



city & hackney  
safeguarding  
children board

# **CITY OF LONDON & HACKNEY SAFEGUARDING CHILDREN BOARD**

## **SERIOUS CASE REVIEW**

### **CHILD M**

**FERGUS SMITH**

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# 1 INTRODUCTION

## 1.1 EVENT TRIGGERING THIS SERIOUS CASE REVIEW

- 1.1.1 On a date in late June 2016 child M (a 13 month old Black British child<sup>1</sup> of African-Caribbean ethnic origin) was taken by mother to 'hospital 1'. On examination, the toddler was found to have bruising to the face and transverse fractures to both femurs.
- 1.1.2 Child M and an elder sibling had been subject to child protection plans since November 2015. At the time of incurring what are considered to be non-accidental injuries, child M was in the birth father's care. Father was arrested on suspicion of grievous bodily harm (GBH) and mother was arrested on suspicion of neglect. Both children were placed with foster carers and during the course of this review made subject of Care Orders by a court.
- 1.1.3 Subsequent proceedings resulted in the court directing the return of the children to their mother's care. At the criminal trial, father was found not guilty of GBH, although both parents were found to be guilty of child cruelty and sentenced in February 2018.

## CONSIDERATION OF A SERIOUS CASE REVIEW

- 1.1.4 In accordance with the Local Safeguarding Children Board Regulations 2006 and local procedures, child M's injuries were discussed at the 'Serious Case Review Sub-Group' on 19.07.16. Following receipt of further information from some local agencies, the independent chairperson of the City & Hackney Safeguarding Children Board (CHSCB) decided on 06.09.16 that one of the required criteria (reproduced in paragraph 1.2.1) was satisfied and that a serious case review would be commissioned.
- 1.1.5 The Department for Education (DfE), regulatory body Ofsted and the 'National Panel of Independent Experts' (NPIE)<sup>2</sup> were informed of the above decision. This review was undertaken between October 2016 and April 2017 in accordance with the terms of reference appended.
- 1.1.6 Following approval by the City and Hackney Safeguarding Children Board a copy of this report is being sent to the NPIE and to the DfE.

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<sup>1</sup> Because the gender of the children is irrelevant to the findings and represents an unnecessary identifying detail, all references in the report are gender-neutral.

<sup>2</sup> The NPIE was established by central government in 2013 in order to advise Local Safeguarding Children Boards on the initiation and publication of serious case reviews.

## 1.2 PURPOSE, SCOPE & PROCESS OF THE REVIEW

- 1.2.1 Regulation 5 Local Safeguarding Children Boards Regulations 2006 requires Safeguarding Children Boards (LSCBs) to undertake reviews of 'serious cases' in accordance with procedures in *Working Together to Safeguard Children* HM Government 2015. A 'serious case' is one in which abuse or neglect is known or suspected and the child has died *or* has [as in this case] been seriously harmed and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard the child.
- 1.2.2 Its purpose is to identify required improvements in service design, policy or practice amongst local or if relevant, national services. An SCR is *not* concerned with attribution of culpability (a matter for a criminal court), nor (when that is relevant), the cause of death (the role of a Coroner).
- 1.2.3 The period of review was agreed as June 2014 through to the date on which it has been estimated that child M was injured (mid-June 2016). An independent report was commissioned from [www.caeuk.org](http://www.caeuk.org) so that on the basis of material supplied, lead reviewer Fergus Smith would:
- Collate and evaluate it
  - Design and conduct consultation / learning events with relevant professionals and
  - Develop for consideration by the serious case review team a narrative of agencies' involvement and an evaluation of its quality, conclusions and recommendations for action by the City & Hackney Safeguarding Children Board, member agencies and (if relevant) other local or national agencies
- 1.2.4 An initial consultation session was held with relevant staff and the purpose and process of the serious case review explained and discussed. A second event was convened at the point when it appeared that all relevant issues had been identified. The aims of such involvement were to ensure the accuracy of information within the report and the justification for conclusions drawn, and to encourage acceptance and application of the learning that was emerging.
- 1.2.5 The SCR review team was comprised of representatives of:
- City & Hackney Safeguarding Children Board (CHSCB)
  - City & Hackney Clinical Commissioning Group (CCG)
  - Hackney Children's Social Care
  - Hackney Learning Trust
  - Homerton University NHS Foundation Trust (HUHFT)
  - National Probation Service (NPS)
  - Metropolitan Police Service (MPS)

## AGENCIES' CONTRIBUTIONS

1.2.6 The following agencies supplied information to the SCR review team:

- Hackney Learning Trust (a brief report of universal nursery settings)
- Homerton University Hospital NHS Foundation Trust (HUHFT) (midwifery, medical and health visiting services)
- NHS City & Hackney CCG (GP Services)
- Royal London Hospital (emergency post-injury treatment)
- National Probation Service (London) (supervision of child M's father)
- Hackney Children's and Young People's Service (family support and safeguarding-related contact)
- Metropolitan Police Service (responding to crime reports)

## FAMILY INVOLVEMENT

1.2.7 Both parents were informed that a serious case review was being completed, although the need to avoid undermining the criminal investigation necessitated postponement of any direct involvement with them.

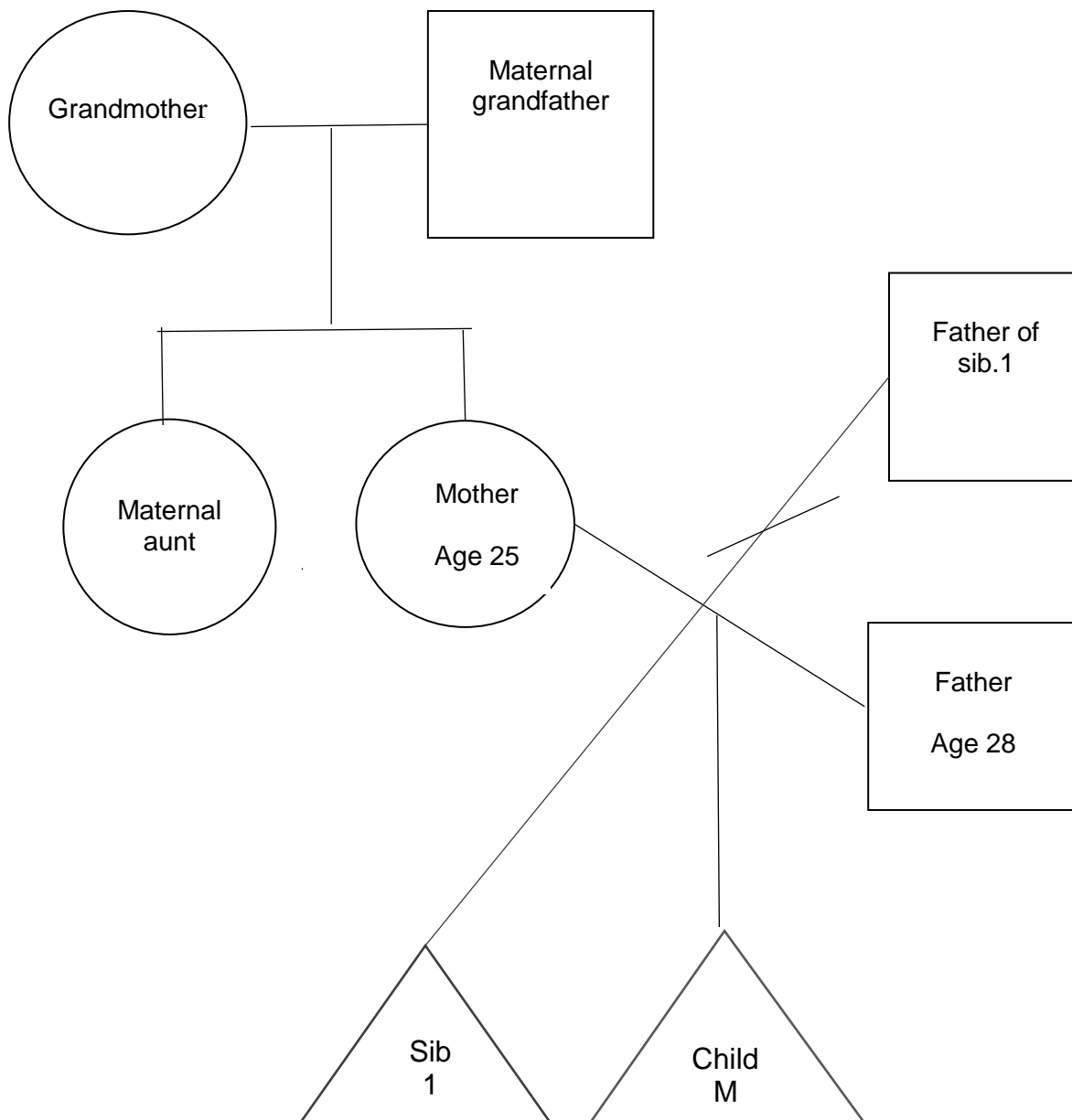
1.2.8 Whilst their views will be established, the absence of these at this point will not delay the publication of this report. Anything of significance will be included as an addendum as necessary.

## TIMETABLE FOR COMPLETION OF SERIOUS CASE REVIEW

<b>Milestone</b>	<b>Date/deadline date</b>
SCR agreement date	06 <sup>th</sup> September 2016
Scoping Meeting (+ chronologies produced)	12 <sup>th</sup> September 2016
First Review Panel Meeting	13 <sup>th</sup> October 2016
Submission of first draft agency IMRs	18 <sup>th</sup> November 2016
First Practitioners Focus Group	22 <sup>nd</sup> November 2016
Submission of final agency IMRs	09 <sup>th</sup> December 2016
Second Review Panel Meeting (+ IMR authors)	06 <sup>th</sup> January 2016
Submission of first draft overview report	13 <sup>th</sup> January 2017
Third Review Panel Meeting (+ IMR authors)	26 <sup>th</sup> January 2016
Submission of second draft report	31 <sup>st</sup> January 2017
Second Practitioners Focus Group	02 <sup>nd</sup> March 2017
Submission of third or final draft report	13 <sup>th</sup> March 2017
Fourth (final) Review Panel Meeting	29 <sup>th</sup> March 2017

## STRUCTURE OF CHILD M's FAMILY

ONLY THOSE FAMILY MEMBERS REFERRED TO IN THIS REPORT ARE SHOWN



## ABBREVIATIONS USED

Abbreviation	Meaning
A&E	Accident and Emergency Department
BMI	Body Mass Index (body mass divided by the square of height)
CPS	Crown Prosecution Service
EDT	Emergency duty Team
FRT	First Response Team
ICE	Immigration Compliance & Enforcement
LSCB	Local Safeguarding Children Board
NPIE	National Panel of Independent Experts
SARA	Spousal Assault Risk Assessment
SCR	Serious Case Review

## 2 SIGNIFICANT ISSUES IN PRE-REVIEW PERIOD

### 2.1 INTRODUCTION

- 2.1.1 Though the period under review is June 2014 to June 2016, it is helpful to consider some older information so that events and professional decisions during those 2 years can be placed in context.

