern because it was so often in unusual places.
3.137 These concerns were addressed in a special circumstances meeting involving the Director of Education and the Local Authority Designated Officer (LADO). An internal investigation was agreed and completed by the Head Teacher. This was found to be inadequate and an external, independent review was commissioned and completed by the LADO. The initial findings of this were that there were concerns about safeguarding activity at the school which had been affected by poor relationships amongst staff and confusion about roles and responsibilities. It was recommended that DSL2 be removed from the school safeguarding team, despite the Head Teacher's reluctance regarding this. An action plan was agreed and an audit of safeguarding practice undertaken which noted the improvements and changes that have been implemented over the last 14 months. The school have also been inspected by Ofsted who were happy with safeguarding practice at the school and judged safeguarding to be effective.

3.138 The action plan has been revisited in light of concerns highlighted regarding safeguarding processes at the school during the inquest and further work has already been undertaken and more action and support is planned.

4 FINDINGS AND RECOMMENDATIONS

4.1 This section draws together the findings of this Serious Case Review. This was a sad and complex case. The death of Child J was shocking to her Mother, Father, close family members and her foster family who all continue to grieve her loss. It was also a shock to all those professionals who had contact with her, they did not suspect that this would be the outcome and it has impacted deeply on all of them. All those professionals have engaged with this review and have sought to ensure that lessons are learned about practice. There is no evidence that Child J’s death could have been predicted, but the overall purpose of any review is to identify areas of practice that can be improved, to identify systemic factors which need to be addressed and factors identified from which others can learn. This review has highlighted a number of factors that affected the professional response to Child J; although each of these is outlined individually, in this case it was the complex interplay of all that had a profound impact.

4.2 A number of recommendations are made for the Nottingham City Safeguarding Children Board (NCSCB). These have been developed in recognition of the work already undertaken by agencies in response to issues arising from this Serious Case Review and individual agency action plans submitted as part of the review. Information regarding these actions forms part of the response document supplementary to this review report. It is the responsibility of the NCSCB to monitor both the implementation and impact of individual agency action plans and the recommendations set out below.
Finding 1: The importance of recognising the impact of parental mental health on children’s wellbeing and giving parents a clear outline of concerns and actions they need to take as part of any rehabilitation process.

4.3 Child J came into care when she was nearly five years old. The reasons have been outlined in the narrative in section 3, as have the concerns that Mother was not provided with appropriate support for what were very serious concerns and there was a lack of authoritative and purposeful action regarding the impact of maternal mental ill health on children.

4.4 Action was taken to consider whether Child J could be rehabilitated at home, and a full core assessment and a specialist psychological assessment undertaken. This was good practice and provided a firm basis for decision-making. Mother engaged with plans and put the needs of her children first by agreeing with the Local Authority recommendation that the children remained accommodated whilst safe decisions were made for them. At this stage Mother did not always feel clear about what action she needed to take to enable her children to return to her care, despite being briefed by her solicitor and given verbal feedback by the social worker.

4.5 The evidence from the assessments was that there were significant attachment difficulties between Mother and Child J and that Mother continued to attribute responsibility for this to Child J and her personality/behavioural issues. This combination of negative factors has been shown by recent researchvii viii to be a contra-indication for rehabilitation and requires a long period of therapeutic input to address, something that would be outside the developmental timescales for both children. The decision was made to seek to place both children permanently away from their mother’s care. This was a difficult decision, but one that was supported by the evidence. At the same time the psychological assessment proposed Mother undertake therapeutic support which she was unable to access because of long waiting lists and her only other choice was to pay for private therapeutic support – something she could not afford to do. The provision of this support would not have made a difference to the final decision, but Mother’s inability to access those services raises concerns for other rehabilitation cases. This part of the review highlights two key points of learning and necessary improvements to practice:

- The need for recognition of the seriousness of concerns regarding maternal mental health, particularly when it relates to unwanted thoughts of harming a child and that there is a clear and appropriate response and plan of action. Parents who are required to undertake psychological therapies need to be enabled to access those therapies.
Recommendation 1:
The NCSCB should seek assurance that the implications of parental mental ill-health are understood and fully addressed in plans for children and young people. This will include an evaluation of the availability of therapeutic support needs of parents, how this is prioritised and the implications this has for local commissioning arrangements.

- The need to ensure that parent(s) are provided with a clear written outline about the Local Authority concerns when children are in care on a voluntary basis and rehabilitation is being considered alongside other options. This should make clear actions required of parents in the rehabilitation plan, support to be provided to enable them to achieve these goals and process of review/decision making.

No recommendation has been made with regards to this issue in recognition of the work already undertaken by Nottingham City council to address this. This work has been further strengthened by recent case law which makes an explicit requirement with regard to consent.

Finding 2: The importance of helping children understand the reasons for being in care and addressing this through appropriate life story/direct work

4.6 Child J was never really clear about why she came into care. This happened in a moment of crisis and it appears that she was told by her first Social Worker that her Mother was unwell and she would return home when she was better, and this was said to her by her Mother who also believed that the plan was for Child J to return home. It appears that Child J experienced profound feelings of loss at this separation which she often articulated.

4.7 Fahrb erg (2008) has highlighted that it is essential to explore a child's beliefs about why they think they have come into care. Children in the age range 3 - 5 are at the developmental stage of magical and egocentric thinking which can lead them to believe that they were responsible for what happened, either because of what they thought or their behaviour. This belief can impact very negatively and exacerbate the grief response. For Child J she will have been aware that her Mother was finding her behaviour difficult as this was often articulated in her presence. The need for direct work/life story work to be undertaken regarding this was discussed in the first Looked After Review and some appropriate direct work undertaken in the transition for the move to Aunt. This lack of clarity about why she had come into care remained and the implications for her that she might have been in some way responsible was never fully addressed and was an outstanding action in the final care plan some 10

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20 Life story work is an intervention with children designed to recognise their past, present, and future. It is prominently used with children who will be adopted or placed with other alternative carers.
months later.

**No recommendation** has been made with regards to this issue as it is addressed in the CSC Action Plan.

**Finding 3: Working effectively with the impact of early trauma on children’s lives**

4.8 One of the most influential issues in understanding the professional response to Child J was the lack of a clear understanding of the impact of early emotional abuse and neglect in the past on young children and the likely manifestation of this in their behaviour in the present and the possible response of adults who care for them. Research has highlighted that exposure to long term hostile and neglectful parenting has significant negative consequences for a child’s brain development, and can result in cognitive, behavioural, emotional, social, and physiologically impeded development\textsuperscript{x}.  

4.9 The most important part of a child’s development is their attachment relationship with their primary caregiver; if this relationship is damaged the evidence suggests that there is likely to be a profound and significant impact on the child’s emotional wellbeing. If this is unaddressed, children may transfer their negative feelings to their new caregivers. If the response they get (often born out of a lack of understanding) is controlling and punitive, a child’s psychological distress increases, and this becomes further manifest in the child’s behaviour setting up an unhelpful circular pattern\textsuperscript{xi}.  

4.10 Given her background and the circumstances leading to her coming into care, it is not surprising that Child J was a traumatised child and this trauma was manifest in her behaviour and emotional wellbeing. Child J was placed with a caring foster family who found Child J’s difficult behaviour hard to manage and they attempted to deal with this behaviour through tried and established management techniques. This strategy was not successful or helpful because routine behavioural management techniques do not work for traumatised children and can often exacerbate the problems\textsuperscript{xii}.  

4.11 There is a clear evidence base regarding the importance of helping foster carers understand behavioural difficulties caused by trauma and to support them to parent therapeutically\textsuperscript{xiii}. It is the task of the professionals supporting foster carers/adopters/friends and family carers to provide advice and support about trauma and to notice when it appears that children are being characterised as inherently difficult rather than traumatised. In essence to notice when carers stop understanding that a child is “troubled” and starts to be viewed as “troublesome”. The foster carers for Child J were subsequently provided with help and support and they were able to adapt their parenting style and this led to improvements in how they felt about Child J and how Child J was able to manage her feelings. However, the view persisted that she was a difficult and complex child and this view influenced the subsequent professional response.  

4.12 Aunt was made aware of Child J’s early difficult experiences and her poor attachment to her Mother during the Special Guardianship Assessment. The Social Worker said this
meant that Child J was exhibiting challenging behaviour. This was a clear outline of the issues and Aunt expressed appropriate empathy for Child J and agreed that a sensitive and loving response was required. This was emphasised within the SGO where it was said that “Aunt was to provide Child J with consistent emotional warmth, structure and boundaries, with parenting that was flexible and warm in style.” What was not included was the specific advice given to the foster carers from the psychological assessment, with its emphasis on not adopting a controlling approach. The agreed plan was that there would be support from CAMHS for the placement, this had been part of the successful strategy for the foster family. Theraplay was to be provided to build the attachment relationship but this did not happen until 16 months into the placement.

