Molly, Isobel, Sophie – Case Summary and Summary of Learning

Summary of Case

Three children, Molly aged 3 years and 10 months, Isobel aged 2 years and 4 months and Sophie aged 1 year and 1 month. The concerns in the case were neglect and physical harm. There were possible missed opportunities by agencies to fully appreciate the lived experience of the children and the level of harm they were experiencing. Molly had a missing front tooth and multiple bruises and marks on her arms, trunk and buttocks, Isobel had an injury to her mouth and a front tooth missing. Six safeguarding referrals had been submitted and two social work assessments completed since July 2020. Health and housing raised concerns regarding the parents not engaging or completing the actions they had agreed. Agencies also described difficulties in contacting the parents. The family were often homeless and therefore housing provision was a priority. Recent concerns related to the children not being appropriately supervised. The children's father received telephone support from Turning Point Counselling Services in 2020 having self-referred with support from the CiN team. The children's mother also self-referred to Turning Point in 2020 with the support of the CiN team but Turning Point were unable to make contact with her and the referral was closed. All three children have been removed from their parent's care and are in long term foster care.

Agency Learning

Health

- The ED card wasn't risk categorised using the safeguarding risk assessment tool. If the tool had been used and attendance appropriately marked as a Level 3, the discharge summary would have been shared with the social worker.
- The Evolve record alert with contact details of the social worker wasn't updated. If it had been, it would have informed any future attendances.
- There is no mention of Molly's father in the documentation and no clarification as to why Molly was brought by her aunts and not her mother.
- The outcome of concerns regarding mother's reluctance to provide basic overnight care to her baby is unknown. There is no evidence of this being shared with the social worker.
- The need to ensure consent and support for any language barriers is in place early on and hospital to consider incorporating this into their safeguarding medical assessment proforma.

- The need for cases to be monitored by management of teams in the absence of the clinician to avoid slippage and families being missed.
- Interpreters should always be used for those clients/families where English is their second language.
- Any lack of engagement from a family should be escalated as a matter of urgency.

Children and Young People's Services

- Lack of a recorded pre-birth assessment meant that there wasn't a comprehensive review of parenting capacity.

Police

- Professional curiosity wasn't shown by Police Officers after the second call in three days from a concerned neighbour reporting assault and injuries to Molly.
- No further action was taken by MASH Police from the referral into MASH.

Multi-Agency Learning

- During the summer of 2022, Babergh and Mid Suffolk Councils raised concerns about lack of supervision and a resident raised concerns about the children being physically abused. This could have been an opportunity for agencies to consider a medical assessment and an overview of the children's health status.
- There were disagreements between the GP and the social worker regarding the need for a Paediatric Medical Assessment (the children's mother didn't want to take the children to the hospital that day and wanted to leave the surgery) which highlights the challenges when there are differing views across agencies and when parents are being challenging.
- The lack of engagement from the family wasn't always responded to in a timely manner.
- Of the six referrals into MASH from numerous agencies over a two-year period, only two resulted in a social work assessment.
- There is an absence of documentation regarding the meeting to be held with the mother and community midwife and it isn't clear what the meeting was for or if it was held. Nor is it clear from the records if the concerns were shared with the social worker.

Good Practice/What Went Well

Health

- The ED discharge summary was completed and shared with the GP and Healthy Child Practitioner.
- The Assessing clinician sought advice about Molly's diagnosis.
- There was good interagency work at the hospital to ensure the children were assessed and discharged into a place of safety and medical reports were submitted quickly for the complex strategy meeting the next day.

- There was good communication between the Health Visitor, the GP and the social worker which ensured the children were seen quickly by a medical professional.
- The GP spoke to the on-call paediatrician in a timely way and arrangements were put in place for the children to have a paediatric medical assessment.
- The GP was persistent in getting her view across for the need for a paediatric medical assessment on the day of the injuries and the surgery has been praised for their actions to prioritise the safety and timely assessment of the children.
- The GP brought the original appointment forward due to the level of safeguarding concern.
- There were episodes of good communication and joint working between health, health outreach and social care despite the family's lack of engagement.
- The case was brought to safeguarding supervision.
- The case was escalated by the Health Visitor when the level of risk had escalated.

Norfolk and Suffolk Foundation Trust

- NSFT signposted the children's mother to the relevant agencies for further support.
- A letter was sent to the GP to make her aware of the support being put in place.

Police

- There was good joint working between Police and Children and Young People's Services, safeguarding decisions were made together and partners informed with regard to the most recent investigation.

Thematic Learning

The themes in the learning are the need to share information and ensure records are updated and current in order that all professionals working with children and families know and understand the work being undertaken across all agencies, to ensure that interpreters are always used where English is a second language, to always immediately escalate cases where lack of engagement is a regular occurrence and where parents are challenging, the need for professional curiosity to be shown when there are several calls regarding incidents of assault and injuries to children, consideration of family history and history of agency involvement when making decisions about referrals.

Good practice from professionals was shown by the GP in terms of the prompt consideration of safeguarding concerns for the children, good interagency working across Health agencies to ensure the children were discharged to a place of safety and the medical reports were submitted timely for the complex strategy meeting. There were several episodes of good joint working between health, health outreach and social care and prompt escalation of the case by the Health Visitor. Good

communication and signposting for support for the mother was put in place by NSFT and there was good joint working between Police and CYPS services on safeguarding decisions and Police informed agencies about the ongoing investigation.