### 2.2 PARENTS' CRIMINAL RECORDS

- 2.2.1 Mother's criminal conduct was first recorded by Police when she was aged 12 (a reprimand for shoplifting). Between the ages of 17 and 19 she was formally warned for theft after snatching a phone from a victim, found 'not guilty' of a robbery in the following year and later received a Community Order for aggravated vehicle taking. A detail (arguably still of relevance) with respect to the latter incident is that mother had held a knife to the throat of her victim and inflicted a cut.
- 2.2.2 Father's recorded criminal history began in 2008 when aged 20, he was sentenced to 8 years of imprisonment for conspiracy to rob. Released in November 2010, he was recalled to prison in 2011 for offences of possession and intent to supply 'class A' drugs (Heroin and Cocaine). He was sentenced in July 2011 to 36 months custody for possession with intent to supply offence and re-released on licence on 21.03.13. According to the report supplied by MPS, on 18.12.15 father was fined for possession of a controlled drug. His release from prison remained conditional and his licence had been due to expire in February 2017.

### 2.3 DOMESTIC INCIDENTS (1 & 2)

- 2.3.1 In February 2014 mother (then aged 22) in the midst of an argument with an (unidentified) partner had made an abandoned 999 call. Officers who attended did not record the name of the other individual and because no offences were alleged, took no further action.

**Comment: sib.1 (then 2.5 years old) may not have been there; no formal notification (referred to as a 'Merlin') to Children's Social Care or Health Services was initiated (an expectation if a child is present); mother later claimed that sib.1 had been with maternal grandmother at the time of the incident.**

- 2.3.2 In March 2014 mother received significant injuries requiring hospital treatment during an altercation with child M's father. Mother later withdrew her allegation and although the matter was still passed to the Crown Prosecution Service (CPS), no action was taken against father.
- 2.3.3 The report submitted by Homerton University NHS Foundation Trust (HUHFT) refers to completion of a DASH<sup>3</sup> risk assessment by HV1 in April 2014 which provided a score of 2 (low risk).

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<sup>3</sup> DASH is a standardised checklist for identifying, assessing and managing risk used by all Police Services and most partner agencies.



## 3 SIGNIFICANT EVENTS DURING REVIEW PERIOD

### 3.1 EMERGING PROFESSIONAL CONCERNS ABOUT SIB.1.

#### WEIGHT OF SIB.1

- 3.1.1 In late June 2014 health visitor HV1 shared her concerns with GP1 about sib.1's excessive weight. The child was well over the 99.6 centile<sup>4</sup> and mother was refusing to accept that this represented a problem. HV1 planned to make a referral to Children's Social Care.

**Comment: HV1's response was well-informed with respect to the relative weight of a sib.1 and by mother's explicit rejection of evidence-based health advice. The referral to Children's Social Care was made in July.**

- 3.1.2 Sib.1's attendance at a nursery (which had begun in January that year) was checked by HV1 and noted to be erratic with none for the previous 3 weeks. Sib.1's weight was reported to be increasing and causing practical difficulties and mother was described as uncooperative. Though mother denied that her current partner (child M's father) was involved with her first child, he was often observed (as described below) collecting his step-child from nursery.
- 3.1.3 The records and recollection of nursery staff were sought during this serious case review. They reported that sib.1 had settled and was confident in making relationships, was polite, managed feelings well and had excellent communication and language skills. The relationship between sib.1 and step-father was noted to be positive. Staff never met sib.1's biological father.
- 3.1.4 Nursery staff had no concerns about child M's mother and the only issues noted had been the child's erratic attendance and weight both of which had been raised with mother. A '27 month integrated review' at nursery 1 was completed on 14.07.14. Sib.1 was fully up to date with immunisations, confident, active and progressing well. Only weight remained of concern and staff recall a referral to the Dietetic Service being 'agreed' (albeit mother was 'not keen' on that option).

**Comment: it appears that the referral was not actually made until October 2014 and the opportunity anyway not taken up by mother; other examples of disguised compliance are described below.**

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<sup>4</sup> Obese children are more likely to be ill, be absent from school due to illness, experience health-related limitations and require more medical care than normal weight children; obese children are also more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood – Public Health England website

### 3.2 DOMESTIC INCIDENT (3)

- 3.2.1 There was a further domestic incident involving Police on 18.07.14 when mother and father argued over the ownership of some articles. No offences were disclosed and no further action was required of attending officers. It is uncertain whether sib.1 was present.

### 3.3 FAMILY SUPPORT OFFERED

- 3.3.1 HV1 made a referral to the Children's Centre 'Multi-agency Team (MAT) panel seeking family support. The case was opened at 'risk assessment level 3'<sup>5</sup> and allocated to the Centre's family support team.
- 3.3.2 In mid-August HV1 received 'child protection supervision' and it was agreed that she should liaise with the allocated family support worker, monitor sib.1's growth 2-3 monthly, and refer to Children's Social Care *if* mother failed to co-operate.
- 3.3.3 By September 2014 family practitioner FP1 was reporting that she had been unable to contact the family in spite of numerous attempts to do so and that nursery attendance of sib.1 was poor. The MAT panel determined that the Health Visiting Service should refer the case to Children's Social Care and following confirmation from HV2 that this had been done on 04.09.14, the case was closed to the MAT.

### 3.4 INITIATION OF ASSESSMENT BY CHILDREN'S SOCIAL CARE

- 3.4.1 On 04.09.14 Hackney's Children's Social Care First Response Team (FRT) received the referral sent on behalf of HV1 (which omitted the name of mother's possibly unknown partner). A decision was made to open the case and it was allocated to the 'Access & Assessment (A&A) Unit 2'.
- 3.4.2 In mid-September at a consultation with her GP, mother revealed that she was pregnant with child M. At social worker SW1's initial home visit on 30.09.14, mother's pregnancy was not referred to. SW1's observations of sib.1 who was playing with toys did not identify concerns about mobility or breathlessness. Mother disagreed with HV1's concerns and SW1 encouraged her to consult the GP about sib.1's weight. Mother consented to agency checks with GP, health visitor and nursery.

**Comment: mother misled SW1 when she claimed to have pressed charges against father but not know the outcome following the incident in April 2014.**

- 3.4.3 On 14.10.14 mother presented sib.1 at the GP and a check on weight indicated a reduction of 3Kgs.

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<sup>5</sup> 'Risk assessment level 3' refers to the MAT Family Support Impact Evaluation Risk Assessment tool that enables a practitioner to score identified risk factors that may impact upon family functioning and safeguarding. The intention is to work with families to reduce identified risks and lower the initial score. Level 1 = moderate risk; level 2 = moderate to serious risk, level 3 = serious risk and level 4 = severe risk which would result in case closure and referral on to Children's Social Care.

3.4.4 Mother was seen in the office on 17.10.14 by SW1 and appeared more receptive to discussing sib.1's weight. She accepted a referral to a healthy eating group in the New Year. Her pregnancy was discussed and mother acknowledged the possibility the child was the result of sexual relationship with an individual described as an 'ex-partner' (whom she declined to identify). Immigration and housing issues were also discussed.

**Comment: it is uncertain whether mother's use of the healthy eating group was to be confirmed.**

3.4.5 Sib.1 began attending a nursery school on 20.10.14 having been withdrawn with no notice from nursery the previous week. Sib.1 remained on roll until transfer to Primary School in Summer 2016. Described by staff as a sensitive loving child who made good progress in all areas of learning and exceeded expected outcomes in the Early Years Foundation Stage curriculum. Weight remained a concern.

3.4.6 Child M's father (sib.1's step-father) has been described as a consistent person in sib.1's life, who from time to time brought or collected the child from the nursery school. Staff contrasted father's 'quiet, emotionally available and warm attitude' toward sib.1 and mother's 'emotional detachment', which had been observed for a while. The nursery school had no contact with sib.1's birth father (until sib.1's last day which was also when sib.1 and child M entered foster care).

3.4.7 On 21.10.14 SW1 followed up the office contact with mother and called sib.1's birth father. She was told that his child was a 'fussy eater' but he denied that the diet was unhealthy and said that *he* had been overweight as a child. He asserted that he and mother maintained a good relationship 'for the sake of sib.1', had no concerns about his 'ex-partner's parenting and 'enjoyed looking after sib.1 when he visited' (the frequency of such visits was not captured).

**Comment: contacting the child's birth father was good practice often not evident in cases audited / reviewed by the author.**

3.4.8 Mother re-presented sib.1 to the GP on 28.10.14 and records refer to a long discussion and a referral (not confirmed in electronic records) on to a 'fussy eaters service' (not the one identified by SW1 earlier in the month). An ante-natal referral to hospital 1 was initiated. At a second home visit by SW1 on 30.10.14 sib.1 was seen alone. Mother insisted that she had not seen her 'ex-partner' since May rather than September as recorded by the nursery school. She described a meeting at her mother's house in May when she *might* have become pregnant. Mother resisted discussing any other intimate relationships. A health visitor phoned Children's Social Care next day, was updated about progress of its then ongoing assessment and was told of mother's reassurance to the social worker that she was making use of the Dietetic Service 'fussy eaters service'.

**Comment: mother did not make use of the Dietetic Service.**

### 3.5 PROBATION SERVICE INVOLVEMENT WITH FATHER

- 3.5.1 On 05.11.14 at a planned office visit father (still subject to licenced release from prison until February 2017) acknowledged to PO1 a casual relationship with a female who had informed him some weeks ago that she was pregnant with his child. He reported that although not wanting a serious relationship with her, he had accompanied her to her hospital ante-natal appointment that day.
- 3.5.2 Father said that he continued also to be in regular contact with an ex-partner and their children in another borough [the Probation Service and the City and Hackney Safeguarding Children Board have alerted Children's Social Care in the relevant borough to child M's experience and consequent potential risk to these children].