4.13 At this point Aunt had not had full time care of any child and more should have been planned to pre-empt what was likely to be a difficult and on-going transition. Aunt reported difficulties in managing Child J’s behaviour immediately Child J came to live with her. Much of what Aunt reported in these early days was similar to the behaviours reported in the early days of the foster placement, such as screaming, stealing, asking to be hit and issues regarding continence. Aunt’s analysis that Child J’s behavioural difficulties were connected to contact with her Mother was accepted and changes made to these arrangements including a change of school. The fact that this did not alleviate the difficulties as described by Aunt was not noted and there was no consideration that these changes might be exacerbating Child J’s difficulties.

4.14 During the next 18 months Aunt continued to report to all professionals that Child J’s behaviour was unmanageable, that she was self-harming and stealing and increasingly she described Child J as being deliberately naughty, defiant and unremorseful; she moved from describing behaviours to attributing negative personality traits to a very young child. This was not sufficiently challenged directly with Aunt, despite the efforts made to address these behaviours.

4.15 Despite there being much discussion of Child J’s early experiences, the records and discussions suggest that Child J started to be seen as a difficult and complex child by professionals. Aunt, who attended all meetings, fuelled this and self-reported issues regarding Child J; she often enlisted the help of other adults, largely from the church. These behaviours were not actually witnessed by other professionals. At school she was seen as a well-behaved child until towards the end of the review period. Aunt’s negativity (which showed a lack of empathy, and was a long way from the parenting style she agreed to adopt) was not sufficiently challenged. She was difficult to challenge, and there is no doubt that at times she showed “false compliance” xv by agreeing to making changes and understanding professional’s concerns. Early trauma was seen statically as an influence from the past, not something that was operating in the present, seen as justifying Aunt’s punitive approach, but not fully considered in the context of Child J’s emotional wellbeing in the here and now, and that the support mechanisms that were in place were not addressing these issues.
**Recommendation 2:** The NCSCB should highlight the importance of recognising and understanding early childhood trauma when communicating the learning from this sub-group. It should seek assurance from partner agencies that this issue has been reinforced through internal communication and training routes.

**Finding 4: The importance of a clear understanding of self-harm**

4.16 A central issue across this review was concerns about Child J’s “self-harming” behaviours. This is in inverted commas because it was never established whether Child J was actually self-harming as this was never assessed and the details were never fully documented. None of the adults who reported these behaviours was asked to clearly record what they were witnessing; the records are quite low on detail. Self-harm in children aged 5-10 years old is uncommon. There were reports from Mother that Child J engaged in behaviour that was harmful, such as threatening to throw herself out of a window, and there were incidents of hair pulling, pinching, and throwing herself at furniture and threats of throwing herself down the stairs when she was in foster care. It could be argued that these were all behaviours linked to her feelings of loss, a manifestation of her feelings and early trauma. This analysis was not undertaken.

4.17 When Child J moved to Aunt’s she was said to exhibit some of these harming behaviours, and in the first six months Aunt began to refer to them as “deliberate self-harm” something she explained as causative of the burn seen by professionals in the Accident and Emergency Department. There should have been a clearer analysis of what these behaviours were and some professional’s scepticism about whether Aunt’s descriptions and labels were correct or whether there was an alternative explanation/differential diagnosis of safeguarding required. Professionals should have also considered why the “self-harm” as they saw it was getting worse, not better, despite changes made and interventions offered. This should have indicated to all that the analysis regarding the cause of these behaviours might not be correct, and required a re-analysis.

4.18 If what professionals were seeing was self-harm they should have been significantly concerned because of Child J’s young age. The guidance regarding the management of self-harm in children focuses on those over 8 years old in recognition that self-harm in younger children is unusual. The guidance makes clear the importance of an assessment of the self-harming behaviours. There should have been more professional scepticism and curiosity regarding this issue; the professional response at this time was influenced by a combination of confusion about the impact of early trauma and fixed views about the motivations of Aunt in particular who was reporting “self-harm”.

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21 A national survey of more than 10,000 children found that the prevalence of self-harm among 5-10 year-olds was 0.8% among children without any mental health issues, but 6.2% among those diagnosed with an anxiety disorder and 7.5% if the child had a conduct, hyperkinetic or less common mental disorder.

Nixon (2011) Self-harm in children and young people handbook
**Recommendation 3:** The NCSCB Practice Guidance regarding self-harm should be updated to address the needs of children aged 5-10. This update should make clear that professionals should not accept the term self-harm in children under 10 without consideration of potential emotional well-being or safeguarding concerns.

**Finding 5: Addressing the complex health needs of children including working effectively with continence issues**

4.19 Child J had long term complex health needs. These were made clear through her Looked After Children’s medical, and were incorporated into the Special Guardianship Support assessment. When the SGO was granted to Aunt she became responsible for managing Child J’s health needs. She had indicated during the assessment process that she was fully aware of this and committed to ensuring that Child J’s health needs were met; there were no indications that she would not do so and therefore no plan was deemed necessary. Aunt did not always fulfil this responsibility; she failed to attend appointments, and these had to be rescheduled. These did not raise major concerns about Child J’s wellbeing by the school nurse who was satisfied overall with her progress. The concerns raised were all related to issues of continence.

4.20 Child J had long-standing problems with continence, night time bed wetting (known as nocturnal enuresis) and some problems during the day (known as urinary incontinence). These conditions are common in children of Child J’s age and these problems sometimes have an organic cause. Child J was found to have a kidney condition at birth and this required her to drink large quantities of water to avoid infections and this would inevitably have impacted on her ability to stay dry in her early years.

4.21 Her Mother reported this was an issue, as did the foster carer. The specialist nurse for continence provided support when Child J was in foster care and this was largely successful. However, in these early days Child J’s struggles with continence, which were relatively normal, got confused with other concerns about her behaviour and these should have been more clearly separated out. At the first Looked After Review it was agreed that there should be some clarification of whether this was a medical issue, linked to her renal problems, or was part of normal child development; this was never done, and was something the specialist nurse for continence would raise again some 15 months after Child J had been living with Aunt.

4.22 When Child J came to live with Aunt her continence difficulties became a major issue. There are few meetings or home visits with any professional where Aunt did not raise it. Increasingly, Aunt reported to professionals that this was evidence of Child J’s bad behaviour and defiant attitude and her response became increasingly hostile and unnecessarily punitive. This was not challenged by any professional.
4.23 There are clear guidelines about how continence issues with children of this age should be managed. The emphasis is on normalisation, no blame, no shame and strictly no punishments. The guidance makes clear the need to emphasise that children should not be held responsible for being dry and night dryness is a developmental achievement over which the child has no control; very few children wet the bed on purpose. The confusion about personal responsibility is highlighted by the use of star charts that can suggest that this issue is under children’s control. Star charts should be used for cooperation in the treatment programme only. The NICE guidelines make it clear that maltreatment should be considered if a child or young person is consistently reported to be deliberately bedwetting, the parents or carers are seen to repeatedly punish the child and the problem is not addressed by advice.

4.24 This was exactly the situation with Aunt. She consistently blamed and humiliated Child J. She also withheld water, something that had the potential to cause Child J some very serious health problems. The specialist nurse for continence did try to give advice, but she did this in isolation from the other professionals. Aunt asked the FSW for advice, and the intensive CAMHS Health Care Assistant also focussed on continence issues. They all gave different advice. There was no sense that professionals considered what this all meant for Child J or what Aunt’s rhetoric about how “deliberateness” or “lack of remorse” might impact on her both physically and emotionally.

**Recommendation 4:** The NCSCB should ensure that all professionals who are working with children who experience continence issues are aware of the national guidance regarding this. The NCSCB will seek assurance that agencies are clear about what action to take when parents/carers adopt a significantly punitive approach and recognise the need for a coordinated response to these issues.

**Finding 6: The importance of a good assessment of potential non accidental injuries**

4.25 There were long term concerns about possible non accidental injuries to Child J from when she was two years old. These early concerns related to unexplained injuries, potentially caused by her Mother and which were never fully investigated or addressed. In 2010 Child J disclosed that she had been physically abused whilst in the care of her Father, his first wife and PGM. A child protection enquiry and medical was undertaken, but there was no assessment of PGM carried out, despite Child J, who was aged two and a half at this time, making a clear allegation of abuse. This meant that possible early concerns regarding the extended family were not assessed and the possibility of exploring how entrenched the use of physical abuse was within the family was missed.

