Child Safeguarding Practice Review

Joanne (pseudonym chosen by Joanne's mother)

Independent Reviewer: Kevin Ball

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1. Introduction & background to the review

1.1. This summary report sets out the findings and learning from a Child Safeguarding Practice Review (CSPR) commissioned by Cambridgeshire Safeguarding Children Partnership (the Partnership). It is intended to build on learning identified at the Rapid Review stage. While the quality of the Rapid Review was commended by the national Child Safeguarding Practice Review Panel[1], the Partnership chose to commission a proportionate independent review to capture further opportunities for learning and improvement.

1.2. In November 2023 a two-year-old child, who for the purposes of this review will be known as Joanne (pseudonym), died as a result of a traumatic head injury received 10 days earlier. The injury occurred whilst Joanne was in the care of her mother and mother's partner; the Police are investigating the injury as a non-accidental injury. Joanne was part of a blended family which included four children; all the blended family members were white British. Joanne had significant complex physical and medical needs from birth.

2. Arrangements for the review, including lines of enquiry

2.1. The decision to conduct a CSPR followed the conclusion of the Rapid Review held in February 2024. This decision was supported by the Child Safeguarding Practice Review Panel in March 2024. The following steps were then taken:

- The Partnership appointed Kevin Ball[2] as the Independent Reviewer in July 2024.
- An initial Review Panel was convened in July 2024 which confirmed the local arrangements for the review, the lines of enquiry, methodology and schedule.
- Based on learning already captured during the Rapid Review, and the wish to carry out a proportionate review, it was agreed that the main task was to convene a multi-agency workshop to further examine two issues that were judged as needing greater exploration. This workshop, which was independently facilitated, took place in October 2024. Those professionals participating in the workshop comprised of practitioners that had contact and involvement with Joanne and family, plus other professionals that hold a specific role within individual agencies who could offer a broader, and more systemic perspective to the issues being explored.
- Due to the Police investigation, there was a delay in speaking with Joanne's mother and father; however, in January 2025 it became possible and the Independent Reviewer spoke separately with both Joanne's mother, and father. Their views have been incorporated into this report where appropriate to do so and a draft copy of this report has been shared with Joanne's mother.

2.2. The following services and agencies were represented at the multi-agency workshop, and as such, have contributed to this Review:

Cambridgeshire Children's Services	Suffolk Children's Services
Cambridgeshire Police	Queen Elizabeth Hospital NHS Trust
Cambridgeshire Community Services	Cafcass
School A	-

2.3. The following two lines of enquiry were agreed as needing to be explored during the multi-agency workshop;

1. Using what happened to Joanne as a spotlight on the system, what can we learn about the use of Early Help versus Child in Need interventions for children with complex health needs? What worked well, and

[1] Child Safeguarding Practice Review Panel is established under the Children & Social Work Act 2017.

[2] Kevin Ball is an experienced independent consultant, chair, reviewer, and scrutineer. He is a member of the Child Safeguarding Practice Review Panel's pool of national reviewers.

what needed to be better? What blocks and barriers existed – at policy, procedural pathway, people & practice levels – that prevented Joanne receiving the care, support and protection needed?

2. What was the quality and effectiveness of information sharing across geographical borders and local authority boundaries? What worked well, and what can we learn about how to improve practice and information sharing arrangements?

2.4. This review has kept in mind the nine protected characteristics outlined in the Equality Act 2010 (age, gender, race, disability, religion or belief, sexual orientation, gender reassignment, marriage or civil partnerships, pregnancy, and maternity). The characteristic of age and disability are relevant - all other characteristics have been discounted as not relevant.

2.5. The agreed methodology chosen by the Partnership did not include the submission of single agency reports. Therefore, the review and this report have relied on information submitted at the Rapid Review, discussions at the multi-agency workshop and any further individual discussions with key stakeholders, including those represented on the Review Panel.

3. Concise account of relevant information & key events

3.1. In the preceding months prior to her death, Joanne's mother had formed a relationship with an adult male, Adult 1, who had recently separated from his own partner. At the time of her death, Joanne's household consisted of an older sibling (6 years), plus two children (1 & 8 years) from Adult 1's previous relationship. Whilst together as a new family unit, Cambridgeshire Targeted Support Services visited the home four times during September 2023 – this was in response to supporting Joanne's mother parenting of the older sibling. Due to the mother having fled a an allegedly domestically abusive relationship in Medway, the Family Worker spoke to Joanne's mother about Clare's Law[3]. The mother stated she was aware of Clare's Law and did her own checks when she and Adult 1 got together. The Family Worker stated over the course of the four September visits that she seemed to be aware of Adult 1's situation, knowing that his children were currently subject to a Child Protection Plan with Suffolk Children's Services. Adult 1, also present at the time, gave consent for the Family Worker to contact the Suffolk Social Worker to discuss the Plan. Adult 1 stated that his former partner made false allegations against him including assault, rape, coercive control, and allegations that he had sexually abused one of his children. Adult 1 had significant previous contact with agencies due to concerns about the safety and welfare of his own children while living in Cambridgeshire a few months earlier. In March 2023, while in Cambridgeshire but before moving to Suffolk in May 2023, Adult 1's children become subject to Child Protection Plans: concerns had included serious domestic abuse and assault, a controlling and coercive relationship, physical chastisement of the children, maternal drug use, paternal mental health difficulties, and one of his children, who had physical disabilities, not having their needs met.