**Comment: in accordance with the National Probation Service safeguarding policy, and reflecting the history of violence and a class A drugs offence, Children's Social Care should have been notified of the pregnancy of father's partner.**

### 3.6 ANTE-NATAL CARE

- 3.6.1 HV3 documented a call from mother on 19.11.14 when mother was 'abrupt' to a colleague and declined without explanation any further health visiting services saying she would not be attending for a weight check or health review of sib.1. In accordance with HUHFT 'No Access policy' HV1 records indicate that she alerted an unnamed social worker.

#### **COMPLETION OF SOCIAL WORK ASSESSMENT / MONITORING OF SIB.1'S WEIGHT**

- 3.6.2 Aside from noting that sib.1's obesity was being monitored by the GP, the report of the assessment completed on 27.11.14 referred to mother having taken 'appropriate action' with respect to domestic abuse in March. *In fact* she had declined to support Police action at the time and she later admitted, had gone on to become pregnant by the same man. Housing and immigration status were identified as unresolved issues but mother's relationship with sib.1 was noted to be warm and responsive and no role for Children's Social Care was identified. The case was therefore closed and mother, GP and Health Visiting Services as well as sib.1's nursery school were sent copies of the completed assessment.

**Comment: with respect to mother's 'protective action' earlier in the year and her apparent choice of 'single parenthood', the conclusion of the assessment (risk of domestic abuse 'low') was based upon false and misleading evidence; in addition, the safety net usually represented by health visiting was assumed.**

- 3.6.3 At a 'link meeting' between GP and health visitor on 01.12.14 it was reported that sib.1 had been seen only once since October and there appeared to remain uncertainty about a referral to the Dietetic Service. It was thought sib.1's weight might have reduced since concerns were first raised and that a review at the end of January 2015 would be sufficient (a formal referral was subsequently sent on 10.12.14).
- 3.6.4 HV1 received child protection supervision again on 05.12.14. It was agreed she liaise with GP, midwife and nursery school head teacher with respect to ongoing concerns. On the same day HV1 received the Children's Social Care assessment confirming that mother had stated she was willing to engage with universal services including health visiting with respect to sib.1's weight and that she was pregnant.
- 3.6.5 The reassurance offered by mother conflicted sharply with her earlier rejection of health visiting and HV1 and SW1 spoke by phone. HV1 proposed to offer mother an alternative source of support via the GP and pointed up the imminent involvement of the Midwifery Service and that a different health visitor would be allocated when the new baby arrived. HV1 was asked to re-refer if her further efforts to engage with mother proved unsuccessful.

**Comment: in the absence of further discussion between a health visitor and social worker, there was no face-to-face contact with sib.1 for 12 months and hence no monitoring of weight or wider welfare needs.**

- 3.6.6 At a further office contact with PO1 on 10.12.14, father offered more reassurance about his ongoing 'not serious' relationship with mother as well as a willingness to support her with their child. Father repeated his account of supporting mother before and after the birth of their child *and* of maintaining contact with his ex-partner and their children.

**Comment: had SW1 been aware of the involvement of Probation she could have compared and contrasted the parents' accounts.**

- 3.6.7 Mother 'stormed out' of a GP2 consultation (attended jointly with a man recorded as 'father', but in all probability step-father) on 09.02.15 because she was dissatisfied with the explanation offered of some spots on sib.1's face. She returned at a later date and accepted the diagnosis (a self-limiting common childhood viral infection). The doctor has reported feeling threatened by the adults' responses to her advice.

**Comment: the presence of step-father offers evidence of his ongoing involvement with the family; also any such perceived threat has significant implications for any child who was dependent upon such adults.**

- 3.6.8 At an ante-natal check on 26.03.15 the midwife noted the presence of a man presumed to be father though her records did not explicitly confirm identity. In mid-April 2015 mother self-presented at an A&E Department for minor symptoms and was provided with routine medical responses.

**Comment: it is in virtually all circumstances, helpful to enquire about and capture responses to the issue of paternity.**

## FIRST A&E PRESENTATION OF SIB.1

- 3.6.9 In the very early hours of 10.04.15 sib.1 was presented to hospital 1's A&E Department with a 2 week history of self-resolving nose bleeds and an acute upper respiratory tract infection (mother reported that a GP had prescribed a de-congestive nasal spray). Sib.1 was noted to be happy and no safeguarding concerns were identified. The GP Practice was notified of this presentation.
- 3.6.10 HV1 received further child protection supervision a week before child M was born. It was agreed that if mother persisted in her refusal to accept health visitor involvement a new referral to Children's Social Care was to be made. Meanwhile HV1 should liaise again with other agencies.

## 3.7 BIRTH OF CHILD M

- 3.7.1 On a date in late May child M was born without complications. Mother and baby were discharged home and a community midwife completed an uneventful first visit 2 days later. A more challenging visit was made when child M was 5 days old. Father was present and MGM presented the baby to the midwife. Mother repeatedly refused to meet her and in consequence, routine checks of her well-being could not be completed.
- 3.7.2 Several attempts were made by HV1 or colleagues to complete a 'new birth visit'. Only when a different health visitor was offered, would mother agree to a visit which was completed on 01.06.15 (day 13 after child M's birth). The priority was the baby and an observation of a clearly very overweight sib.1 was not developed further.
- 3.7.3 The home was noted to be clean and tidy and mother reported that she was coping and being supported by her boyfriend (assumed to be the father of child M) and her mother. The baby had regained his birth weight and no immediate concerns were identified.
- 3.7.4 Father's update to his probation officer PO1 that month suggested that he and child M's mother might become 'a couple'. PO1 spoke of completing a home visit at this time though did not do so (such a visit is an expectation of the National Probation Service).

## 3.8 HOUSING REFERRAL & GP REFERRAL OF SIB.1

- 3.8.1 Children's Social Care received a referral from Hackney Homes on 12.06.15. Child M's father and child M had attended 'Housing Options & Advice'. He reported they had been kicked out by mother who was he claimed, depressed following child M's birth. Father planned to take the baby to the child's paternal grandmother, though refused to provide her address. The case was re-allocated to A & A2 for a further assessment.

**Comment: it was helpful to re-allocate the case to those with some familiarity with the family; it is unclear whether the risk inherent in entrusting child M to father's care was tested nor if mother's consent (as sole person with parental responsibility had been obtained.**

- 3.8.2 Sib.1 was seen again at the GP Practice on 16.06.15 in response to a referral from a pharmacist who was concerned about the child's 'off the scale' weight / height. A referral was made to the Paediatric Department at hospital 1. Mother failed to make any appointment and the child was subsequently discharged back to GP care on 13.07.15.

**Comment: the pharmacist's initiative was commendable; mother's response offers a further example of her disguised compliance.**

### **3.9 FIRST POTENTIAL NON-ACCIDENTAL INJURY TO CHILD M**

- 3.9.1 A week later in the early hours of 22.06.15 child M (aged 3 weeks) was presented at the A&E Department of hospital 1 and admitted to the Paediatric Ward. The baby was reported to have an unexplained history of nose bleeds, a bleeding gum and marks under the right eye and cheeks whilst in the care of his father.
- 3.9.2 Health Visiting Services and Children's Social Care were notified and in a phone call from a paediatric registrar to the 'First Access and Screening Team' (FAST), she reported her suspicions that the injuries were non-accidental. A CT scan was completed and a full skeletal survey and an ear nose and throat (ENT) examination scheduled. Child M was admitted and the parents were noted to have 'shut down' after the examining consultant 1 discussed a referral to Children's Social Care e.g. no eye contact and no responses to questions.
- 3.9.3 By 23.06.15 completed tests had revealed nothing abnormal. The results of an ophthalmological test by Great Ormond Street Hospital were awaited. A reference was made to mother's post-natal depression. An aunt had by this time provided the medical staff with a clearer account which had somewhat allayed professional anxieties.
- 3.9.4 A discussion on 23.06.15 with the FAST 'screening and referral manager' resulted in agreement to hold the case until all the medical results became available. The hospital was asked to alert Children's Social Care to any further A&E presentations. The paediatric consultant reportedly suggested a joint visit by a health visitor with the social worker. Police were not involved.
- 3.9.5 A GP consultation by mother on 24.06.15 included no reference to the hospitalisation of child M. Mother reported no mood disturbance and spoke of the support provided by MGM, sister and 'partner' [sic].

**Comment: it is reasonable to conclude that mother's failure to mention her child's emergency admission was avoidant behaviour.**

- 3.9.6 On the same day as mother's consultation with her GP (whether before or after is unclear from the records) and following a brief discussion at the hospital's paediatric psycho-social meeting there was a recorded intention to further discuss the case at a second meeting. Child M was discharged from hospital and an email referral was sent to Children's Social Care.

3.9.7 The FAST record captured the above events and prompted an 'alert' on child M's health records to reflect recent referrals from Housing and Hospital. A further conversation with consultant paediatrician 1 revealed that remaining tests had confirmed nothing untoward (an additional test for haemophilia was awaited). It was agreed there remained no evidence for originally suspected non-accidental injury.

3.9.8 A call to mother by SW1 in Children's Social Care (to whom the case was re-allocated on 26.06.15) elicited consent to initiate agency checks and an agreement to meet at the office. Mother diminished the significance of the relationship with child M's father by saying he provided no financial support. She admitted feeling 'low' but reported her GP had not identified depression. She claimed (inaccurately) to be supported with respect to sib.1's weight by a Children's Centre.

**Comment: 'financial support' was of little relevance to the fact or nature of the relationship or risk father posed mother and children; a comment 'advised whilst at her mum's house Children's Social Care cannot visit', required challenge.**

3.9.9 In a subsequent phone contact, mother denied father's account of being ejected from her home and said that he had taken sib.1 out for the day. A conversation on the same day between SW1 and HV1 shared concerns about family engagement though established that the latter professional and a colleague HV3 who had made a joint visit with a midwife, had no concerns about either child (except sib.1's weight).

**Comment: records of Housing and FAST earlier in June refer to father and child M (not sib.1) – possibly an attempt to deceive or confuse professionals.**

3.9.10 The recorded output from the further paediatric psychosocial meeting held on 01.07.15 concluded that there would be no further active involvement from the safeguarding children team because Children's Social Care was actively managing the case. An unidentified health visitor met MGM on 02.07.15 at the family home. Mother and child M were reported to have gone out. The GP Practice was notified of child M's A&E presentation.