4.26 There were many concerns regarding bruising and injuries, from six months after Child J moved to live with Aunt. These were noted by school, either by the Class Teachers or the teaching assistants. Up until the summer of 2013 these were held in handwritten
records by the DSL1. The DSL1 was not aware that she needed to record these on a formal safeguarding concern form, and when she completed her safeguarding training she designed a form and in the summer of 2013 she filled these forms in and destroyed her contemporaneous records. This meant it was not clear whether the FSW was informed of five incidents of concern; however, in June 2013 the FSW was made aware that there had been a number of concerns about bruising and neither the DSL1 provided detail and the FSW did not ask for them.

4.27 The Aunt would often pre-empt these concerns about bruising/injuries, either by informing the school what had happened or by ringing the FSW, giving some credence to her subsequent explanations. Information was sought from the school, and Aunt, who alleged that all the injuries were attributed to either Child J’s self-harm or accidents. Aunt often enlisted the help of friends to bear witness to the self-harm and Child J often agreed that she had lied. There were occasions, such as with a bruise to the eye, said to be caused by Child J itching chicken pox, where the professionals witnessed her doing this.

4.28 There were two occasions when Child J was seen in hospital. The first for a burn where all agencies were convinced by Aunt that this was self-harm, and this was agreed by Child J. No further enquiries were undertaken, when they clearly should have been – particularly in the context of self-harm – an issue already explored. On the second occasion a full child protection medical was sought and carried out. This provided a detailed look at Child J’s injuries and was contextualised alongside some of the recent history. The focus here was also self-harm as an explanation for the injuries fitted with the explanation provided; there were two which did not fall into either of these categories, but they were not explored or assessed further. This raises the importance of social workers sharing all available psycho-social information before the child protection medical, so a full holistic picture can be formed. This is addressed in the recommendations that follow.

4.29 Although enquiries were undertaken, there was never a full assessment which brought together all the available information in the context of possible physical abuse. A number of professionals noted that Child J looked uncomfortable in the presence of Aunt when issues regarding bruising were discussed, but this was not routinely shared or recorded. It is essential that professionals are aware of the importance of observing the parent child /relationship and where concerns are held these are noted.

4.30 Although the national\textsuperscript{viii} and local procedures\textsuperscript{22} make it clear what the definition of physical abuse is, and give a general overview of the process of undertaking child protection enquiries, there is no clear outline regarding what should be covered and what the focus should be. This is in stark contrast to sexual abuse, emotional abuse and neglect all of which have additional guidance locally and nationally.

\textsuperscript{22} http://nottinghamshirescb.proceduresonline.com/index.htm
4.31 A recent review\textsuperscript{xx} makes clear that the first principle of enquiries regarding physical abuse is to be clear about the purpose, which is to establish whether the causes of unexplained injuries in children is accidental, caused by child abuse, is part of a congenital or acquired illness or part of a pattern of poor supervision and neglect. This review could add to this those caused by emotional distress and self-harm. The assessment must also end with a conclusion and professional judgement about the cause, and implications for any services. In this case enquiries stopped where it was found that there was a suitable explanation, and neither the conclusion nor the implication of this was fully recorded. If this was a lack of supervision, and many of the injuries were attributed to accidents, then this should have led to appropriate action. If it was emotional distress and self-harm, an action plan should have been developed. What was of concern here is that the explanations for injuries did not change, and action such as support from CAMHS did not make a difference. This should have indicated that there was not a clear understanding of what was happening.

4.32 The NICE Guidelines\textsuperscript{xx} which are applicable to all professionals, but not always fully implemented, make it clear that in order to establish whether injuries to children are non-accidental there are a number of issues which must be considered and it is important not to focus on just one area, for example a medical explanation. These are:

- the nature of the injury;
- the explanations provided by the child;
- the explanations provided by the parent and any other person involved;
- any contradictions or discrepancies in the story;
- family history and known risk factors;
- history of other injuries.

4.33 In assessing potential non-accidental injury it is important to consider the attitudes and behaviours of the adults caring for the child. Adult behaviour can be attributed either to contextual factors and circumstances, external issues which are outside of an individual’s control or they can be attributed to internal or innate psychological traits or personal characteristics. This is often referred to as understanding behaviour as either situational or dispositional. When trying to understand the cause of behaviour in a safeguarding context it is important to establish whether the influences on adult behaviours are to do with people’s environment and circumstances or some internal characteristics or traits. This will help to establish what would be an appropriate response. Research suggests in a safeguarding context professionals are both reluctant to consider causal factors in this way, and where they do make professional judgements they often get the attribution wrong.

4.34 For Aunt, the cause of her behaviour was seen as contextual or situational; most professionals believed that she was responding to the stresses of caring for a difficult child in difficult circumstances and was not being abusive. There appeared to be little reflection on whether some of her behaviours and responses to the injuries to Child J were dispositional. This is not to use the benefit of hindsight because the outcome is
known, but to suggest that in cases where there is uncertainty about the nature of injuries it is important to consider the causes of adult behaviour and for practitioners to ask themselves if it is dispositional or contextual on a more regular basis.

4.35 This information should then form the basis of an analysis and a clear conclusion drawn from all the available evidence. This did not happen for Child J because there were only limited enquiries. There were discrepant explanations for injuries; the school kept full records of the injuries, but these were not included in the analysis and each incident, of which there were many, was treated in isolation. There were differences of opinion across the professional network about the cause of these injuries, yet there was no professional challenge and no agency invoked the escalation procedure. Ultimately, the assessment of potential physical abuse should be a multi-agency task, differences of professional opinion acknowledged, and this should be reflected in the final conclusion. In this case the dominance of Aunt alongside ineffective multi-agency practices and a lack of a clear framework for assessing potential physical abuse meant that practice in this area was not effective and it remains uncertain what the causes of the many injuries seen were.

**Recommendation 5**: The NCSCB should review the guidance for all professionals regarding the assessment of potential non accidental injury and ensure it is compliant with the existing NICE Guidelines regarding child maltreatment. This revised guidance should also include:

- Guidance for all professionals about child centred disciplinary approaches
- A mechanism for ensuring relevant information about a child’s known psychosocial history and history of previous concerns/injuries is completed in preparation for a child protection medical and that this is recorded where it is not possible to do this in advance of the medical this information must be considered alongside the outcome of the examination.

**Finding 7: Professional approach to child discipline and punishment**

4.36 The circumstances in which Child J lived with her Aunt raise important questions about professional beliefs and actions regarding appropriate disciplinary approaches. Aunt was very clear with all professionals that discipline was important and was necessary to address Child J’s behavioural issues.

4.37 The issue of discipline had been discussed during the SGO assessment and Aunt had said that she had been “physically chastised” by her Mother (she underplayed the extent of this actual physical and emotional abuse) and that this had caused conflicts between them into adulthood. Aunt linked this approach to discipline to the family’s cultural heritage, but said that the family recognised that times had changed and that this was now no longer acceptable. Aunt had been clear that she did not see this as part of her cultural heritage and would not engage in such practices and it was agreed that Child J needed sensitive and caring parenting.
4.38 Child J told the school on a number of occasions that she was hit with a brush on her hand, was force-fed and made to face the wall with her hands outstretched. Aunt said this approach was necessary because of Child J’s behavioural difficulties Aunt also described withholding water, locking the bathroom and threatening Child J with punishment. Professionals accepted that Aunt was primarily engaged in disciplinary measures, but that these were overall too harsh and punitive. Work to address this was undertaken with intensive parenting support and more latterly therapeutic training to improve the parent-carer relationship. Aunt reported that this support had changed her approach to parenting, and there was less reporting of concerns. Aunt’s negative attitude regarding Child J’s behaviour remained, but was often counter balanced by warm and caring exchanges witnessed during home visits by the FSW and CAMHS support worker.

4.39 There has been a significant amount of research regarding parenting styles and approaches which contribute to optimal developmental outcomes for children. This work consistently identifies that non-punitive disciplinary practices based on reasoning are associated with positive outcomes. Disciplinary approaches which inflict physical or psychological harm are not effective, are harmful, and are not consistent with the requirements of either the UNCRC or the Human Rights Act. A clear distinction is made between discipline which is aimed at meeting the needs of a child and helping them meet adult expectations, as opposed to punishment which is usually initiated to alleviate adult needs and frustrations and is often associated with humiliation of the child.

4.40 There is no evidence that professionals considered that Aunt’s approach to discipline and punishment was in any way a cultural issue, and Aunt never raised this as an issue. Aunt was asked to develop a gentler response and was provided with services by CAMHS to do so. Yet despite a verbal commitment to change, Aunt never stopped her punitive and abusive approach. She should have been more fully challenged regarding this and professionals should have been clearer and more united in their advice about what constitutes effective approaches to discipline as opposed to punishment.