3.2. Joanne and older sibling, prior to moving to Cambridgeshire in July 2022 with their mother, had lived in Medway; the mother had allegedly experienced domestic abuse resulting in acrimonious separation from the children's father. Due to Joanne's complex health and medical needs, she was known to a range of health agencies in Medway. Cambridgeshire health agencies became aware of, and began having regular contact with Joanne, either in the home or at hospital appointments in the Cambridgeshire area between September 2022 and October 2023; these included Health Visiting Services, Dietetics, Speech & Language Therapists and Occupational Therapy.

[3] Clare's Law is a Domestic Violence Disclosure Scheme where someone can apply for information about their current or ex-partner because they are worried, they may have a history of abuse and are a risk to you, plus you can request information about the current or ex-partner of a friend or relative because you are worried, they might be at risk.

3.3. A MASH referral was made by the older sibling's school in September 2022, when a small bruise was seen on his left cheek; the sibling was clear this had been caused by his mother *'Mummy bashed me because I answered back'*. The mother denied causing the bruise when contacted by Cambridgeshire MASH[4], but it did result in safety planning being discussed, and her sharing that there were a number of professionals involved with her given Joanne's additional needs. Records indicate there is no evidence to suggest, at this point, consideration was given to Joanne and what support or safeguards she may need. An Early Help Assessment was then initiated by the older sibling's school in November 2022, but there was a significant delay in the case being moved into the Targeted Support Service, with this not happening until March 2023. The family were allocated a Family Worker in August 2023 when this request was received by the District Team from the Early Help Hub and the initial Team around the Family meeting took place in October 2023 - it is unclear what work, if any, was undertaken.

3.4. In July 2023, Cambridgeshire Children's Services received a referral from Cafcass[5] following the mother making an application for a Child Arrangement Order[6] in respect of the children spending time with their father. As a result of the information from Cafcass, a Family Worker from the Early Help Team started to work with Joanne's older sibling at the end of August 2023. The mother advised the Family Worker that she had formed a new relationship with Adult 1, and that they both have 'baggage'. There is no evidence that Joanne was considered as part of the support offered or that questions were asked about Adult 1.

3.5. The Cambridgeshire Family Worker contacted the Suffolk Social Worker in early October 2023, who confirmed that Adult 1's children were on Child Protection Plans in Suffolk, due to concerns regarding their mother, not Adult 1. There had been concerns about Adult 1, but there was no evidence to support his partner's allegations and it was likely that his children will come to live with him once private law proceedings conclude. The Suffolk Social Worker also requested *'… to stay involved rather than handing over to Cambridgeshire social care as she knows the family well …'.* This information was shared with the Cambridgeshire Family Worker's manager the following day, along with Adult 1's view that he was not wanting any support from Targeted Support in Cambridgeshire.

3.6. Joanne became unwell in early October 2023, needing to be admitted to hospital on two occasions. Joanne's older sibling was seen at school in October by the Family Worker to have a small bruise on his face; he later disclosed feeling sad when he is told off by his mother and Adult 1, stating *'… I get a slapped bottom from my mummy, really hard …'*. The Family Worker spoke with the mother about this, but she denied smacking him. The day after Joanne's second discharge from hospital, the Early help Team received a referral from the Health Visiting Team to enable Joanne to access support from the SEND Support Service. Five days later, Joanne was taken to hospital with a significant head trauma; she sadly died 10 days later.

[4] MASH – Multi-Agency Safeguarding Hub.

[5] Cafcass – Child & Family Court Advisory & Support Service.

[6] Child Arrangement Order A 'child arrangements order' decides: where your child lives, when your child spends time with each parent, when and what other types of contact take place (phone calls, for example), section 8, Children Act 1989.

4. What have we learnt by coming together?

1. As noted earlier, learning has been captured by the Partnership during the Rapid Review phase. In summary, learning identified at that stage highlighted the following areas:

4.1. Professional curiosity

4.1.1. Most agencies that submitted responses to the Rapid Review highlighted learning about a lack of professional curiosity about these children. This is a critical finding and is hugely impactful on other areas of learning, and related to several areas, including;

- Why Joanne's mother was moving from Medway to Cambridgeshire,
- Family dynamics and relationships,
- Whether the family felt under pressure,
- Who the children were living with at various points throughout their history,
- Allegations of abuse by Joanne's father towards her mother,
- Allegations of abuse by Adult 1 towards his former partner,
- Exploration of Joanne's needs, plus the needs of one of Adult 1's children who also had physical disabilities,
- Exploration of the Non-Molestation Order, and involvement of Cafcass.