3.9.11 At his monthly report to PO1, father reported on 10.07.15 that he and mother had presented child M to Great Ormond Street Hospital for an eye check-up. He made no mention of the concern that child M's observed symptoms had been suspected to be non-accidental.

3.9.12 The hospital contacted SW1 on 13.07.15 and she confirmed a meeting that day when she would ask mother to contact health visitors. Father was present at the meeting (which revealed no immediate concerns) and admitted contact with Housing had been an attempt to obtain his own accommodation.

**Comment: father's responses to PO1 and SW1 indicate he too was seeking to mislead professionals; 3 days later, mother refused access (claiming to be asleep) to the health visitor making an opportunistic visit.**



### 3.10 PARENTS' CRIMINAL CONDUCT

#### MOTHER'S ARREST

- 3.10.1 On 16.07.15 mother was arrested for assault of her sister and criminal damage. Child M's aunt was reported to officers (by mother) to have been looking after the baby for 3 weeks. Mother allegedly wanted (according to her sister) to resume care 'so as to give child M away to Children's Social Care'. Child M (not present at the time of mother's arrest) was left with his MGM. Police subsequently 'NFA'd' the episode because the sister refused to provide a statement and MGM was a reluctant witness. A notification was sent to Children's Social Care.

**Comment: this episode offered a useful insight into the relationships of wider family; it was shared with the Health Visiting Service a week later by which time the account was of the baby being left only 'at night' for 3 weeks.**

- 3.10.2 Mother subsequently offered a different explanation in which her sister had cared for child M for only 1 week and had argued *only* about money. Mother denied ever wanting to relinquish care of child M, saying that the break was to enable her to deal with her need for re-housing.

**Comment: no evidence has been provided that mother used the 1 or 3 (it remains uncertain which) weeks to address housing-related issues.**

- 3.10.3 On 20.07.15 Children's Social Care was alerted to the inability of the health visitor to contact mother. Mother was seen by her GP 2 days later and given what appears to be a thorough medical examination. No signs of depression had been noted in a 'chatty and engaged' mother and (aside from weight about which mother had taken no action) sib.1 appeared well. A 6 week child health examination was also completed on 20.07.15 and child M's BCG vaccination were administered. A GP record referred to 'puerperal depression' (now known to have been a recording error). Contraceptive advice and assistance was provided.

- 3.10.4 At a 'link meeting' between health visitor and GP that day, the doctor reported no concerns about mother's affect. A letter was sent next day to Children's Social Care in which the above findings were shared. On 24.07.15 social worker and health visitor shared and agreed a concern about some form of 'disconnect' between mother and child M. SW1 subsequently liaised with her agency's 'Clinical Hub' (a source of therapeutic assistance in this case potentially offering a programme '*New Beginnings*' for mothers and babies).

- 3.10.5 Mother failed to present child M for outstanding immunisations and the health visitor informed Children's Social Care. SW1 made further attempts during the remainder of July to establish contact with mother and on 31.07.15 updated the clinician colleague whose intervention she planned to engage (subject to mother's consent).

**Comment: the health visitor and social worker were making substantive individual and joint efforts to encourage mother to access relevant services.**

- 3.10.6 Child M's immunisation was eventually administered on 10.08.15 by a GP. Also that day mother phoned SW1 to report she could no longer remain at her mother's address. She was advised to consult the Housing Service and the charity Shelter to discuss options. Several further (unsuccessful) attempts were made by the Social Work Unit to contact mother and text messages were left.
- 3.10.7 Mother initiated contact with the Social Work Unit on 14.08.15 and explained that she was staying with a friend outside of London. An appointment was made for 19.08.15 though postponed on several occasions and eventually completed on 03.09.15.
- 3.10.8 Mother turned down the suggestion of the 'New Beginnings' programme and other unspecified Multi-agency Team (MAT) services. She claimed that a GP referral to a paediatrician concerned sib.1's *height* not *weight* and that she needed no further help in that regard. Mother's interactions with her children gave no cause for concern. A check with the Practice on 04.09.15 confirmed the issue prompting a paediatric referral had been weight *not* height as claimed by mother.

**Comment: SW1's action taken showed commendable and wholly justified caution, given that many other claims by mother were demonstrably inaccurate or false.**

### **FATHER'S ARREST**

- 3.10.9 On the same day mother finally ensured that child M received the outstanding immunisations, father (in the company of others) had been arrested on suspicion of possession with intent to supply a large quantity of cocaine and cannabis. The Probation Service was informed.

**Comment: within Probation it was agreed that if charges were brought, father would be recalled to prison; in the event after several months on bail, the Crown Prosecution Service decided in April 2016 to take no further action.**

- 3.10.10 Insofar as mother sought an update about events from Probation, it seems her partner had not (3 days after arrest) shared the news. SW1 discussed the case at a Unit meeting on 19.08.15 and in view of mother's resistance to engage, concluded she would need to complete her assessment without the involvement of a clinical colleague.

### **3.11 RESUMED CONTACT WITH ANTE-NATAL SERVICE & CHILDREN'S SOCIAL CARE**

- 3.11.1 On 03.09.15 midwifery notes refer to mother's refusal of a random blood sugar test and her report that she had ceased to take recommended vitamins and iron supplements. On the same day mother, child M and sib.1 were seen at Children Social Care (the first face to face contact since July that year). The issue of weight was again raised with mother still refusing to access support. Observations of her interactions with the children were more positive.

- 3.11.2 A call was made by SW1 to the GP Practice next day and the concerns about mother's response shared. It was thought the referral initiated by GP1 had not been followed up and the GP agreed to check this out.

**Comment: this was an example of good (and in terms of the national picture, atypical) collaboration with a GP Practice.**

- 3.11.3 In SW1's view (as recorded by the GP with whom she spoke), sib.1 was not 'at risk of significant harm'. The social worker later held a discussion with a consultant social worker and on 23.09.15, with a service manager. The latter manager directed that a 'professionals meeting' should be convened in an attempt to formulate a plan. If that failed, consideration should be given to initiating s.47 enquiries.

- 3.11.4 In a later phone exchange with mother, SW1 referred to the planned meeting to which mother proposed to bring a solicitor, indicating she was being 'picked on' because she was single parent. At this time, father was offering PO1 a consistent account of continuing contact with child M though he claimed that he and 'the baby's mother were no longer in a relationship'. By the end of September mother had decided that she *would* accept a family support worker.

#### **PROFESSIONALS (TEAM AROUND THE FAMILY/ NETWORK) MEETING**

- 3.11.5 The meeting was held on 08.10.15 with mother and father who by then had admitted their resumed relationship, present. Concerns felt across the network were shared. Mother continued to deny that sib.1's obesity was a problem. Attendance at nursery school was reported to be good. The attending health visitor later provided feedback to GP colleagues.

**Comment: only days before this, father was denying the relationship had resumed.**

- 3.11.6 A consensus was apparently formed at the meeting that there were no concerns that would justify s.47 enquiries. The family was to be supported by the 'Family Support Service'. *If* mother sustained her refusal to engage in meeting the emotional needs of her children, a referral back to Children's Social Care was contemplated.

**Comment: the position with respect to sib.1 following the meeting was no different than that which preceded it.**

- 3.11.7 Only 4 days after the above meeting mother failed to bring sib.1 for his paediatric appointment. Father (further undermining earlier claims that his relationship was over) presented child M to a 'baby clinic' on 19.10.15 though declined to wait until seen by a health visitor.

- 3.11.8 Children's Social Care's re-assessment was completed on 14.10.15 and highlighted the concerns about sib.1's weight and mother's varying levels of warmth with her children. Father's inconsistent contact was identified as unhelpful, though observed direct care was of no concern.

- 3.11.9 The assessment characterised the adults' relationship as 'long-standing friends' but (because of his lack of support) no longer in a relationship

**Comment: the parental description of their relationship (which appears still to have included sexual intercourse and significant co-parenting) could usefully have been explored further.**

- 3.11.10 A handover visit was completed at the office on 26.10.15 and mother met a family support worker. She and father indicated they would co-operate. Mother claimed to have no mobile and asked for contact via her partner. An initial appointment was agreed for 03.11.15 at the nursery school because mother reported that child M's grandmother with whom she was again living, remained unwilling to receive Social Care agencies in her home.

**Comment: being denied access to where the children were living placed the staff at a disadvantage; it would have been worth making direct contact with the children's grandmother to test out her reported opposition.**

### **3.12 SECOND POTENTIAL NON-ACCIDENTAL INJURY TO CHILD M**

- 3.12.1 At 04.38 on 31.10.15 child M (nearly 6 months old) was presented to hospital 1's A&E by mother and father, maternal aunt and an unnamed 'God mother'. The child was examined and noted to have bruising and a minor head injury. Of particular concern was that father who had reportedly been in bed with the baby at the time was unable to provide a consistent explanation. An account to the Emergency Duty Team of Children's Social Care by the hospital's paediatric nurse differed in some respects to father's initial accounts.
- 3.12.2 Notes of a medical examination indicated ...'bruising to the right upper eyelid and inferior to right eye, with bloodshot area on sclera [white of the eye] visible latero-superiorly [above and to the sides] to the iris. 2 linear marks extending from between the eyebrows diagonally left to the hairline, right one 0.5cm width, left one slightly narrower. Lateral to this to the left, some streaky red marks, less well defined'.
- 3.12.3 Although consent for photographs was reportedly taken, this is not evident from notes and no photographs were taken. A body map was completed but no written report accompanied it. The report submitted to the review points out that father's account of his 5 month-old baby standing up in a 'Moses basket' was very unlikely to be developmentally possible<sup>6</sup>. A report from a speciality doctor at the hospital cited by Children's Social Care indicated that mother had reported that she did not believe father's account of events.

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<sup>6</sup> According to Denver Developmental Screening Test (DDST), commonly known as the Denver Scale, an average age for a baby to pull to a standing position is 8-10 months old.

3.12.4 In a phone call between the above doctor and SW1 it was agreed that the child could return to care of mother (then living with the child's grandmother), pending completion of an assessment. The parents signed an agreement that father would *not* access child M and that if he did so, mother would alert Police.