4.41 There are currently no national or local guidelines regarding appropriate disciplinary practices and it is therefore left to professionals to take a view on a case by case basis on what is reasonable. In this case professionals should have had a view that the approach that Aunt took was punitive, not disciplinary, was not focussed on the needs of Child J and amounted to child maltreatment.

**See recommendation 5**

**Finding 8: The important role of schools in safeguarding children**

4.42 Current Guidance makes clear the important role that school play in safeguarding children. Schools see children daily and teachers, classroom assistants, dinner staff, playground staff are all in a good position to notice concerns, changes in children’s behaviour and the response and attitude of parents/carers to any concerns raised. All
school staff have a responsibility to identify children who need support, or who are suffering or likely to suffer significant harm. In order for this to happen schools need to have clear and robust systems in place which supports effective safeguarding practice; this would include designated safeguarding professional(s) who bring expertise, guidance and advice, clear recording systems, supervision and policies and procedures. It is also essential that schools are recognised as an integral part of the safeguarding network, are included in meetings, have records, assessments and plans shared with them.

4.43 Child J attended a number of schools. When she lived with her Mother, the school appropriately shared concerns with professionals and provided support to Mother.

4.44 Child J spent most of the time at the school she moved to 6 months after moving to live with her Aunt. This school were aware of brief family details, but the transfer of records to the school was slow, and this meant the school did not have full historical information about Child J’s experience of abuse in the past, her trauma related behavioural difficulties or her health needs. This meant that the school were not aware of the need for a multi-agency meeting. The terms of the FAO were such that under usual circumstances no meeting would have been required, but given the discussion between the FSW and Aunt about how this transition from one school, in the context of other changes, was likely to be difficult, a meeting would have been helpful. The lack of a meeting, coupled with the lack of historic information meant that there was no formal established working arrangement between the school and the wider network, and this was not a helpful start for effective multi agency working.

4.45 It is now clear that the safeguarding arrangements at this school were chaotic and at times unclear. When Child J moved to the school there were unclear processes. There were no established processes regarding recording concerns about children and DSL1 reports she kept a handwritten record of information that was shared with her by teachers and other school staff. DSL1 attended safeguarding training in 2013 and as a result designed a safeguarding form onto which she transferred all these handwritten records ready for the start of term in September 2013. She destroyed her hand written notes. This meant that there were at least five incidents regarding bruising/injuries to Child J which were only communicated verbally and for which there was no written record and there is some dispute regarding the content of the form, completed so long after the actual incident. This was not appropriate safeguarding practice. The FSW became aware of the lack of communication in June 2013 but this did not lead to any reflections regarding what the school did know.

4.46 There were poor working relationships between DSL1 (assistant head) and the Head Teacher which had its roots in both concerns about recruitment practices and personal differences. This led to a new school safeguarding team being developed in February 2014. The Head Teacher saw himself as part of this team, rather than needing to exercise management oversight and to provide an objective supervisory view regarding both the existing personal disputes and the deep differences of professional
opinion. This meant these were never resolved, and ultimately led to several incidents regarding bruising to Child J not being shared with other professionals.

4.47 The school were not initially aware that CAMHS meetings were being held about Child J and issues regarding school, such as stealing, were being discussed; this meant they could not share their perspectives or concerns. Child J had told the school about Aunts’ abusive behaviour to her, and this was recognised by DSL1 as a cause of concern. A school meeting with the family support worker was organised and the issues of “inappropriate parenting” were discussed, Aunt denied the issue and no plan was put in place; these issues were planned to be discussed at a CAMHS meeting in two weeks’ time, but the school were not invited.

4.48 At this next CAMHS meeting issues regarding Child J’s behaviour and stealing at school were discussed, again without school being present and they did not receive the minutes of the meeting or the action plan. The school became aware of CAMHS involvement through the work of the CAMHS Intensive Intervention Service, but were not invited to a meeting until 11 months after Child J had started at the school. It is clear that the school were on the margins of professional thinking regarding Child J for many months, and when they became included Aunt sought to discredit their input by suggesting they were not communicating with her, being critical and did not understand the nature of Child J’s difficulties. This splitting off was largely successful and is addressed below.

4.49 The Class Teacher and TA in both of the school years had many concerns regarding Aunt’s attitude to Child J and noted incidences of bruising. They shared these with DSL1 initially and then DSL2. There was no effective feedback loop and the Class Teacher and TA felt they could not challenge the lack of action. It is important that all professionals working with children are aware of escalation and whistleblowing processes when they have concerns regarding a child which they feel are not being listened to. The circumstances at the school made challenge complex, but it is the professional responsibility of all professionals to ensure that they find a way of alerting others to safeguarding concern and seek feedback to ensure that action is taken. This did not happen for Child J.

4.50 The Class Teacher in the 2013-2014 year faxed a concern form and body map directly to the FSW as she had been asked to do and was told that this was not a correct course of action in front of Aunt, the DSL and the Head Teacher. This was clearly inappropriate and effectively silenced this teacher.

4.51 The Class Teacher and TA were equally not asked for their views or to consider what information they held, either during the school safeguarding meetings or as part of the work of the FSW. This information was important, and if contextualised alongside the Aunt’s complete negativity about Child J in meetings, was suggestive of emotional abuse. It is striking the extent to which school staff noted that Child J looked downcast when with her Aunt. This was particularly when bruises or concerns were discussed.
These were never recorded or shared with professionals, and only became apparent as a concern at the Trial and Inquest. School staff reported that they were unclear whether they could record or share this information because they believed it to move beyond what was factual. It is critically important that all professionals recognise the need to noticing and respond to how a child appears, and when discussing concerns, they notice the parent/carer – child relationship and record and share concerns regarding this.

4.52 The Class Teacher and TA kept a separate record when they had more general concerns about Child J, for example when she seemed unhappy, but which they considered were not issues of a safeguarding nature, such as Aunt not allowing Child J to go on school outings because she “did not deserve to go” and Aunts request that Child J be excluded or punished because she was naughty. These were worries, but were not issues that would normally be recorded on safeguarding forms, and were also not formally shared across the school network.

4.53 For some of the time the school were on the margins of the professional response to Child J. Aunt was often rude and aggressive to the teachers and TA, and although some boundaries were put around this by the school, there was evidence that Aunt was able to split professional opinion and cause some conflicts between school staff, and other professionals. This was not recognised or addressed, and the lack of any supervisory processes in school regarding the response to safeguarding concerns did not help.

4.54 There were huge tensions within the school safeguarding team which went unaddressed and meant that DSL1 felt unable to challenge the fixed view of DSL2 and the Head Teacher that Aunt was being unnecessarily accused of potential harm. The perspective became about supporting Aunt, and ensuring that communication was improved. This led in the latter stages of Child J’s contact with school with concerns regarding bruising and being abused by adults not being shared with CSC and no action being taken. This was unacceptable.

4.55 Within the review of the circumstances it has been identified that there were strained relationships within the school at times. This was as a result of the school going through a period of change in terms of staff roles and leadership. These concerns led to an internal investigation which was deemed inappropriate and led to an external investigation led by the LADO. This brought about significant changes. Audit has demonstrated that these changes were positive. The full outline of action already taken, and action to be taken is included in the education action plan.

4.56 This action plan has been revisited in light of concerns highlighted regarding safeguarding processes at the school during the inquest and further work has already been undertaken and more action and support is planned.
Recommendation 6: The NCSCB should reinforce the need for all professionals to recognise
the important role played by schools in the support and safeguarding of vulnerable
children and promote a multi-agency approach to all aspects of assessment and planning for
vulnerable children.

This action should include ensuring that the Designated Safeguarding Leads Network creates
practice standards which reinforces the requirement for schools to routinely follow up
referrals to Children’s Social Care in writing, including details of all concerns that have been
recorded by staff within the school; and establishes consistency in the way that “soft”
information that raises concerns about a pupil’s wellbeing is collected and reviewed both
directly during staff supervision sessions and through recording processes

Finding 9: The influence of the Special Guardianship Process and Placement with
relatives

4.57 Once the decision was made that Child J and her sibling could not be rehabilitated to
the care of their Mother, the Local Authority appropriately looked to place them with
family members. This is in line with legislation and current national policy. It is also
good practice because research suggests that these placements are beneficial to
children’s outcomes xxvii.