4.1.2. A Briefing Paper[7] on the Cambridgeshire & Peterborough webpages, issued in February 2022, helpfully examines the concept of professional curiosity, stating; '*Professional curiosity / opportunities to be curious is about exploring and understanding what is happening with children or adults at risk and their wider environment. It is about enquiring deeper and using proactive questioning and challenge. It also relates to understanding own responsibility and knowing when to act, rather than making assumptions or taking things at face value. In practice, opportunities to be curious is aligned to multi-agency working, collating information from different sources and applying different perspectives. This will lead to developing a better understanding of a child or adult at risk and the context their life is embedded in aiding a systematic analysis'.*

4.1.3. As commented on during the Rapid Review it is important to distinguish between the concept of professional curiosity and professional responsibility. Opportunities clearly did exist for multiple professionals from across a range of agencies and services to ask more questions, and be more curious with the mother about her move from Medway to Cambridgeshire, but more critically, about who else might be in her new life in Cambridgeshire and the impact of the move, and new life, on the children.

4.1.4. Since the Rapid Review, work has been underway to further promote the idea of asking questions, being professionally curious and not accepting information at face value. Given the changing nature of the workforce and demands on day-to-day practice, further work is needed to promote professional curiosity and professional responsibility across the Partnership. The Partnership will undertake further work to understand the reasons that inhibit or prevent professionals asking questions, and challenging information they hear or receive.

4.2. Voice of the child and their lived experience

4.2.1. Given the lack of professional curiosity, and simply not knowing about their history, it naturally follows that agency records and professionals had a very limited appreciation about the children's day to day experiences, or their views. The Rapid Review noted '… *While there was some evidence of [the older sibling] speaking to workers telling them about being smacked, these recordings were limited. For Joanne, a child with physical disabilities there was even less sense of her day-to-day experiences, or her needs. The Partnership noted that they have numerous*

[7] Briefing: Professional curiosity - opportunities to be curious

training packages, tools, guidance, and resources around lived experience, but they do not place a strong enough emphasis on gaining lived experience of children with complex health needs. These guides will be updated to ensure there is a focus on the importance of both capturing and using the child's lived experience …'. In speaking with Joanne's mother, she felt that during Joanne's hospital admissions in October 2023, health professionals were not listening to her, or Joanne's calls for help and not recognising Joanne's experience – she described Joanne as crying, which she considered unusual, being indicative of her being in pain or discomfort.

4.2.2. The recognition by the Partnership that training materials or training opportunities, plus guidance, does not place sufficient emphasis on children with complex needs is important. Research[8] reminds us that children with disabilities are at significantly higher risk of abuse or maltreatment than non-disabled children. Finding ways of gaining the child's voice and/or understanding their day-to-day experiences is critical to gaining assurance about the style and level of care they receive.

4.3. Understanding of the family dynamics and relationships

4.3.1. The finding that there was a lack of understanding about family dynamics and relationships during the Rapid Review phase is unsurprising given the allied finding relating to the lack of professional curiosity.

4.3.2. The Rapid Review noted '*… Both [the children's father] and [the mother's current partner – Adult 1] had a history of domestically abusive relationships* [or alleged abuse]. *When the mother moved away from [the children's father], agencies considered that the* [alleged] *domestic abuse aspect of her relationships had been removed and risk had been reduced. Whist this was true regarding her relationship with [the children's father], the dynamics of her new relationship and the bringing together of four children … was not fully understood or explored by agencies at any point in the process. …agencies had a range of differing dates for when the mother and Adult 1's relationship commenced and moved in together and none of these were consistent. This meant the family were potentially together up to 7 months prior to when agencies thought they had come together. As a result, organisations were not fully sighted on the risk and needs of the household. … There was mention in agencies records of mum's new 'partner' but little exploration of who he was, his background and the bringing together of two children with physical health needs. There was also a lack of genograms on file …'.* School A confirmed that they had one of Adult 1's children attending their school, not knowing he was subject to a Child Protection Plan.

4.3.3. There is considerable research[9] confirming that adult males are often overlooked during assessment activity. One key recent report[10] reflected from its findings that there is '*…an urgent need to improve how the system sees, responds to, and intervenes with men who may represent a risk to the babies they are caring for. For this group of men, the role that they play in a child's life, their history of parenting and their own experiences as children and how this affects them as adults, are too frequently overlooked by the services with responsibilities for safeguarding children and for supporting parents …'.* For this review the men, Adult 1, and the mother's former partner, were not 'invisible', but information was known and knowable by a range of agencies, and could therefore have been used to inform assessment and decision making. There was a clear over-reliance on the mother's capacity to safeguard the children, strengthened by the positive act of her separating and relocating from one abusive

[8] a) Global estimates of violence against children with disabilities: an updated systematic review and meta-analysis, Fang, Zuyi et al, The Lancet Child & Adolescent Health, 2022, Volume 6, Issue 5, 313 – 323, b) d/Deaf children and children who have disabilities: learning from case reviews, NSPCC, February 2024, c) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies, Jones, Lisa et al., The Lancet, 2012, Volume 380, Issue 9845, 899 – 907.