**Comment: though not all the evidence (father's criminal record etc) was available to SW1 at this time, mother's misleading accounts of her ongoing relationship with father indicate that she could not be relied upon to comply with any such agreement; in addition the grandmother was (according to the account provided by her daughter) opposed to any visits by Children's Social Care staff.**

3.12.5 In the view of consultant paediatrician 2, the parental explanation provided was 'plausible' and further investigations not required. The report submitted to the serious case review by HUHFT points out that the medical team's records do not offer an explicit conclusion e.g. whilst accepting the plausibility of father's account, the report sent to the GP implies an 'unexplained' injury. In the period between child M's first and second hospital presentation, a move toward 'electronic paper records' (EPR) had resulted in some staff being unaware of the need to complete a child protection form / report in addition to standard documentation on EPR. The GP Practice received notification of this incident on 31.10.15.

3.12.6 On 02.11.15 a management decision was made, that in the light of the injury the case would transfer back to A&A Unit 2 for further assessment. A home visit and a conversation with sib.1 (alone) revealed nothing more. He said he had been asleep when child M was hurt. This was recognised as possibly true *or* the result of coaching. Mother agreed to stick with the safeguarding agreement and SW1 planned to meet father and to speak with sib.1 again at his nursery. Records indicate a strategy discussion (preceding s.47 enquiries) *might* follow. At an office visit on 04.11.15 father gave a further account of how child M was injured. At a case discussion on 06.11.15 involving SW1, consultant social worker and the service manager, the overall family functioning was considered and a decision made that a child protection conference was justified because:

- Of the observed injury to a pre-mobile baby
- Father's accounts were inconsistent
- In the light of a previous injury, doubts existed about his capacity to keep child M safe
- Of insufficient confidence in mother's protective capacity

**Comment: this response was evidence-based and proportionate.**

3.12.7 A subsequent strategy discussion with Police on 09.11.15 acknowledged that although there was no evidence to confirm non-accidental injury, there were real doubts about the capacity of both parents to safeguard their children and a conference was required.

## SECOND A&E PRESENTATION OF SIB.1

- 3.12.8 Before the initial protection conference was convened, sib.1 (3.5 years old) was again presented to A&E on 07.11.15 and seen by the Primary Care Service due to an insect bite. Because the child was known to Children's Social Care, a 'safeguarding alert' was completed and the Safeguarding Children Team informed Children's Social Care and (via its team planner) initiated a request for a follow-up by a health visitor.

### 3.13 INITIAL CHILD PROTECTION CONFERENCE

- 3.13.1 The initial child protection conference was held on 26.11.15. All those who were invited attended i.e. health visitor, head-teacher, Police, social worker and mother. It would appear that GPs were invited but did not attend (or provide a report) and Probation, the involvement of which remained unknown to Children's Social Care, was not invited.

**Comment: Both GP and Probation services held relevant information and would have been useful contributors.**

- 3.13.2 A report from Children's Social Care referred to an agreed view of the speciality doctor and SW1 that father's account of the injuries to child M in October were 'plausible'. They retained concerns about his capacity to offer safe care of very young children. Conference records indicate a plan to refer father for a 'parenting support for risk and safety awareness' programme. The case was to be transferred to the CIN Unit 9 for ongoing service delivery.
- 3.13.3 The MPS representative referred to a 2007 incident in which father had been questioned over a potential rape though not charged. It would appear that although a comprehensive account of father's criminal record including lengthy prison sentences and current bail was shared, the fact that he was on licensed release was not considered.

**Comment: it was known mother had 'no recourse to public funds' and it is unclear how agencies perceived she was feeding or clothing her children<sup>7</sup>. Her wish to avoid the attention of 'Immigration, Compliance & Enforcement' (ICE) may have been a factor in avoidant behaviours.**

- 3.13.4 The formal decision of the conference chairperson was that both children should be made subject of a child protection plan:
- Sib.1 for emotional abuse
  - Child M for physical abuse

**Comment: that decision was wholly reasonable and proportionate; the records of discussion and agreed actions appear sparse and the child protection plan that was formulated was rooted in an apparent belief that child M's injuries to date had been accidental rather than (more precisely) of uncertain causation.**

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<sup>7</sup> 'Supporting people with no recourse to public funds (NRPF): Guidance for homelessness services' May 2016 offers some guidance to this complex issue.

### 3.14 DOMESTIC INCIDENT (4)

- 3.14.1 Within a week of the initial child protection conference, police officers chanced upon mother chasing father up the road. She alleged that an altercation at her doorstep had ended with him slapping her and that officers had witnessed what followed.
- 3.14.2 Father was arrested for the alleged assault but as a result of mother's unreliable evidence only a charge of cannabis possession was proceeded with (and resulted in a fine). Mother claimed that her relationship with him had ended in June and that he was not interested in maintaining contact with his child. She claimed (inaccurately) to be seeking an injunction against him. Mother also referred to 2 incidents in which child M had sustained bruising whilst in father's care. Scrutiny of text exchanges confirmed mother had lied in order to get him to visit her. Officers had confirmed that child M was safe in the care of MGM and Children's Social Care was notified via a 'Merlin'.

**Comment: it seems likely that child M (aged less than 6 months) was just left at the doorstep while the parents acted out their disagreement; MGM's denial that she had been aware of what was going on stretches credulity.**

- 3.14.3 The chronology provided to this review indicates that there was an appointment for sib.1 with consultant paediatrician 1 on 01.12.15 (in the event a registrar completed the examination). Aged 4 years and 2 months sib.1 was recorded as being over 99.6 centile for weight and height. Mother refused the offer of a referral to Dietetic Services. The clinician was unaware of the earlier safeguarding concerns which were on the Community 'Rio' system but not on the hospital's electronic patient record (EPR).
- 3.14.4 At a home visit by newly allocated social worker SW2 mother repeated what she had previously said i.e. that she did not want child M's father having unsupervised access to his child. On 07.12.15 child M was brought to the Health Centre. Weight was on 75<sup>th</sup> centile and the child appeared well and appropriately dressed.

#### **CORE GROUP 1**

- 3.14.5 A timely first 'core group' was held on 08.12.15 at the nursery school and attended by SW2, nursery staff member and health visitor. It was noted that neither the father of sib.1 nor the father of child M were permitted to collect the children from nursery school. A further meeting was scheduled for 22.01.16 and results of the December paediatric appointment were to be chased up.
- 3.14.6 A further 'link meeting' was convened at the Health Centre on 14.12.15 when the fact that child M and sib.1 were subject of protection plans was shared.

**Comment: health visitor - GP liaison appears to have been a consistent strength.**

3.14.7 A home visit by SW2 was completed on 22.12.15 and mother complained that father was not helping and that she did not want him to have child M. Just after Christmas mother was hospitalised briefly for pregnancy-related symptoms. About 2 weeks later, on 05.01.16 SW2 was told by mother that her relationship with child M's father had resumed. Mother said that she 'wanted him to move back in' [sic]. Mother was noted to be affectionate toward the baby but dismissive of sib.1 when that child sought some attention.

**Comment: without regard to what father was telling PO1 (and his account of the December altercation differed from mother's), he had clearly been cohabiting (at least part-time) with child M's mother and thus misleading his probation officer.**

3.14.8 PO1 informed father that as a result of his arrest and discovery of cannabis, a senior colleague would be consulted and the possibility of a recall to prison considered. PO1 commendably sought confirmation from Children's Social Care on 11.01.16 that it was involved and asked to be alerted to any safeguarding concerns. His email included an assertion by father that he was to be involved in an impending parenting class. A 'manager's warning' was sent to father on the same day reminding him of the possibility of a recall to prison.

3.14.9 PO1 received a prompt confirmation from SW2 of agency involvement, that the children were subject of protection plans and that the family was engaging. SW2 sought and was later sent a proportion of the information about father's current criminal conduct and licence conditions. PO1's intention to seek an update from SW2 was unfulfilled.

3.14.10 An 8-10 month development review of child M (who presented and appeared well) was completed on 19.01.16 and prompted no concerns. A joint home visit was made by SW2 and consultant social worker CSW1 on the same day and elicited from mother a promise of co-operation. Mother reported her wish for child M's father to remain involved but that they were no longer in an intimate relationship (this contradicted what SW2 had been told as recently as 05.01.16).

3.14.11 By 25.01.16 (when MGM presented sib.1 with an injury / bite to his left 4<sup>th</sup> finger) the GP had still not received a report of sib.1's paediatric assessment of early December. Its findings would have been of relevance for the imminent review conference. In response to a request from Children's Social Care for a report, the GP Practice sent its July 2015 report and the recent A&E discharge note.

**Comment: material submitted should have been more current and considered.**

3.14.12 At a further unannounced home visit on 01.02.16 mother was forewarned of the recommendation that the protection plans should continue, primarily because of father's lack of engagement. Mother again indicated that she no longer wanted his inconsistent involvement.



- 3.14.13 The case was allocated to Family Unit 7 on 18.12.15 with a view to starting parenting sessions (aimed at enhancing father's confidence in parenting both children) in the New Year. A planning meeting scheduled for 18.01.16 was postponed because the social worker had been unable to contact father.
- 3.14.14 The account being provided by father to PO1 at this time was of approximately twice weekly visits to child M. Father also claimed a parenting programme which he was due to attend had been postponed until 10.02.16.

**Comment: records supplied by Family Unit 9 show parenting support workers PSW1 and (from March 2016) PSW2 remained unable to contact father; hence the delays in starting the planned work were a function of his lack of engagement (as well as a refusal by his grandmother to allow staff in her house whilst she was away on holiday).**

### 3.15 REVIEW CHILD PROTECTION CONFERENCE

- 3.15.1 At a Unit meeting the day before the review conference on 10.02.16 a decline in sib. 1's nursery school attendance was noted. The conference included parents, social worker and health visitor, parenting support worker and head teacher. Neither GP or Police were present (though the latter provided a report). Probation was not invited.

**Comment: Probation had a relevant contribution and had demonstrated a willingness to collaborate; its absence denied the network valuable intelligence.**

- 3.15.2 The conference re-iterated the expectations of more responsivity from both parents and asked mother to produce the paediatric report of her elder child's weight-related assessment in December. Father was asked to sign a written agreement that he would refrain from use of drugs when in contact with the children. The substantive decision of the chairperson, informed by the evidence of little change in circumstances or reduction in risk was that both children would remain subject of protection plans under unchanged categories.