4.58 Action was taken to seek a possible family placement for Child J. The Courts place a
duty on the Local Authority to consider all family members; in this case the adults who
were approached were not suitable carers for Child J and the process of them ruling
themselves out meant that their unsuitability was not recorded. Mother had always
made it clear that she had concerns about these members of the extended family. The
pressure to evidence that family members have been consulted influenced practice.
They could be considered, but their unsuitability made clear. This acknowledgment
would have led to a discussion about the appropriateness of future contact but this
never happened.

4.59 Father also suggested one of his sisters and she agreed to be assessed. Mother had no
objections to this and the Special Guardianship process was started.

4.60 The Special Guardianship Order (SGO) was introduced in 2005 as an alternative
legal pathway to permanent out of home care for children, often within the extended
family network. xx23 It was envisaged that children would be placed with family members
or adults with whom they already had a prior and established relationship xxviii. This
meant that within the statutory framework for the SGO there is no requirement for a
matching process, introductions, transition planning process or a period of monitoring
and the assessment requirements are more limited. These processes are routine for

23 Special Guardianship offers greater security than long-term fostering as it lasts until the child reaches 18, but it does not require the legal
severance from the birth family that is the result of an adoption order.
A Special Guardianship order gives the Special Guardian parental responsibility for the child. The birth parents remain the child’s legal
parents and retain parental responsibility though their ability to exercise this is very limited.
other types of placements. This was profoundly influential for Child J. Child J had only met Aunt once before and did not have an existing relationship with her. This was known and acknowledged and should have been more clearly factored into the transition process. The SGO guidance makes no provision for these circumstances and recent research\textsuperscript{xxxix} has highlighted the need for this to be addressed.

4.61 **SGO Assessment:** The assessment of Aunt was planned and met most of the requirements of the current SGO Guidance. It was modelled on the national assessment framework\textsuperscript{xxx} as would be expected. More could have been done to engage education and health services in the SGO process, although existing information about Child J’s health and education needs were included. Independent references were sought and these were positive, though all from the same organisation, the church, and interviews were not conducted with these individuals. The SGO was granted, and there was no evidence to suggest that it should not have been. In reviewing the assessment and court process there are several points of practice outlined below.

4.62 **The need for a psychological assessment of Aunt:** Psychological assessments are not routinely undertaken as part of the SGO process, but there will be circumstances where this is necessary. There was a need for a psychological assessment of Aunt because this was a completely new relationship for Child J and Aunt; it was known that Child J had significant emotional, behavioural and health needs and it had been established that she needed a specific style of parenting to overcome her early trauma; Aunt had never parented before and had a complex and traumatised background herself. This indicated the need for a psychological assessment, something that had been undertaken previously to assess whether Mother had the capacity to parent Child J. This psychological assessment made clear that Child J needed sensitive and attuned parenting. At the point of the SGO planning it was not clear whether Aunt could provide this, except for her own assertion about her parenting skills (see the point below). This pointed to the need for a psychological assessment to have a more objective and balanced view.

4.63 **Reliance on self-report:** The assessment relied almost entirely on Aunt’s self-report. The social worker undertaking the assessment could not know that Aunt was not truthful through the assessment process, but a recent review of child protection processes\textsuperscript{xxxi} has highlighted the importance of the routine triangulation of information and reflection on the extent to which parents/carers views are merely reported rather than analysed.

4.64 **Influence of history:** Aunt provided information about being physically abused as a child and sexually abused by a teacher and these recent abusive experiences required more analysis. Research\textsuperscript{xxi} suggests that abuse in childhood/adolescence can have an impact on future parenting. This is not inevitable, but is dependent on the adult’s awareness of the impact of the abuse on them and the ability to reflect on the influence of these experiences in the present. This should have influenced the support plan more clearly.
4.65 **Consultation with Child J:** Regulation 21 of the guidance makes it clear that the wishes and feelings of the child for whom a special guardian is being assessed should be consulted about the proposed plan, their thoughts where relevant about their contact with family members and any wishes they have regarding their religious and cultural upbringing. This did not happen for Child J. The issue of consulting children about placements before the final decision is made is a complex one. Those responsible for seeking an SGO can only recommend it; it is the Courts who ultimately make the final decision. Professionals need to weigh up whether to talk to a child about a move that might not take place. In the case of Child J there is no recorded evidence that this debate took place and her views about her future as she had so often shared them were not included in the final assessment or reports to court.

4.66 **Police information as part of the SGO:** There is no requirement within the SGO Guidance about seeking police information as part of the assessment process. The social worker believed she had sought this information, and it had been returned with no concerns. This information is not available on the CSC files, and the police have no record of the request being made. Personal information was available if an enhanced check had been requested, which related to Aunt’s personal life and would have added to the information provided by Aunt regarding the abuse by PGM and the sexual abuse by the teacher. The information would have made it clear that Aunt had not always been entirely open about her circumstances. It is unlikely that this would have changed the decision to seek the SGO, but would have influenced the subsequent support plan.

4.67 **SGO Support Process:** The Children’s Guardian highlighted the need for high levels of support to this placement and a full SGO support plan was also prepared. This covered all the important aspects of Child J’s life, but did not include expected outcomes, timescales or proposed reviewing mechanisms. The Court agreed the SGO and in addition a FAO24. The FAO does not come with a clear set of guidance regarding the expectations of support, what sort of plan should be developed or what the reviewing mechanisms should be. Cafcass have developed their own guidance25 but no Local Authority has done this. This meant that there were three potential plans for Child J, the Children’s Guardian recommendations, the SGO Support Plan and the FAO. In the event the former two were not implemented and no support plan for the delivery of the FAO was developed. This was hugely influential in the provision of support which followed, which lacked aims and a clear purpose, had no reviewing mechanisms or contingency arrangements. Most crucially there was a lack of a coordinated multi-agency approach. Researchxxxiii highlights the importance of good quality plans to support new placements and to ensure their success, particularly where children have complex needs.

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24 A Family Assistance Order is intended to provide focused short-term help to a family. The nature of the help to be provided will normally be in the assessment or case analysis provided by Cafcass to the court. The order requires that a local authority is to make an officer of the authority available, “to advise, assist and (where appropriate) befriend any person named in the order” (section 16(1)).

4.68 **The transition process:** The SGO guidance does not stipulate how the process of transition for a child from any current placement to the Special Guardian should be managed. This is largely because the assumption is that the child may be already living with the person who is applying to be the Special Guardian, or the child is moving to live with someone who is well known to them and with whom they already have an established relationship. Local Fostering and Adoption processes and research makes clear that good transition arrangements are imperative to the success of new placements.

4.69 A timetable was put together for Child J’s move from the foster carer to Aunt. This was practical in nature and was well managed and supported by the foster carer. There was not enough focus, however, on the emotional transition and although some direct work was done with Child J, it was not sufficiently focused on her desire to return home, or stay with the foster carer, or her worries about her Mother’s health. Child J needed an opportunity to think about these issues in the context of life story work – something mentioned in the SGO support plan, but was never started.

4.70 One of the essential elements of life story work is to help children understand their recent history and decisions that have been made about their lives. It also enables memories to be captured. It is unclear, for example, what Child J brought from her Mother’s home to the foster carer’s home and what she brought from there to her home with Aunt. There is no sense of her likes and dislikes, what she was good at, what toys she liked to play with, what television programmes she liked, who were her friends and did she have a favourite toy/object that she used for safety and security. These may all have been discussed informally between the foster carer and Aunt, but should have been part of a more formal transition plan. Finally, research around transitions highlights the importance of foster carers staying in contact with children for a period of time after they have moved to a new permanent home. This was not formally planned for, but happened informally in the first few weeks after Child J moved to live with Aunt.

4.71 **Contact arrangements:** The SGO guidance does not provide any specific guidance regarding contact arrangements, and there is a presumption that this happens more easily within a family context. The lack of a support plan meant that there were unclear expectations regarding contact between Mother and Child J. The need for this to happen was outlined in the SGO support plan, and contact did take place. It was initially supervised by a contact worker and then by Aunt. There is very little information about the contact sessions or arrangements and they were never subject to formal review. Mother has said as part of the review process that she shared concerns about Child J and her wellbeing with the contact supervisor, but there is no record of this. Aunt raised concerns about the contact between Child J and her Mother, suggesting that it was disruptive to Child J. Although there are sometimes difficulties in contact between children and their birth families, it is important that these links are
maintained, and efforts are made to resolve problems\textsuperscript{xxxvii}. Contact was made with Mother, but there was no assessment of whether the contact was really having an impact and decisions to alter arrangements should have been made in a more considered way.

4.72 There is also little information about contact between Child J and Sibling 1. A number of concerns had been raised about the relationship between Child J and Sibling 1 and Child J’s feelings of jealousy. Research suggests that these relationships need clear assessments and planning if contact is to be successful and helpful to all\textsuperscript{xxxviii}.