[9] a) Unseen men: Learning from case reviews, NSPCC, September 2022, b) The myth of invisible men: Safeguarding children under 1 from non-accidental injury caused by male carers, Child Safeguarding Practice Review Panel, September 2021, c) Working with fathers: key advice from research, Community Care Inform, February 18, 2018.

[10] The myth of invisible men: Safeguarding children under 1 from non-accidental injury caused by male carers, Child Safeguarding Practice Review Panel, September 2021.

relationship. This was then reinforced by the formation of a professional bias that she appeared to be managing Joanne's needs adequately herself and had taken the necessary steps to ensure Joanne received the health/medical support needed. In speaking with Joanne's father, he indicated that he was not contacted by Children's Services at the point that Joanne's mother and Adult 1 began living together and an assessment was being undertaken, nor contacted about the incident in October 2023 regarding Joanne's sibling having bruising. Whilst he acknowledged there were complications in their relationship, he felt that as the children's father he could have been approached to seek his views. He was complimentary about Joanne's mother's parenting of Joanne. An additional bias was formed in respect of Adult 1, when he was viewed as 'the safe parent' because his former partner was the one that had been judged 'dishonest' having made allegations of rape and these not being processed due to insufficient evidence. These biases were confirmed as being present, with the benefit of hindsight, at the multi-agency practitioner workshop.

4.3.4. Changes have been made to Cambridgeshire Children's Services policy and practice guidance in respect of case recording and what might constitute a significant event i.e. a change in family circumstances, plus expectations about increased management oversight and decision making, and how this is recorded. This change is intended to reduce the likelihood of new information emerging about a child's family or circumstances, but being missed as relevant, it then needing assessment.

4.4. Language & recording

4.4.1. The Rapid Review made a finding about the use of language and recording in agency records. Arguably, this goes beyond just language and recording but reflects a mindset about understanding of risk, critical analysis skills and the communication of risk.

4.4.2. The Rapid Review noted '*… Adult 1's former partner made disclosures against Adult 1 of rape and physical assault. These disclosures were investigated by the police and there was deemed to be insufficient evidence to prosecute and no further action was taken. Within children's social care recording, there was mention of her dishonesty and consideration of false allegations. It is important to remember that the police found on balance, there was not sufficient evidence to prosecute, this is not the same as the events not occurring. … It is impossible to know with certainty what impact using words like, insufficient evidence, dishonesty, and false allegations would have had on professionals' perspectives of the dynamics in this case but it is highly likely it would have created some impact and may have led professionals to make inaccurate assumptions regarding both [Adult 1's former partner] and Adult 1, particularly regarding Adult 1 being seen as a 'safe' parent …'*. There is considerable research[11] which highlights the gap between rape allegations, charges by the Police, and then convictions. The BBC report[12] that '*… over the past four years, rape prosecutions in England and Wales have fallen by 70% … rape prosecutions represent a small percentage of all reported rapes. And an even smaller proportion lead to a conviction - when someone is found guilty …'*. While the mother turned down an opportunity to receive information via a Clare's Law[13] disclosure, stating that she felt she knew Adult 1's background history, it was not clear how much she knew, and whether this was gained via Adult 1, who may have been bias in how he reported it. Again, this information was known and knowable by the multi-agency network, and represents a serious missed opportunity to consider the children's safety once the new relationship had formed.

4.4.3. It was also noted that inappropriate phrases and language was used to describe behaviours, the inaccurate or inconsistent spelling of names resulted in delays identifying individuals and locating records which contained

[11] a) Why do so few rape cases go to court? BBC News, 27 May 2022, b) Investigation and prosecution of rape, Home Affairs Committee, UK Government, 12 April 2022.

[12] Why do so few rape cases go to court? BBC News, 27 May 2022

[13] Clare's Law is the name often used to describe the Domestic Violence Disclosure Scheme.

highly relevant information i.e. information relating to MARAC (Multi-Agency Risk Assessment Conference in respect of the management of domestic abuse concerns).

4.4.4. The use of language and phrases is important to consider; phrases used about the children's behaviour such as '*kicking - off … hyper … unruly …'* which may have been a convenient phrase to describe behaviour, fail to recognise what may be trauma induced behaviours, or lack of adequate parental supervision, home routines and guidance, nor describe the context in which those behaviours were displayed. The use of language such as '*dishonest … and false allegations …'* when referring to Adult 1's former partners accounts of rape or assault fail to describe the circumstances or the context. Critically, the narrative formed by using such phrases and them being recorded on file have the potential to create a forever meaning and discourse; words carry meaning and then form sentences which become spoken – the way in which information is then communicated, verbally or in writing, create opinions and bias. For Adult 1's former partner, her accounts of rape and assault may have become – albeit unwittingly - firmly embedded into organisational thinking, and therefore judgements.

4.5. Frameworks for assessing need - What worked well, and what needed to be better?

4.5.1. Under section 17 of the *Children Act 1989* local authorities are under a general duty '*to safeguard and promote the welfare of children within their area who are in need… by providing a range and level of services appropriate to those children's needs'*. Section 17 of the Act defines a child in need as a child who:

- is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision … of services by a local authority… ,
- whose development is likely to be significantly impaired, or further impaired, without the provision of such services; or
- is disabled.