**Comment: 'agreements' depend upon a level of honesty and openness that (in the light of history) was questionable for this couple; the decision to continue the protection plan was, on the basis of engagement to date, wholly justified.**

- 3.15.3 A further core group meeting was planned for 25.02.16 (though postponed until 03.03.16) and the review conference for 19.07.16. Attempts a few days later by both social worker and clinical worker to make contact were initially thwarted but the social worker made a second unannounced home visit and saw both children who were being cared by MGM. Sib.1 was seen alone and responded well to the attention offered. Child M was sleeping.

3.15.4 Contact continued to be difficult to achieve for both social worker and health visitor. On 24.02.16 the case was discussed at Family Unit 7 meeting and a decision made by the service manager to re-allocate the case as SW2 was leaving.

3.15.5 At the health visitor's safeguarding supervision that week, she usefully clarified the salient issues: mother continuing to allow father unsupervised access to his child and her lack of insight into professional concerns. Set against that, the health visitor discerned some signs of engagement and the basic needs of her children were being met.

**Comment: a reference in the health visitor's supervision to there being 'no sign of mother attending the paediatric registrar-led community clinic' may be a reference to the December appointment and doubts that she had actually presented her son; this could have been checked.**

3.15.6 Father's reports to PO1 at this time refer to seeing child M a '2 or 3 times a week' at the paternal grandmother's home. He also indicated that he was awaiting confirmation from SW2 about the availability of a parenting programme.

**Comment: at his last session, father had reported it would begin on 10.02.16.**

## **CORE GROUP 2**

3.15.7 The core group on 03.03.16 was held at the nursery school and proceeded without father who could not be contacted. SW2 observed sib.1 and noted that he was clean, appropriately dressed and appeared happy. SW2 also made a home visit that day and was reassured by her observations of mother with child M. Mother reported that sib.1's father had had phone contact with his child and might be visiting that night.

3.15.8 SW2 arranged an office appointment with sib.1's father for 08.03.16 but he failed to appear. A further appointment was made and also failed. The father of child M also failed to attend an appointment that day to discuss the plan for contact with his child.

## **EXECUTION OF DRUG WARRANT**

3.15.9 On 10.03.16 Police executed a drugs warrant at mother's home address. The subject of the warrant was child M's maternal uncle. His response was recorded as 'obstructive'. Mother and child M were present. No drugs were found and a strong smell of cannabis was attributed by MGM to be a result of her smoking in the garden whilst watching sib.1 play.

3.15.10 Though clean and the kitchen well-stocked, the house was very cluttered. Child M was noted to appear happy. A standard notification to Children's Social Care was initiated. A case discussion was undertaken on 15.03.16 by the CIN Unit 9 meeting. The social worker's difficulty in maintaining regular home visits was noted (mother was advocating *only* pre-arranged visits).

- 3.15.11 Later that day SW2 made an announced home visit and observed mother shouting at sib.1. The issue of MGM smoking cannabis was raised and mother claimed that she did not allow it in front of the children. SW2 informed mother there would be a new social worker allocated. Planned 'parenting support work' had yet to begin.
- 3.15.12 Contact with child M's father resumed briefly when he provided a new mobile number and agreed to attend the office next day (17.03.16). He failed again to attend his appointment.
- 3.15.13 On 21.03.16 mother made a call to enquire about the next child health clinic. She was given the date and encouraged to contact her health visitor if any concerns could not wait until 04.04.16. Also on 21.03.16 SW2 was involved in a 'clinical consultation' involving a clinician colleague and PSW1 (parenting support worker). They provided information about 'child-centred' play and the lack of mother's engagement was acknowledged. After the above session a planned joint visit by SW2 and the PSW1 was arranged for 22.03.16. Mother was not in, and the visit was re-scheduled for a week later.
- 3.15.14 A further case discussion in Family Unit 7 was undertaken on 23.03.16. The approach to be taken was modified and became an exploration of whether mother could supervise contact between the avoidant father and child M, seeking father's agreement to random drug tests and the (previously agreed) need to complete a parenting course. Only 1 drug test was subsequently administered.

**Comment: In Hackney, cases are discussed and decisions made in Unit meetings rather than individuals' supervision sessions, which instead focus upon professional development.**

### **3.16 PARTIAL ENGAGEMENT WITH 'PARENTING SUPPORT'**

- 3.16.1 A week later a 'planning meeting' was held with the Parenting Support Service' (PSS) in which work by it and the parents was 'agreed'.

**Comment: all reasonable attempts to meet familial needs had been denied or diverted by both parents though a degree of engagement did in fact follow.**

- 3.16.2 The planned joint home visit was completed by SW2 and PSW1 on 29.03.16. Both children were seen and mother reported that she had supervised a recent visit lasting some hours by child M's father.
- 3.16.3 Father was meanwhile reporting to PO1 that that the delay in starting a parenting programme had been due to illness and that he was awaiting contact by the social worker. He also reported seeing child M 2 / 3 times a week when the child was brought by his partner to father's given address (father's grandmother's home).

**Comment: liaison between PO1 and social worker at this time might have clarified the real reasons for the failure to begin a parenting programme.**

- 3.16.4 Mother brought child M (45 weeks old) to the Health Centre Baby Clinic on 04.04.16 where the baby was assessed as looking well and dressed appropriately. Weight had risen to above 99.6<sup>th</sup> centile according to chronology and BMI was 24.3 (ideally it would be 13.9 -16.8). Mother was noted to be 'receptive to advice on diet and nutrition'.

**Comment: if the examining health professional has been aware of the history of care of sib.1 she might have been more sceptical.**

### **THIRD A&E PRESENTATION OF SIB.1**

- 3.16.5 A presentation of sib.1 to hospital 1's A&E Department on 10.04.16 raised no safeguarding concerns (nocturnal nose bleeds and no reported trauma). Sib.1 though clearly overweight, appeared to be alert, happy and active.
- 3.16.6 On 12.04.16 SW2 introduced mother to her replacement SW3. Observations of the children raised no new concerns. What was described as 'parenting support session 2' (the first had been held a week earlier) also took place that day. Mother, MGM and father met PSW2. Father stated that he wished to engage and spoke of wanting to work to support his family.
- 3.16.7 Mother subsequently failed to bring or present sib.1 for a check-up at the GP Practice on 2 occasions (13.04.16 and 14.04.16) and an examination on 15.04.16 focused on apparent eczema. Though sib.1's weight was reportedly checked, the result was not included in the records provided.
- 3.16.8 'Parenting support session 3' took place at the nursery school on 19.04.16 when father reported that he was calmer and more confident in handling his child. He said that he would like to take up the offer of an employment-related course – '*Ways to Work*'.
- 3.16.9 The case was again debated at a Family Unit 7 meeting on 25.04.16. PSW2's report was that she had observed sib.1 at his nursery; also that the parental relationship seemed more relaxed. SW3 made a home visit on 26.04.16 when her only concern was a cot that needed to be replaced. The social worker undertook to ask her agency to pay for the required replacement.
- 3.16.10 At his regular reporting session to PO1 on 27.04.16 father was still reporting that the parenting programme had 'not begun'. It is unclear whether father was misleading PO1 or just confused. PO1 anyway obtained confirmation from Police on this date that no further action was to be taken with respect to his potential 'possession with intent to supply class A drugs'.
- 3.16.11 At a link meeting at the GP Practice on 25.04.16 an agreement was reached to chase up the report of December's paediatric appointment. Sib.1 was seen again at the GP Practice 2 days later (and for the last time within the review period on 12.05.16 for a routine eczema review).

3.16.12 On 03.05.16 PSW2 undertook a further home visit and observed improved parental interactions. She suggested ways of improving his interaction with sib.1 and at the next planned visit, said that she would observe father bathing child M.

### **CORE GROUP 3**

3.16.13 At the core group meeting held at the nursery school on 11.05.16 (parents, health visitor and nursery present) the need for father of child M to be accompanied by child M's mother was repeated. Father had reportedly signed an agreement not to use any drugs whilst in contact with the children and had agreed to random drug testing.

3.16.14 Father was said to have attended 4 'parenting support sessions' though confusingly, father's report to PO1 was that he had only *just* signed consent forms for a parenting programme; mother was said to have attended 1. Mother was asked (again) to provide a letter relating to the paediatric appointment of 01.12.15.

3.16.15 At a link meeting on 16.05.16 with GP and health visitor, it was noted that a report of the paediatric appointment had still not been received.

**Comment: after a 6 months delay the apparent unavailability of the anticipated paediatric report should have been followed up.**

3.16.16 At a CIN Unit 9 meeting on 17.05.16 the signed agreement requiring supervision by mother / MGM when father was present was noted. Mother remained unwilling to address the issue of sib. 1's weight.

**Comment: weight had been the originating and real concern and had become overshadowed by a high level of avoidance and disguised compliance by both parents.**

3.16.17 At a home visit on the day of the Unit debate, SW3 and PSW2 met parents and MGM. They observed 'vast improvements' with respect to interactions. The next session was to be the final one because all targets 'had been met'. SW3's contact with the family included administration of a drug test on father (which proved to be positive for cannabis).

**Comment: records latterly provided to the serious case review confirm the (delayed) contact by PSW2 and positive observations of some of father's practical skills e.g. bathing the baby'; the drug test result offered further confirmation of father's dishonesty and (had Probation been informed of it) could have helpfully informed its assessment of father's compliance with licence conditions.**

### 3.17 FOLLOW-UP PAEDIATRIC CONSULTATION

- 3.17.1 On 20.05.16 at an outpatient appointment in a general paediatrics clinic, a junior doctor reviewed sib.1 for weight and possible syndrome (Prader-Willi<sup>8</sup>). A referral was made to the Royal London Hospital.

**Comment: sib.1's unremarkable behaviours and high achievement levels at nursery school (if shared with the clinician) would have contra-indicated this condition.**

- 3.17.2 At father's contact with PO1 he was still referring to a *future* parenting course (possibly a reference the planned final session on 17.06.16 which was anyway postponed by mother until 21.06.16). SW3 completed a further child protection contact on 26.05.16 in a park when father sought to explain away his positive test result for cannabis.
- 3.17.3 At a safeguarding supervision the health visitor referred to a 'completed re-assessment of the children's weight'. Mother was to 'consider the types of food she offers to the children', though it remains unclear whether she was aware of the results of either paediatric assessment.