4.73 The SGO support plan also highlighted the importance of Child J having contact with her wider family. There was no plan regarding this, and the concerns raised by Mother about the extended family were not addressed. Again there is a national assumption, which appears to have influenced local practice, that families are able to sort these arrangements out themselves. This position does not take account of complex and difficult family arrangements and this was a significant issue for Child J. Recent research\textsuperscript{xxxix} regarding SGO’s has highlighted that children placed with relatives actually have less contact with the birth family and more needs to be done to formalise arrangements.

No recommendation has been made given the work undertaken by Nottingham City Council to respond to these issues. Information regarding this is set out in the response document. This work has been further strengthened by national developments in relation to the use of Special Guardianship Orders.

The NCSCB will need to seek reassurance this work is making a difference to the issues raised in this report.

Finding 10: The importance of effective plans, assessments and effective multi-agency processes

4.74 The SGO process influenced planning when Child J came to live with her Aunt, particularly because the FAO had created some confusion about planning processes and Child J’s status. It was clear that she was not considered to be a child in need and was not subject to child in need regulations. The absence of any guidance regarding the FAO did not help – but over the whole period there was an absence of what would be considered routine family support practice in response to a child with complex educational and health needs. The process of assessment, planning, provision of support and services, review and multiagency planning is embedded into services for children for a reason. It supports children’s safety and wellbeing and the absence of such processes is consistently highlighted in Serious Case Reviews and child abuse inquiries\textsuperscript{xl}.

4.75 Absence of plans to address need: There were historical concerns about the absence of a coordinated plan to address Child J’s needs and circumstances; when her Mother
was struggling to care for her and Sibling 1, support was offered, but not in a coordinated way. There was no clear articulation of the nature of the family's difficulties, a plan to address them and a reviewing process to see how successful the support had been.

4.76 This was a similar picture when Child J came into the care of her Aunt, as has already been discussed there was an SGO plan and the Childrens Guardian recommendations when the SGO was granted, but neither were implemented and the FSW was left to provide support without any clear aims or focus, and without knowing exactly what was to be achieved. It should be a core requirement that all children in receipt of services from Children’s Integrated Services (as the lead agency) should have an individual plan tailored to meet their needs and focused on the precise nature of support and service provision and with a clear reviewing mechanism built in.

4.77 **Unclear multi-agency processes**: The absence of any plan for the placement with Aunt meant there was a lack of a multi-agency approach, and no professional or agency questioned this. Neither health nor education were included in the SGO assessment or support planning and so were unaware of what the implications of the SGO were for their provision of services to Child J. There was further confusion caused (unintentionally) by the first meeting held after Child J had moved to live with Aunt being the CAMHS consultation. CAMHS made clear the nature of this consultation process, and their minutes sent out to all reiterated that they were there to provide support and reflection and that usual planning and case work processes would continue outside of the meetings. However, this was the only meeting where different agencies got together, and in the first case consultation was described as a “review” of Child J’s circumstances. The CAMHS consultation sessions were held regularly from six months into the placement and with the exception of school, they were the only place where members of the multi-agency group came together. This was not a consistent group of people, and only short term plans were made at these meetings, in response to the concerns raised. There was one meeting described as a multi-agency meeting and this was held at school when CSC were to close the case in July 2014. This was in fact a meeting of school and the FSW and no plans were made. There was no process which took take an overview of Child J’s circumstances and considered what she needed.

4.78 **Assessment practice when children’s circumstances change**: Child J was subject to a core assessment when she came into foster care, but there were no other assessments undertaken over almost a two-year period. This is despite there being a number of times when concerns were raised about Child J’s wellbeing and circumstances. These concerns should have prompted a further assessment to explore and understand the nature of the problems and to form the basis of further interventions and support.

4.79 **Lack of a chronology**: Despite the many concerns raised, each incident of concern for Child J was treated as an isolated issue, and there was no reflection of the overall
picture, no chronology of events and no assessment to step back and try and understand what was happening. No recommendation has been made in relation to this issue in recognition of the work undertaken by Nottingham City Council to address this issue. This is set out in the response document.

4.80 **Working with discrepancies:** There were many examples highlighted through the case review where professionals were working with discrepant information, but did not notice this or further analyse its meaning. Examples include Aunt complaining about finding it hard to deal with some aspects of Child J’s behaviour, but not attending the appointments organised to support her. There were many occasions when the information provided by Aunt regarding concerns for Child J was inconsistent and discrepant. This was not noticed, and not addressed.

4.81 **Poor recording practices:** There were many examples of poor recording practice across the review. For example, the Team Manager for the FSW did not fully record their supervision discussions about Child J. The CAMHS minutes did not include the challenges made to Aunt about her punitive parenting approaches, and the FSW did not record the many play sessions she had with Child J. It is important that professionals have time to spend with the children and adults they work with, but these were all important issues that should have been more clearly recorded.

4.82 **Confusion regarding roles and tasks:** Across the period when Child J lived with her Aunt there was confusion about roles, responsibilities and tasks. This was exacerbated by the lack of a plan or multi-agency process, and were unintended by all involved, but often meant that professionals thought action was being taken when it was not. Professionals were unclear about the role of CAMHS and saw them as the lead agency. The role of the meetings and the tasks they were meant to fulfil was not well understood and there was a misconception that Child J herself was receiving services because of her difficulties. This was fuelled by Aunt, but never clarified, and many professionals were reassured that something was happening to address concerns. The provision of intensive support by CAMHS created further reassurance and confusion. Professionals believed this was a highly specialist service intended to address the significant concerns about Child J’s disturbed behaviour. In fact, it was a specialist parenting support programme intended to address positive disciplinary approaches and improve relationships. The role of the FSW was not always clear. She was allocated to fulfil the requirements of the FAO, which was to befriend and support. A new social worker was brought in when there were concerns regarding safeguarding. She had no existing relationship with either Child J or the Aunt and her role was never really made clear to other professionals.

4.83 The specialist nurse for continence was clear about her role, but unclear about her place in the multi-agency network. This confusion meant that there was a muddled response across the professional network, and despite the many professionals who were involved with Child J and their commitment to her, the response was much less
effective than it could have been. Aunt manipulated professionals and caused divisions between people; this should have been recognised and seen as a cause for concern.

4.84 **Differences in professional opinion:** There were some differences of professional opinion that remained unacknowledged and unaddressed. The school were marginalised early on, and Aunt suggested that the school concerns were indicative of poor parent-school communication which led to these concerns being discredited. This was in essence a difference of opinion about the nature of the problem. The belief that Aunt was struggling to manage Child J’s behaviour was the dominant professional view. Some members of the school staff held the professional view that Aunt was hostile and abusive, other believed that she was being unfairly targeted. These differences were never fully aired or discussed and ultimately it was Aunt who dominated most meetings and the analysis of concerns. This was particularly apparent in the months leading up to Child J’s death, where the Class Teacher was challenged in the school meeting for making a safeguarding concern directly to the FSW. The school and CSC took the position that this issue was conflict between a member of staff and a parent/carer rather than step back and reflect on the meaning of this significant difference of opinion.

4.85 **Working with complex and fragmented families:** At the start of this review process it was anticipated that this case would shed light on the complexity of working with complex and fragmented families. Child J was part of an extended family, which included her Father having a number of families and meaning she had many siblings, some of whom she had no contact with. Very little was known about the role that Father played in Child J’s life; this was in part because he was in prison for some of the time. PGM was known briefly to professionals, but was not seen as part of Child J’s life. There were early opportunities to connect parts of the family together, but it was hard to make sense of the nature and influence of family relationships. This case highlights the importance of viewing children in the context of their wider family, however complex this is.

No recommendation is made regarding these issues about routine casework practice in recognition of ongoing work being completed by agencies and outlined within the action plan.

**Finding 11: The influence of fixed views and confirmatory bias**

4.86 A key feature of the work in this case is the extent to which a number of professionals formed a fixed view about Child J and her circumstances, and despite professional differences of opinion this view did not change. One of the key purposes of supervision is to provide professionals with the opportunity to critically reflect on their practice and explore the wide range of influencing factors that might be affecting their decision making, including biases, assumptions, and attitudes to parents/carers and working relationships. It is through this type of supervision that practitioners can slow down
and carry out the analytical thinking for the complex task of working with children and their families. This was a complex case and required the opportunity to take a step back and think about the professional task. There was little evidence of consistent reflective supervision for any professional involved. Some professionals received no supervision, others sought advice from their safeguarding supervisors, but agreed no actions and some professionals attended supervision regularly but did not use the time to explore the circumstances of Child J in any detail. The paradox is that the fixed view that this was not a safeguarding case stopped professionals from seeking supervision to explore if this was a correct analysis and to have their decision making challenged.