4.5.2. The Act explains that '*… a child is disabled if he is blind, deaf, or dumb or suffers from mental disorder of any kind or is substantially and permanently handicapped by illness, injury or congenital deformity or such other disability as may be prescribed; and 'development' means physical, intellectual, emotional, social, or behavioural development; and "health" means physical or mental health …'.* Local authority areas can set their own eligibility criteria for when a case should be referred to children's social care for an assessment to determine whether a child is in need and the nature of any services required – services which may range in frequency, intensity and nature depending on level of need. Under the 1989 Act, local authorities are required to take steps to identify children in need in their area. For Cambridgeshire, this is detailed in their thresholds document: Effective support for children & families (thresholds) document.

4.5.3. Joanne, albeit at two years of age, very clearly had identified health and medical needs that were complex, reflected by the range of specialist health professionals involved in her life (paediatrics, dietician, occupational therapy, physiotherapy, speech & language therapy), along with universal health professional involvement i.e. GP and Health Visiting.

4.5.4. Following Joanne's admission to hospital in November 2023 and the initial Rapid Review it became apparent that Joanne was not known about by the local authority in her own right as a child with disabilities, had not benefited from an assessment of needs by the local authority under section 17 of the Children Act 1989 to determine eligibility for support. As a result, there had been no consideration about safeguarding and promoting her welfare. Opportunities for this to happen did exist from June 2022, when Joanne had moved to Cambridgeshire with her family, and include:

- Despite the range of health professionals involved with Joanne, none had made a referral to Cambridgeshire local authority Children's Social Care about Joanne during this period. In speaking with

Joanne's mother, albeit with the benefit of hindsight, she indicated that she was not made aware of the support services that were available to her and Joanne, feeling alone in having to navigate and organise everything herself. Positively, she found the community nurses helpful (could not recall their exact job title) as they always came to help when they could, plus a baby Play Group, set up to support parents of children with disabilities – which she described as being helpful for both her and Joanne.

- In September 2022 the MASH was contacted because of bruising on the older sibling's face. This, it seems, did not prompt a wider assessment of the family, but instead a discussion about safety planning i.e. a discussion about not using physical chastisement and using support networks.

- An Early Help Assessment was completed by the school in March 2023, due to the mother struggling to manage Joanne's older siblings' behaviour. A 'Team Around the Family' was created but records fail to show what work was undertaken and how support needs, safety and risk were all considered in the context of the family circumstances.

- In July 2023, Cambridgeshire Children's Services received a referral from Cafcass following the mother's application for a Child Arrangement Order to determine how much time the children should spend with their father. The information known by Cafcass about the extensive history of alleged domestic abuse but also the new relationship she had with Adult 1 and their combined 'baggage' (as described by the mother) was shared by Cafcass, but this did not provoke a step-up in response from Early Help involvement by Children's Service; Cafcass did not challenge this.

- Whilst it was known that Adult 1's children were subject to Child Protection Plans, initially while in Cambridgeshire (March 2023) then formally transferred to Suffolk (May 2023), information about their informal transition back to Cambridgeshire and living with Joanne's family (believed to be around October 2023), was not used to re-evaluate the level of support that Joanne's older sibling might need given he was subject to Early Help support, nor was it used to assess risk to all children in the household. A second bruise on Joanne's older sibling, also noted in October 2023, was not taken as an opportunity to assess, and re-evaluate the level of intervention.

4.5.6. The lack of professional curiosity at each of the above opportunities has been cited as a significant contributing factor accounting for why these opportunities were not maximised; they reflect opportunities that were missed to not only assess Joanne's unique needs as a disabled child, but also the risks she might have faced.

4.5.7. Research[14] reminds us that '*… The concept of good enough parenting can be particularly challenging to apply with families of children with complex needs. Some children undoubtedly need more parenting or more skilled parenting than others; some children need 'intensive' parenting for much longer than others. Some children are parented in a far less supportive social context than others. Parenting a child with complex needs is, by definition, likely to be more complicated, more time consuming, less familiar, more anxiety provoking, physically harder and emotionally more difficult. Knowing just what is involved in a child's day to day care can operate powerfully on our expectations about what is good enough parenting. One possible consequence of realising the demands is a downward shift in our assessment standards, for example lowering expectations of what constitutes reasonable parenting … The more complex the child's needs, the higher the risk of skewed expectations and standards … ….'*. Joanne's mother confirmed many of these points relating to the increased workload associated with parenting

[14] Marchant, R., Making assessment work for children with complex needs, p. 208, in The Child's World, The comprehensive guide to assessing children in need, Edited by Horwath, J., 2nd Edition, 2010, Jessica Kingsley.

Joanne and feeling like she wanted help. Additional research[15] states *'… Children who have disabilities or complex health needs often require added vigilance and arguably a higher standard of parenting …'.* Further to this, research[16] one potential risk factor when working with neglect and child disability may result in practitioners *'… seeing the disability, not the child, and viewing a case essentially as supporting disability rather than supporting or protecting the child …'.*

4.5.8. Explanations about how these events unfolded provide some context, and include:

- From an organisational and system perspective, Adult 1's name was misspelt or he was known to use variations of name – not all data systems can search using wildcard variations, resulting in information not being retrieved in a timely manner.