**Comment: there was over 12 months-worth of evidence that mother's feeding of sib.1 (and it appears child M) were placing their health at a real risk of harm.**

- 3.17.4 On 08.06.16 both children were seen at a child protection visit to the nursery. Sib.1 reported to SW3 a parental instruction *not* to talk about 'the flat' and would offer only positive comments about father. At a home visit that day SW3 met a man who entered with a key. Father claimed not to know him (though was by then admitting that he stayed there often). Mother claimed it was an uncle who was living there.

**Comment: the 'child's voice' was being stifled by his parents' instructions and this required robust challenge.**

- 3.17.5 Mother further explained that she, father and the children were currently staying at her brother's flat (for which she offered an address) because she said, he had been remanded to prison. On 10.06.16 sib.1 (aged 4 years and 7 months) was brought to the Health Centre by mother and child M's father. Relative weight remained at over 99.6<sup>th</sup> centile and BMI 24. Once again diet was 'discussed'.
- 3.17.6 The case was again debated, this time by CIN Unit 9. SW3 described a growing confidence in the parents' renewed relationship. She described their temporary residence at the new location. The positive drugs result was not discussed though the need for a further test was noted. SW3 was asked to consider further, father being allowed unsupervised (perhaps hour-long) contact with his child.

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<sup>8</sup> According to [www.nhsdirect/conditions](http://www.nhsdirect/conditions) Prader-Willi syndrome (PWS) is a rare genetic condition that causes a wide range of problems including a constant desire to eat food, which seems driven by a permanent feeling of hunger and can easily lead to dangerous weight gain, restricted growth, leading to short stature, reduced muscle tone (hypotonia), learning difficulties, lack of sexual development and behavioural problems, such as temper tantrums or stubbornness.

- 3.17.7 On 21.06.16 SW3 completed a home visit to the temporary address of the family. Sib.1 was seen to be less boisterous than usual and child M sleepy. The flat was clean and tidy and all the belongings seemed to be those of mother and the children. The risk of eviction was discussed. It was agreed that father would have an hour of unsupervised contact with child M over next weekend whilst mother took sib.1 out to the park.

**Comment SW3 completed careful observations of the environment but her proposed plan appeared to take little account of the accumulated evidence that neither parents could be relied upon to be honest or open.**

- 3.17.8 Also on 21.06.16 final parenting support session was completed and offered reassurances about the parents' ability to relate well to both children. Sib.1's nursery school attendance had meanwhile improved from about 60% to 90%. The nursery attributed an observed improvement in mother's warmth and positive affirmation of sib.1 to the encouragement and modelling of nursery staff.

### **3.18 THIRD POTENTIAL NON-ACCIDENTAL INJURY TO CHILD M**

- 3.18.1 On 23.06.16 (a Thursday) mother phoned SW3 to report that child M had had an accident during unsupervised contact (previously agreed for the weekend) with father and appeared to be in pain. Mother readily agreed to present the child to A&E at her local hospital. SW3 alerted the Police and sought a strategy discussion.

**Comment: existing knowledge of mother would have justified accompanying her or at minimum forewarning the hospital so that further action could be taken if she failed to bring child M; such action might also have served to accelerate child's examination which was not completed for 3 hours after presentation.**

- 3.18.2 Mother's subsequent report at A&E was that father had returned with child M at about 15.00 on 22.06.16 having been to visit a friend. Father reported that the toddler had self-inflicted a leg injury with a walking stick. In the morning mother reported noticing swelling on both thighs and that child M was refusing to walk or sit. She reported administering pain relief. By the afternoon her concern about further swelling had become such that (prompted by SW3) she had attended A&E.
- 3.18.3 A member of the CIN 9 Unit phoned mother at the hospital and advised her not to allow father or anyone else implicated in the injuries, access to child M. The bi-lateral displaced femoral fractures were described by the attending paediatrician in her alert to the EDT as 'horrendous' and child M was transferred to the Royal London Hospital for surgery. Bruising to the head was also noted. A prompt strategy meeting was convened on 24.06.16. At that point father had been arrested and was in custody and mother was not considered a suspect. The Health Visiting Service was also informed.

## 4 ANALYSIS / RESPONSE TO TERMS OF REFERENCE

### 4.1 INTRODUCTION

- 4.1.1 In order to render the report more accessible, the elements of the detailed terms of reference appended to this report have been summarised in this section and the performance of each agency relevant to that element evaluated. The broader learning that emerges is outlined in section 5.

#### **AWARENESS / SENSITIVITY TO NEEDS OF CHILDREN ?**

##### **Homerton University Hospital NHS Foundation Trust (medical and community services)**

- 4.1.2 Hospital and community staff remained unaware of the criminal history of both parents and were therefore dependent upon clinical observations and information provided by GP or Children's Social Care. Because the possible bruising noted at the first presentation in June 2015 of the then non-mobile child M faded soon after admission, no skeletal survey was completed (as anticipated by the Royal College of Paediatrics and Child Health (RCPCH) *Child Protection Companion* 2013).
- 4.1.3 In the view of the authors of the Trust's report, the 2<sup>nd</sup> presentation of child M would have benefitted from a discussion with the named or designated doctor for safeguarding and presentation at a safeguarding peer review. They highlight the fact that such an arrangement had been introduced into the Paediatric Department in June 2015.

#### **GP Service**

- 4.1.4 Whilst GPs appear to have been attentive to the needs of mother at the times she sought help, it is less clear to what extent they considered the needs of her dependent children and what implications mother's health-related condition / conduct might have for either child. For example the referral for a paediatric view of sib.1's gross obesity was not followed up with any rigour. Nor was the implication for very young children of mother's (and accompanying partner's) threatening manner at the consultation in early 2015, recognised.
- 4.1.5 The absence of any response in Summer 2015 and submission of outdated material to Children's Social Care when asked for a report to inform its review conference in 2016, suggests insufficient regard for the welfare of the children who were known to be vulnerable and by late 2015, subject of child protection plans.



## **National Probation Service (NPS)**

- 4.1.6 The probation officer maintained an active interest in father's role as a partner and parent throughout the period under review. However, he overlooked from November 2014 to January 2016, the implication of this relationship for sib.1 and the then unborn child M. NPS safeguarding policy and procedures required him (on the basis of the drug-related offences) to alert Children's Social Care. The reported domestic abuse further reinforced the need to involve that agency.
- 4.1.7 A home visit (intended but not accomplished) would have rendered the children more than just names and accounts from the father / step-father. Similarly, had a 'Spousal Assault Risk Assessment' (SARA) been completed it might have highlighted the associated risk to children in the context of domestic abuse between parents.

## **Metropolitan Police Service**

- 4.1.8 It seems likely that there was no child present at the Summer 2014 parental altercation, hence no 'Merlin' notification triggered. On the other occasions that the family came to notice, the required notifications were sent. Police also supplied routine information and updates to the initial and review child protection conference.

## **Children's Social Care**

- 4.1.9 Enquiries made at the time of child M's 2<sup>nd</sup> observed injuries in Autumn 2015 illustrated a sensitive awareness of the possibility that sib.1 really knew nothing of the circumstance triggering child M's injuries or was being primed to adopt that position.
- 4.1.10 The newly allocated consultant social worker and independent conference chair showed recognition of the children's needs at the initial child protection conference in 2015. They put on record that they were unconvinced by the father's changing accounts, were aware that mother sometimes told professionals what she thought they wanted to hear and recognised therefore, the risks that remained for the children. However the record of the discussion (and the emerging protection plan) suggest some 'cognitive dissonance' i.e. – a discomfort arising from not knowing whether injuries to that date had been non-accidental and (in order to resolve that discomfort) a preference to regard and report the incidents as 'accidental'.
- 4.1.11 Contact levels with the family (and with sib.1 at nursery school) were good and significant efforts made to engage with and encourage sib.1 to contribute.
- 4.1.12 Sib.1's voice was effectively silenced in early June 2016 when SW3 was told and apparently accepted that the child was not allowed to talk about the home and when *only* positive comments were made about the step-father.

## **ASCERTAINMENT OF CHILDREN'S EXPERIENCES ?**

### **Homerton University Hospital NHS Foundation Trust (medical and community services)**

- 4.1.13 Insofar as child M was and remained 'pre-verbal' throughout the period under review, an understanding of the child's experiences was of necessity derived from direct and indirect / reported observations. These were adequately represented by hospital and community professionals at core groups and conferences.

#### **GP Service**

- 4.1.14 Though sib.1 and child M were seen on a number of occasions at the GP Practice and relevant diagnoses made, few observations were captured (or anyway reported to the serious case review). Records refer for example to a 'well and happy child' but none offer elaboration about behaviours in the (known) context of children subject of child protection plans.

#### **National Probation Service (NPS)**

- 4.1.15 In consequence perhaps of a lack of training coupled with inexperience, the probation officer may have lacked certainty about the subject areas that were (or should have been) of common interest between NPS and Children's Social Care. Even when in early 2016 there was mutual awareness of each agency's involvement, there remained insufficient focus on the implications for each child of father's behavioural history and relationship with the mother of sib.1 and child M.

#### **Children's Social Care**

- 4.1.16 Social work staff were observant of and appropriately recorded the mother-child interactions and relationship. In the course of the assessment completed in 2014, sib.1 was helpfully seen alone as well as with mother and SW1 commendably sought the views of the birth father in order to better evaluate the child's obesity.
- 4.1.17 Staff also drew on the observations of nursery staff whose opportunity to get to know sib.1 was naturally greater. It is regrettable that the proposed joint health visitor / social worker home visit in June 2014 did not take place. It might have offered further insights into the actual experience of sib.1 and child M.
- 4.1.18 Sib.1's report in early June 2016 of not being allowed to talk about home should not have been accepted without challenge of the parents. It may have been that the level of (justifiable) suspicion about the 'lived experiences' of the children had been lowered by the positive reports provided by those who had completed 'parenting support work'.

## **KEY POINTS / OPPORTUNITIES FOR ASSESSMENT & DECISION-MAKING**

### **Homerton University Hospital NHS Foundation Trust (medical and community services)**

- 4.1.19 The 2 A&E presentations of child M aged less than 6 months in the context of sole care of father represented the key opportunities for assessment and decision making. During the second such event, there was a clear recognition of risk leading to a safeguarding agreement pending a completed social care assessment.
- 4.1.20 Had a strategy discussion / meeting been held on this occasion it seems likely that at least the recent history of domestic abuse (if not father's earlier serious criminal history) would have been recognised and factored into professional thinking.