4.87 This fixed view was to some extent a consequence of the deficiencies in the multi-agency response. This was exacerbated by the impact of confirmatory bias. Research\textsuperscript{dii} and Serious Case Reviews\textsuperscript{dii} have highlighted the tendency of professionals in the safeguarding arena to develop fixed ideas about a child's situation (whether that is positive or negative) and to stick to this notion, taking account of information which supports the existing hypotheses and rejecting any information which appears to contradict it. This pressure comes in part from the emotional nature of the safeguarding task and in part from the complexity and contradictory nature of the information being evaluated.

4.88 The view of a number of agencies was that Aunt was struggling to manage in a difficult situation, but was doing her best when faced with complex issues such as self-harm and disturbed behaviour. The over reliance on Aunt’s own self-report of the circumstances tended to reinforce this view and therefore she was not challenged or questioned about inconsistencies in her explanations of what actually happened. In fact, because she often pre-empted enquiries about bruising, this tended to reinforce the largely positive view held. She was also extremely articulate and presented as a credible source of information.

4.89 Some members of the school staff found Aunt aggressive and obstructive, and were clear that the bruises were of concern. Aunt managed to discredit their view, alleging that they did not communicate well with her, and had falsely accused her of child abuse. This “splitting” of the professional group was not reflected upon in a professional context and the fixed view remained.

4.90 Confirmatory bias needs to be addressed by professionals having the opportunity for good quality reflective supervision, the space to reflect on cases and to have ways of “playing devil’s advocate”. There were organisational pressures that made this more difficult for some agencies, and it did not happen. This also highlights the need for multi-agency meetings where differences in professional opinion about the needs and circumstances of children can be openly discussed, and strategies to address differences of professional opinion formulated. Major differences in professional opinion in a network of professionals who are charged with meeting the needs of a child or group of children are indicative that no one agency has fully understood the needs of the child or family, and a new approach is required.
**Recommendation 7:** The Safeguarding Children Board should seek assurance from partner agencies about:

- The criteria they use to determine how reflection and critical thinking is embedded within their organisation in order to enable practitioners to consider the information they hold, what additional information they need, who would hold this information and how this process addresses the potential impact of confirmatory bias.
- Why they are content that this is working well
- Any steps that need to be taken to improve this aspect of safeguarding practice.

**Finding 12: Lack of focus on the child and her lived experience**

4.91 The Nottingham City Children Safeguarding procedures\(^{xliv}\), underpinned by Working Together 2015\(^{xlv}\), makes clear that one of the core principles of effective safeguarding and support practice is a child centred approach which is focused on the needs and views of children. This is reinforced by the United Nations Convention on the Rights of the Child (UNHCR CRC), which recognises a child’s right to expression and to receiving information. This right is also reinforced by Article 10 of the Human Rights Act 1998 and the Children Act 1989, which requires a Local Authority to ascertain the ‘wishes and feelings’ of children and to give consideration to these when determining what services to provide or what action to take (taking into account the child’s age and understanding).

4.92 Despite this mandate, evidence\(^{xlv}\) shows that children nationally are not being routinely fully included in safeguarding and support work. The consistent finding from Serious Case Reviews is that professionals did not speak to the children enough; a report by Ofsted\(^{xlv}\) on the themes and lessons to be learned from Serious Case Reviews across the country highlighted that child were not seen frequently enough by the professionals involved in their lives, professionals focused too much on the needs of the parents and overlooked the implications for the child. Many of these issues were present for Child J.

4.93 Child J was not always consulted about matters that affected her. She was not formally consulted as part of the looked after reviewing process (being described as too young) and her views were not included in the SGO assessment. She was seen regularly during the court process by the Social Worker and the Children’s Guardian; her views were incorporated into court reports. She was not always asked about injuries and bruises, although the school and the FSW did seek to ask her regularly about what had happened to her. However, when she was asked her inconsistencies, changing of story and assertion that she had lied or harmed herself were accepted as either fact, or indicators of her behavioural and emotional difficulties which were as described by Aunt. These were accepted far too readily and were not sufficiently explored or
analysed. There was no sense that professionals considered that she might either be afraid or have been told not to tell the truth. Professionals did not know that this was the case but they should have considered it.

4.94 Child J was reported on a number of occasions to have reported “harming herself”, but her exact words are not recorded, and so it is hard to evaluate what this meant. There is little evidence across agency records of what Child J actually said herself about her circumstances and there are insufficient reflections on her lived experiences, what was everyday life like for her.

4.95 Although professionals were concerned about the harsh, critical and punishing approach taken by Aunt and this was often discussed, there is no recorded view of what this might mean for the day to day lived experience of Child J.

4.96 There were many occasions that Child J made disclosures about the harsh and critical care she was receiving from Aunt and she made a direct allegation of abuse about her Aunt’s friend who was looking after her. These incidents were enquired about and a pattern emerged where Child J would then withdraw the disclosure either saying she had lied or had self-harmed. This happened on many occasions, but the lack of a chronology of incidents, or appropriate reflective supervision for the professionals hearing these disclosures meant the pattern was not recognised. When Child J made a direct allegation of being hit by her PGM and another adult she was asked to discuss this in front of Aunt and again said she had lied. There was never any discussion regarding why a child of 6 or 7 might lie, what this might mean about her wellbeing or how this might impact on her own help seeking behaviour. When children make disclosures they are asking adults for help. If they are being abused they are taking a risk, as the disclosure might lead to further abuse. It is essential that professionals handle these disclosures sensitively, that children are reassured that they are right to talk to adults, that they will receive help, that being harmed is wrong and that in the short term the adult responsible will be asked to repair any damage. The onus here was on Child J to prove what had happened to her, rather than on Aunt being asked to take responsibility for what was clearly emotionally abusive care.

4.97 All children deserve sensitive caregiving, where secure and loving attachments are fostered, where love and care is provided and children are enabled to experience empathy and are treated fairly and justly. Parental attitudes to children which are about blame, harsh and critical care and scapegoating are recognised as a key indicator of emotional abuse. Emotional abuse has the capacity to impact negatively on children’s development in the short and long term and thus needs addressing urgently.

Aunt was recorded as saying many negative things about Child J, including that she was remorseless, wilful and knowingly difficult. These very negative views, expressed about a child of six were wholly inappropriate, and in terms of the records available do
not seem to be accompanied by a sense of empathy by Aunt for Child J and her circumstances. Aunt should have been challenged regarding this, and these very negative views should not have been recorded as facts.

In addition, there were concerns in school regarding how downcast Child J looked in the presence of her Aunt, and how unhappy she seemed. This was not consistently recorded and not reported to any professional. There was confusion regarding what could be asked about, and what constituted a fact regarding safeguarding issues. The Class Teachers and Teaching Assistants were rarely asked by other professionals about how Child J seemed – and this information was not reflected upon during the school safeguarding meetings, when safeguarding concerns were being discussed or during the CAMHS consultations. This meant that the lived experience of Child J was not really known.

They were Aunt’s view and there was rarely corroboration for them from any professionals. It is of concern that Aunt made use of her friends and church members to substantiate her claims about this child. Professionals wanted to support Aunt, and allow her to air her feelings whilst working with her to develop her attachment but too often the self-report of Aunt about Child J became seen as fact, not opinion.

4.98 It is essential that all professionals recognise and empathise with the lived experience of children and use this as the cornerstone for plans, assessments and decision making. They also need to recognise when adults attempt to divert attention from the child and be challenging of this. This requires good reflective and challenging supervision and management oversight.

**Recommendation 8:** The NCSCB should seek assurance from all partner agencies about the quality of child focussed practice and draw on any current work, such as audits, to consider whether there is any other evidence regarding poor child focussed practice which requires action.

**Finding 14:** Partnership practice and the importance placed on engagement with parents/ carers can mistakenly lead to both a lack of challenge and collusion leaving children at risk

**Recommendation 7** addresses this issue.

**Finding 15:** Awareness that parents/carers may be covertly recording meetings.

4.101 The trial and inquest process has meant that it became known that Aunt covertly recorded many meetings and telephone calls, as well as discussions after meetings...
with Child J. These recordings highlighted some unprofessional behaviour and unguarded comments which could have been seen as collusive by Aunt. This raises the importance of professionals being aware that this can happen, and to also ensure that they behave in a professional way at all times.