- Not all professionals have access to all systems – this is particularly an issue within different health agencies therefore a joined up 'health view' was not possible.

- As a complicating factor, there was a delay and lack of information sharing between health professionals when the mother moved from Medway to Cambridgeshire; professionals relied on the mother to share information during the delay and because she moved during crisis the lack of health information being shared in a timely way resulted in a limited health assessments and a lack of referral to the 0-25 Disability Service. As there had been no safeguarding related concerns logged by Medway during this crisis there was no other notification transferred across local authority boundaries. The mother's records were not open at the point of transfer by the Cambridgeshire Health Visiting Service, as Joanne was over 1 year old. Once information had been linked and shared professional input focused on Joanne's complex health and medical needs above the reasons and circumstances of the mother leaving Medway, resulting in the risk element being missed.

- There were different Cafcass Family Court Advisors working with the mother and her own proceedings in respect of her children's contact with their father, and Adult 1's proceedings in respect of his children's contact with their mother. The reason there were different Family Court Advisers (FCA) was because the two different families were being dealt with by different Courts. The issue then being that Cafcass did not link the cases, which had this linkage been made, could have prompted discussions between the two Family Court Advisers – this would have enabled an overview of issues and risk factors.

- A point about the referral pathway not triggering the right assessment has been raised. While this might be accurate for this scenario, the referral pathway for assessing and supporting children with disabilities more routinely, appears to be clear, robust, and effective. A recent report[17] noted *'… disabled children receive effective services from a workforce that is sensitive and understanding of their additional needs …'* which suggests a functional referral pathway. For this set of circumstances, it seems Joanne's presence, social needs, and any risks she may have faced, simply failed to register at the point of assessing her older sibling; for Joanne there was no referral to the Disabled Children Access Team which would then have prompted an assessment of her needs. Factors which diverted attention away from Joanne will have been the mother's engagement and compliance with health professionals to meet Joanne's health needs

[15] Brandon, M., Glaser, D., Maguire, S., McCrory, E., Lushey, C., Ward, H., Missed opportunities: indicators of neglect – what is ignored, why and what can be done? November 2014, p. 25, Department for Education, HM Government.

[16] Brandon, M., Belderson, P., Responding to child neglect: learning from case reviews, p. 228, in Gardner, R., Tackling child neglect: Research, Policy and evidence-based practice, 2016, Jessica Kingsley.

[17] Ofsted, Inspection of Cambridgeshire local authority children's services, March 2024.

herself, a perception that she was coping with Joanne but that Joanne's older sibling was 'the issue'; and that she had acted appropriately to flee domestic abuse (alleged) and was therefore a competent and safe parent.

4.5.9. There was a strong view expressed at the multi-agency workshop, by those agencies or services outside of Children's Services about not understanding the legislative and practice frameworks that can be applied to children with disabilities, particularly the use of section 17 of the Children Act 1989. Discussions with Joanne's mother confirm that from her perspective, as a parent, she too did not understand the framework that might have been available to her, and Joanne. This included a lack of understanding about what the remit was, and what services were offered, by the 0 – 25 Service. The 0 – 25 Service[18] is the dedicated Service in Cambridgeshire that assesses and supports children with disabilities. The implication of this expressed view about a lack of understanding about the service, is that the multi-agency nature of the assessment stage led by Children's Social Care, and then any intervention offered, is potentially not as embedded as it might be and that there might be elements of silo working rather than the benefits of multi-disciplinary working.

4.5.10. As a possible complicating factor, review of the Partnership's webpages, Effective support for children & families (thresholds) document alongside the local authority's webpages, 0 - 25 Disability Social Care, show limited synergy especially in relation to linking thresholds with tiers or levels of possible support. It is however acknowledged that work has been underway to revise the thresholds document but review of the draft highlights there could be greater read across between the two sets of guidance.

4.5.11. As Joanne's health and medical needs were seemingly known about, and being managed by the appropriate health professional network, and her mother engaged with and complied with health professional support, there was no consideration about her social needs. The assessment of Joanne's social needs alongside her other needs was justified given the referrals about her older sibling.

4.5.12. More systemically, the expressed view from non-local authority agencies attending the workshop, was that despite working with and supporting children with disabilities there was a lack of assurance that they were recognised formally as Child in Need, and supported through section 17 arrangements. Despite work undertaken since the Rapid Review to raise awareness about the 0 – 25 Disability Service, it is evident that further work is needed across the Partnership area to raise awareness and understanding about the use of different legislative and practice frameworks, the differing levels of eligibility (levels 1 – 4), and what those mean in practice and for children and families but also the range of other agencies that might be involved with the child, beyond just Children's Services. It may also be appropriate to consider how parents can be informed about these practice frameworks. Due to the level of her need Joanne, it is argued clearly met a level 3 tier, if not level 4 purely in terms of her vulnerability and impairment. In threshold documents terms, arguably, not only did she have complex individual needs, but also her family circumstances were complex given their reconstituted nature, the 'baggage' each family had, and the unknowns. While it is noted that changes to the legislative framework for children with disabilities may change[19], opportunities exist within current arrangements for them to be reviewed and strengthened.