**Recommendation 9**: The NCSCB recognises the significant issue of staff being recorded and will seek reassurance from partner agencies that they provide staff with clear guidance about this matter.
5 CONCLUSIONS

5.1 This is an extremely sad case and the death of Child J has caused a great deal of pain to all those who knew her.

5.2 Child J was removed from her Mother’s care and although this was a difficult decision, the available evidence suggests that it was appropriate given the information at the time. This was a hard decision for professionals to make and they truly believed that placing Child J in her family network would ensure that her cultural needs would be met and that she would remain in the orbit of her family network. This decision was made without knowledge of the complex or corrosive nature of some of the family relationships or that Mother would be able to overcome her poor early experiences; she has worked hard to create a new and settled life for herself whilst always holding Child J in mind. This is very sad and the thoughts of all those involved in the Serious Case Review are with her.

5.3 Child J spent over a year with a loving and caring foster family who did their best for her. They were not sufficiently prepared for the task of caring for a traumatised child, but after seeking advice they found a way of forming a relationship with her which was beneficial to all. The whole foster family are left with the loss of her.

5.4 It is a huge responsibility for professionals to ensure that children who cannot live with their birth families have secure and permanent families for life. They are only too aware of the damage that is caused to children by lack of certainty, and insecure placements. Aunt presented as an adult who was committed to Child J and wanted to provide her with a home in the long term. She did not tell the truth about her past family life, or her personal circumstances, and she provided information that suggested she was a mature and able individual. There was no available evidence in the context of the SGO that suggested she would not be an appropriate carer.

5.5 It has become clear as a result of the criminal trial, the inquest and the end of the Serious Case Review, that Aunt was harsh, cruel and abusive to Child J. She manipulated and deceived professionals, and incorporated friends into this process of deception.

5.6 The level of Aunt’s cruelty was glimpsed, but not fully known. It was the absence in this case, caused in part by the granting of a FAO, of routine processes such as ongoing assessments, plans which make clear the nature of a child’s needs and good multi-agency working arrangements, effective reviewing arrangements, clarity of task and role alongside an awareness that parents/carers who are abusing children create divisions and diversions so they are not found out. This was not recognised in this case. Most professionals lost sight of the need to keep the child and her lived experience in mind.
5.7 Although there was no clear evidence that Child J would die (and the trial did not make clear who was responsible for this) it was possible to recognise that she was being harmed by Aunt and in the last few months of her life concerns about bruising known at school were not shared with other professionals because of a mistaken belief that these were false allegations. The lack of awareness of escalation processes meant that those who were concerned felt they could take no further action to ensure that she was safeguarded. This points to the need for all professionals to recognise their responsibilities to take action, even when faced with hostility and reluctance from others, using either the escalation processes or whistle blowing processes in place.

5.8 It is essential that all professionals working with children and their families do so in a respectful and open way. This is the cornerstone of partnership practice as embedded in the Children Act 1989 and subsequent guidance and legislation. However, research and Serious Case Reviews emphasise the importance of not taking at face value what parents or carers say when asked about the possible abuse of children. The Munro review commented that adults in this situation have a number of motives for not always providing a full picture of their or their children’s circumstances. The task of professionals is to remain in a position of “respectful uncertainty” and display “healthy scepticism” which in practice means:

- checking the validity of information provided by parents/adults by cross referencing/triangulating with other sources
- testing out the level of parental care and concern for children and the extent to which parents feel a sense of responsibility for their children and their well-being

5.9 It has become clear as a result of the covert recording of meetings by Aunt that she dominated much of the professional response and brought in friends strategically to support her view and this meant that Child J’s needs and lived experience got lost in the process.

5.10 In the last few months before Child J died the divisions in the school provided further opportunity for Aunt to play professionals off against each other. When the Class Teacher became increasingly concerned, Aunt was able to characterise this as poor communication and unfair targeting. DSL2 believed this and a taped telephone conversation showed how much she sought to reassure Aunt that the school did not believe that she was abusing Child J and would ensure that communication improved. This position was further reinforced when the Class Teacher was asked to communicate better during a meeting with Aunt in attendance. The lack of any supervisory processes in the school, and absence of leadership or management oversight of the school safeguarding response meant that the differences of opinion were not addressed appropriately and unintentionally served to enable this collusion with Aunt against another member of staff.

5.11 The FSW was not always provided with a clear picture of concerns regarding bruising and injuries by school, but was aware that school staff were concerned. The covert recordings show that in an attempt to maintain a partnership approach with Aunt, the
FSW sought to reassure Aunt and to take her side against the school. This collusion by one professional with a parent/carer in the context of safeguarding concerns is a feature of many case reviews, and should never happen. Professionals should seek support through local processes to resolve professional disputes, and although parents/carers have the right to discuss concerns they have about how they are treated this should be managed in a professional and non-collusive way.

5.12 All the findings point to the importance of good quality reflective supervision and complex case processes for the multi-agency group. There was evidence that the FSW had supervision, but there was little case discussion and little reflection regarding emerging and new information. CAMHS workers did not access supervision during the time under review, and so were not able to reflect on some of the discrepancies and worrying information they were hearing. The continence nurse did seek safeguarding supervision, but did not act on the advice given. There is no routine of safeguarding or reflective supervision in schools and the complex picture that has emerged about the chaos and lack of leadership, lack of action and at time collusion with Aunt shows the need for it.

5.13 There was no indication to professionals that Child J would be killed, and this is also the conclusion of the inquest. However, a more authoritative approach to the harsh and cruel parenting, bruising and injuries and very negative attitudes of Aunt to Child J should have been adopted. The lack of a full understanding of Child J as a child who had been traumatised and the likely impact on Aunt who was herself someone with a traumatic and complex background meant that Aunt was considered to be struggling with the task of parenting. This was an inaccurate conclusion which was fuelled by fixed views and an adult focus, but also by what is now clearly known to be Aunt’s deliberate manipulation and splitting of professionals.
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<th>Recommendations to the Nottingham City Safeguarding Children Board</th>
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<tr>
<td>1.</td>
<td>The NCSCB should seek assurance that the implications of parental mental ill-health are understood and fully addressed in plans for children and young people. This will include an evaluation of the availability of therapeutic support needs of parents, how this is prioritised and the implications this has for local commissioning arrangements.</td>
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<td>2.</td>
<td>The NCSCB should highlight the importance of recognising and understanding early childhood trauma when communicating the learning from this Serious Case Review. It should seek assurance from partner agencies that this issue has been reinforced through internal communication and training routes.</td>
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<td>3.</td>
<td>The NCSCB Practice Guidance regarding self-harm should be updated to address the needs of children aged 5-10. This update should make clear that professionals should not accept the term self-harm in children under 10 without consideration of potential emotional well-being or safeguarding concerns.</td>
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<td>4.</td>
<td>The NCSCB should ensure that all professionals who are working with children with continence issues are aware of the national guidance regarding this. The NCSCB should seek assurance that agencies are clear about what action to take when parents/carers adopt a significantly punitive approach and recognise the need for a coordinated response to these issues.</td>
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<td>5.</td>
<td>The NCSCB should review the guidance for all professionals regarding the assessment of potential non accidental injury and ensure it is compliant with the existing NICE Guidelines regarding child maltreatment. This revised guidance should also include</td>
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<td>- Guidance for all professionals about child centred disciplinary approaches.</td>
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<td>- A mechanism for ensuring relevant information about a child's known psycho-social history and history of previous concerns/injuries is completed in preparation for a child protection medical and that this is recorded where it is not possible to do this in advance of the medical, this information must be considered alongside the outcome of the examination.</td>
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6. The NCSCB should reinforce the need for all professionals to recognise the important role played by schools in the support and safeguarding of vulnerable children and promote a multi-agency approach to all aspects of assessment and planning for vulnerable children.

This action should include ensuring that:

- Schools routinely follow up referrals to children's social care in writing including details of all concerns that have been recorded by staff within the school.
- Nottingham Education to work with head teachers to establish consistency in the way that “soft” information that raises concerns about a pupil's wellbeing is collected and reviewed both directly during staff supervision sessions and through recording processes.

7. The NCSCB should seek assurance from partner agencies about:

- The criteria they use to determine how reflection and critical thinking is embedded within their organisation in order to enable practitioners to consider the information they hold, what additional information they need, who would hold this information and how this process addresses the potential impact of confirmatory bias.
- Why they are content that this is working well
- Any steps that need to be taken to improve this aspect of safeguarding practice.

8. The NCSCB should seek assurance from all partner agencies about the quality of child focussed practice and draw on any current work, such as audits, to consider whether there is any other evidence regarding poor child focussed practice which requires action.

9. The NCSCB recognises the significant issue of staff being recorded and will seek reassurance from partner agencies that they provide staff with clear guidance about this matter.

6  APPENDIX 1

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<th>Agencies who provided a Chronology and Appraisal</th>
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<td>Nottingham City Council: Children's Integrated services</td>
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