[18] 0 - 25 Disability Social Care

[19] The Law Commission is reviewing the legal framework governing social care for disabled children in England to ensure that the law is fair, modern and accessible, allowing children with disabilities to access the support they need, The Law Commission, 2024

Reflective question for senior leaders and the Partnership:
What activity and data are currently in place that provides assurance about whether all children with disabilities in the local area, have been offered an assessment of need by the local authority (as lead agency)?
Does this activity or data sufficiently scrutinise and provide confidence that the individual needs, but also vulnerability and potential risks to those children with disabilities, are fully understood and have not been missed? Does the information reflect a truly multi-agency view? What would the parental view be?

4.6. Working across local authority boundaries – opportunities for improvement?

4.6.1. Reference to the delays in transferring and sharing health related information between Medway services and Cambridgeshire agencies has already been detailed. Given there were no identified safeguarding related matters dealt with by Medway Children's Services in respect of Joanne or her older sibling, and neither Joanne or her older sibling were subject to either Child in Need arrangements or Court processes, there would be no justification for Medway local authority to share any other information. Information has subsequently emerged following the Rapid Review about information held on Joanne's mother's own childhood history and safeguarding related matters however, during her time as a parent, and whilst living in Medway, no concerns came to their attention. On this basis, local authorities cannot transfer historical information to other local authority areas without good reason – and on this occasion there was no rationale for Medway Children's Services to share this history.

4.6.2. The issue of greater interest for this review are the complications caused by Adult 1's movements, with his two children, from Suffolk back to Cambridgeshire around May 2023. Cambridgeshire Children's Services knew about Adult 1, his children and family circumstances because they had made his two children subjects of Child Protection Plans in March 2023, and then dealt with them re-locating to Suffolk in May 2023, correctly via the procedural route of a transfer Child Protection Conference. What Cambridgeshire Children's Services, nor other services involved e.g. Cambridgeshire Community Services, School A, Queen Elizabeth Hospital NHS Trust, Police or Cafcass did not know about was his return, his new relationship with Joanne's mother and them then all living together and his children still being subject to Child Protection Plans. While it is believed that them living together was a relatively new arrangement, occurring a short while before Joanne had been admitted to hospital in October 2023, it does highlight that due process was not followed by Suffolk Children's Services. Suffolk Children's Services cite complicating factors, which mostly related to Adult 1 suggesting he was in Cambridgeshire on holiday and was not planning a permanent relocation, thereby creating some uncertainty about how long he and the children would be in the area, and whether a transfer Child Protection Conference was required. An additional complicating factor was that Suffolk Children's Services were directed to complete a section 7 report[20] as part of the legal proceedings concerning where Adult 1's children should reside.

4.6.3. The view about the temporary nature of the move across border went unchallenged between Cambridgeshire Early Help (Targeted Support) Service, who had contact with the Suffolk Children's Services Social Worker. Statutory guidance[21] does refer to children that are subject to Child Protection Plans moving across local

[20] A section 7 report, Children Act 1989, is a detailed assessment of the disputed issues relating to a child's welfare to assist the Court make decisions about the child's best interest. These reports may be prepared by Cafcass or a local authority appointed Social Worker.

[21] Working Together to Safeguard Children, p. 100, HM Government, 2023.

authority boundaries and when to discontinue a Child Protection Plan, stating '*… A child should no longer be the subject of a child protection plan if: the child and family have moved permanently to another local authority area. In such cases, the receiving local authority should convene a child protection conference within 15 working days of being notified of the move. Only after this event may the original local authority discontinue its child protection …'.*

4.6.4. This missed opportunity to share important and highly relevant information has been considered, with Suffolk Children's Services reflecting '*… Cambridgeshire were not informed the children were staying with their father in Cambridgeshire, and neither was a transfer in conference requested. This was given the live private proceedings where Suffolk had been requested to complete a S7 report. Whilst Cambridgeshire may not have accepted transfer given the proceedings, the learning is the request should have still been made. This learning point will be shared in Suffolk's learning from case review group and within the Child Protection Steering Group …'*. However, in response, Cambridgeshire Children's Services have noted '*… this is the fourth case where transfer between Cambridgeshire and Suffolk has been raised as an issue. This case clearly evidences the issues regarding transfer between the two local authority areas is not resolved. The discussion and Rapid Review highlighted that there may be cultural issues which are causing these repeated issues and this needs to be addressed as a matter of urgency …'*. Review of the *East of England region Children's Services joint protocol on children subject to Child Protection Plan moving between local authority boundaries* (version 4, 22/10/22) clearly sets out the circumstances and guidance of when a transfer notification should be made. Given the experiences reported by Cambridgeshire Children's Services it is reasonable to expect there to be further work and discussion about this matter, and for a timely resolution and change to practice. It is however recognised that practice about transfer arrangements, across local authority border, is a national issue and not unique to either Suffolk or Cambridgeshire Children's Services.

5. Summary of learning captured from this review

Research[22] reminds us that '*… Assessments are fallible, and contexts constantly changing. Therefore, professionals need to keep their judgements under constant critical review … practitioners must be willing, encouraged, and supported to challenge, and where necessary revise, their views throughout the period of intervention …';* such practice will be supported using information held across the multi-agency footprint.

Children with disabilities are at greater risk of abuse and neglect than non-disabled children. Ensuring practitioners and managers are aware of this increased risk, and are supported through training, policy, procedure, and guidance, will be critical for all professionals to aid timely and high-quality assessments being carried out. This should include support about how to gain the child's perspective, and explore the child's day to day lived experience.

The formation of bias is an inevitable human characteristic; which is likely compounded when professionals operate in a busy and demanding environment, where forming judgements and making decisions is a requirement. Bias, especially when working with risk, must be constantly checked. Ways to check it might include strengthened management oversight to offer a level of impartiality, a peer review of information, playing one's own devil's advocate, or confidential group discussion/supervision.

[22] Burton, S., The oversight, and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information? November 2009, Safeguarding Briefing 3, C4EO.

Assessment of children's needs, whilst being led by one agency, will always require a multi-agency approach – especially for children with disabilities. Promoting a multi-agency legal literacy about the differing frameworks under which assessment activity can take place may support greater collaborative working, and more robust assessments.

Ensuring transfer procedures and practice between one Partnership area and another are timely, robust, and effective is important to keeping children safe and maintaining any support needs they may have. No matter how effective arrangements might be within a Partnership area, if transfer arrangements across local authority boundaries are not effective, gaps in the safety net for those children transferring border may emerge and have serious consequences.

6. Concluding remarks

6.1. This focused and proportionate Child Safeguarding Practice Review has examined the contact of agencies with a two-year-old child who tragically died in November 2023. The review has built on information gathered during the Rapid Review, and then gained views from multi-agency professionals via a facilitated multi-agency workshop. It has also benefitted from the contributions of family members.

6.2. The Rapid Review noted '*… there is significant learning in this case regarding assessments of risk being undertaken on a family as a whole and the vulnerability of children with complex health issues being identified and understood. As a child with a disability, she should have been in receipt of statutory support throughout her short life but this was not recognised or responded to by agencies and is a failing in this case. … As a partnership there is a need for organisations to ensure that the needs of all members of a household are considered in assessments and plans of support. Focus should be paid to the support needed for households where there are children with complex health needs, this should be considered and recorded in its own right …'.*

6.3. The review has captured learning points for dissemination across the Partnership, and concludes with a series of recommendations to strengthen local arrangements.

7. Recommendations

7.1. The following recommendations are made in addition to any actions identified at the Rapid Review stage:

1. Senior leaders and the Partnership should consider the reflective questions set out above, and take forward any actions arising.

2. The Partnership Board should promote resources and training about assessing men in households, and in doing so urge the use of genograms, ecomaps and other assessment tools which can be used to encourage discussion and curiosity. This should include assessing, where proportionate, relevant, and safe to do so, absent fathers who still maintain some level of contact with their children.

3. The Partnership should disseminate and promote awareness of the professional curiosity guidance currently on the website, plus provide support about how to improve critical thinking skills for frontline practitioners and managers in their day-to-day work, which recognises the context and complexity of the work they undertake. This should include guidance about how personal and professional experience, and unconscious bias can inform judgements, decision making and actions.

4. The Partnership should promote the Safeguarding Children & resolving professional differences (escalation) policy to all agencies.

5. Review the Partnership's Effective Support for Children and Families (Thresholds) Document to align and provide greater synergy with the local authority 0 – 25 Disability Social Care webpages (particularly tiers/levels descriptors).

6. The Partnership to review and strengthen the collective approach to responding to children with disabilities, notably in respect of workforce assessment skills for children with disabilities, eligibility for access to services criteria, and legal frameworks. Areas to focus on include assessing risk in the household and close family network, developing a shared understanding of safety and risk through the multi-agency lens, and gaining the voice/or understanding the day-to-day experiences of children with disabilities.

7. Both Suffolk Children's Services and Cambridgeshire Children's Services should undertake an assurance exercise examining local practice when children and families move to other local authority areas, whether temporarily or permanently, to test whether practice reflects policy and procedure, and whether opportunities exist to strengthen expectations. In completing this exercise, consideration should be given to whether the lessons learnt are applicable to the wider region, given the status of the joint protocol on children subject to Child Protection Plan moving between local authority boundaries guidance, being regional.

8. Cafcass should ensure that safeguarding interviews with parties should ideally be undertaken by the same Family Court Adviser; where this is not possible the records should be thoroughly read at each stage of the work. Family Court Advisers need to remain curious about the child's lived experience, including in the home in which they reside. Where a party has a partner/ other children, full details (including spelling) should be sought and agency checks considered.