### **GP Service**

- 4.1.21 Within the review period, the most substantive opportunity for the GP Practice centred around the paediatric referral. This offered the possibility of excluding alternative diagnoses and enabling the GPs and health visitors to focus on the quantity and quality of food being provided to sib.1 (and indeed child M).
- 4.1.22 The Practice could also (potentially) have gained a more holistic appreciation of both children's health needs if it had actively contributed to either child protection conference.

### **National Probation Service (NPS)**

- 4.1.23 The probation officer PO1 appears to have been unaware of his agency's expectation that he alert Children's Social Care when father reported in Autumn 2014 that his partner was pregnant with his child.
- 4.1.24 The report supplied by the National Probation Service explains the expectations of officers' responses when a client on licenced release commits further offences. The report points out that in the context of a lengthy delay before the Crown Prosecution Service decided *not* to charge with respect to the class A drugs, the possibility of a 'licence warning' should have been considered.
- 4.1.25 In January 2016, when PO1 became aware of the domestic abuse and father's possession of cannabis (he had been claiming not to use this drug) contact was appropriately made with Children's Social Care.

### **Children's Social Care**

- 4.1.26 The need for an assessment in early Autumn 2014 and re-assessment in 2015 (by the same staff) was clearly recognised. A strategy meeting at the time of child M's first A&E presentation would have been useful.

- 4.1.27 Though the convening of a strategy meeting following child M's second presentation was delayed, it provided an effective response and triggered the required initial child protection conference.

#### **DID ACTIONS ACCORD WITH ASSESSMENTS / DECISIONS ?**

##### **GP Service**

- 4.1.28 The January 2015 consultation during which the doctor felt threatened by the parents offered (though it was not recognised as such or acted upon) a useful insight into the children's lived experiences.
- 4.1.29 Given the extensive experience of mother's reluctance to address sib.1's obesity, the GP Practice should also have acted more decisively in pursuing the long overdue report of the paediatric assessment of December 2015.

##### **National Probation Service**

- 4.1.30 PO1's appropriate decision made in Summer 2015 to complete a home visit to father (which might have clarified where he really lived) was not followed through.
- 4.1.31 Though it had been PO1's initiative that had triggered the inter-agency communication with Children's Social Care (and that agency's responsibility to invite him to contribute to protection conferences), he could have been more active in pursuing during June 2016, liaison with SW3.

##### **Children's Social Care**

- 4.1.32 Staff showed a high level of commitment in their assessment of need and in their attempts to encourage sufficient engagement and delivery of clearly much needed services.
- 4.1.33 The value of the child protection plan developed in consultation with partner agencies, was inevitably limited because it did not explicitly address the possibility of non-accidental injury and how that risk might be mitigated.
- 4.1.34 The value of communication between health visitors and social work staff was inevitably reduced when in the period preceding child M's birth, mother maintained her refusal to engage with the Health Visiting Service.
- 4.1.35 Whilst there existed amongst some staff a wholly justified level of scepticism about mother's honesty or openness, there was relatively little challenge of her deceitful assertions.

## **ISSUES IN COMMUNICATION / INFORMATION SHARING ETC IN & OUT OF OFFICE HOURS ?**

### **Homerton University Foundation Trust & Children's Social Care**

- 4.1.36 Until child M's third presentation to A&E in June 2016 there had been no issues linked to any 'out of office hours' constraint. On that occasion, though SW3 had notified Police of mother's report of an injury while child M had been in father's care, she had not forewarned the hospital (nor it is presumed, her agency's Emergency Duty Team EDT).
- 4.1.37 Child M arrived at the hospital at 16.13 on 23.06.16 but was not examined by a paediatrician until 19.30. EDT was then immediately involved and subsequent liaison between them, medical staff and family was efficient.

## **WAS PRACTICE SENSITIVE TO RACIAL, CULTURAL, LINGUISTIC & RELIGIOUS IDENTITY ?**

### **All involved agencies**

- 4.1.38 Records of individual family members capture their age, gender and ethnicity but none record their preferred language.
- 4.1.39 Mother's immigration status was noted in the records of Children's Social Care but its implications for her or her children had been addressed only by means of a suggestion that she seek specialist advice (if such advice was later shared with staff, it was not included in reports of completed assessments of need submitted to this review).

## **WERE SENIOR MANAGERS / OTHER ORGANISATIONS INVOLVED WHEN NEEDED ?**

### **All involved agencies**

- 4.1.40 Members of the hospital team were not invited to the initial child protection conference of October 2015 and the probation officer was not included in those invited to contribute to the review conference in February 2016 though his involvement was by then known. The issue of which agencies or professionals may be relevant inevitably needs to be determined on a case-by-case basis.
- 4.1.41 Within Children's Social Care, there were regular reviews within the Units dealing with the case as well as involvement of experienced consultant social workers. EDT had also appropriately sought advice from senior management at the time of child M's Autumn 2015 presentation.
- 4.1.42 The GPs' source of challenge or reflection was limited to the link meetings with health visitors, though the author has been assured that the opportunity for routine and regular case reflection is now available across all Hackney-based GP Practices. The health visitors made use of safeguarding supervision from the named nurse.

#### **4.1.43 WAS WORK CONSISTENT WITH AGENCIES' & LSCB POLICY & PROCEDURES ?**

##### **All involved agencies**

4.1.44 Aside from the absence of and delay in convening strategy discussions, other response within Children's Social Care was consistent with London's Child Protection Procedures.

4.1.45 Some actions taken by the allocated probation officer and which are specified in the above report were inconsistent with his agency's policies or procedures i.e. not reporting to Children's Social Care father's acknowledged paternity of child M; not completing a home visit; not capturing the Police account of the class A drugs-related incident; not recording the rationale for the decision made not to recall father to prison and not completing a 'SARA'.

#### **ORGANISATIONAL DIFFICULTIES E.G. LACK OF CAPACITY (STAFFING OR RESOURCES)?**

##### **All involved agencies**

4.1.46 The absence (since February 2015) of a designated doctor for safeguarding children denied the named doctor at hospital 1 what would otherwise have been routine supervision.

4.1.47 No such organisational deficits have been identified in any other involved agency, though it seems that there was an unmet need for training within Probation and the GP Practice.

## 5 CONCLUSIONS

5.1.1 In spite of considerable commitment and the persistence of many professionals in this very difficult case, there are several examples of familiar systemic weaknesses.

### AVOIDANCE & DISGUISED COMPLIANCE

5.1.2 Examples of parental avoidant behaviour or 'disguised compliance:'

- Mother's apparent 'agreement' in July 2014 at the nursery and subsequent failure to follow up the GP referral to the Paediatric Clinic later that month
- A pattern of non-attendance at agreed health appointments and failure (of father as well as mother) to attend pre-arranged meetings with Children's Social Care staff
- Mother's agreement then failure to follow up and use the two sources of advice about nutrition / diet
- Deceptive reassurances in December 2014 that mother had reversed her negative stance and *would* accept health visiting support and advice
- Mother omitting to mention to her GP in June 2015 to child M's first suspicious presentation to A&E only 2 days earlier
- (Having accepted Midwifery Services) a refusal in September 2015 to accept routine tests or make use of standard prophylactic medication
- Attempts in early 2016 to accept only 'pre-arranged' (more easily avoided) visits from the allocated social worker

### INSUFFICIENT PROFESSIONAL CURIOSITY / CHALLENGE

5.1.3 On occasions a more robust challenge would have been justified:

- The GP Practice was well positioned (mother's frequency of use and level of engagement seems to have been higher than with other professional sources) to make good use of the trust extended and to link events / professional concerns, challenge discrepant accounts and form and share a holistic view of risk
- Mother's report that her mother would not allow home visits by Children's Social Care required exploration and challenge
- Acceptance of father's positive test for cannabis in spite of his repeated reassurances of 'no use around the children'
- Establishing the extent to which father was actually staying with the mother of child M not his required residence with his own grandmother
- The vulnerability arising from mother's NRPF status and the extent to which it rendered mother more dependent upon her partner might usefully have been further explored

## **OPTIMISM**

5.1.4 There were examples when professional responses appeared more positive than available evidence would suggest:

- The assessment of November 2014 capturing mother's misleading account of her domestic abuse in April and end of her relationship with her unborn baby's father
- The hope shared by health visitor, GPs and social workers that mother would in due course come to appreciate that sib.1's weight was likely to be harmful
- PO1's acceptance of the accounts provided by father, not following up his useful initial contact with Children's Social Care and not completing an intended home visit
- The medical assessment at child M's 2<sup>nd</sup> A&E presentation
- The absence of conclusive evidence confirming non-accidental injury led participants at the initial child protection conference to give insufficient consideration to which protective measures might be required if a risk of deliberate harm existed e.g. supervision of contact was left with a mother known to be unreliable and non-protective
- The decision made by the Probation Service (for which the rationale may have been that father was not going to be charged in relation to his arrest in Summer 2015) not to recall him to prison

## **LEARNING & SERVICE IMPROVEMENT OPPORTUNITIES**

5.1.5 The narrative and commentary on professional practice in section 4 has identified scope for improvement in the following areas:

- The ability of professionals to hold in mind the possibility of accidental and non-accidental injury rather than resolving discomfort / uncertainty by moving to an insufficiently-informed conclusion
- GPs' appreciation of child protection processes (by means of more effective information sharing, more reflective supervision and linking the impact of an aggressive parent to its implication for a dependent child)
- More robust and explicit safeguarding documentation e.g. body maps from the hospital Paediatric Department even in cases not progressing to s.47 enquiries
- A shared and clear appreciation of the required responses if parent/s within family cases closed to Children's Social Care, subsequently



refuse to or insufficiently honour commitments to co-operate with universal services

- A heightened recognition of and a greater readiness in Children's Social Care to identify and involve all relevant professionals at forums e.g. child protection conferences
- Confidence in the lawfulness and expectations of information sharing
- Ensuring that probation officers are up to date with safeguarding training and have associated confidence in risk assessments and liaison with Children's Social Care
- A clearer appreciation across the network of the role and expectations of probation officers

## **THEMES ANTICIPATED BY THE SCR SCOPING GROUP**

5.1.6 The 'scoping' group had at its meeting in September 2016 asked that agencies consider the following anticipated themes as they formulated responses to the elements of the appended terms of reference:

### ***Communication: was this clear within and across agencies?***

5.1.7 There was scope for improved efficiency in record-keeping and responsivity to information—requests within the GP Practice though the use of regular link meetings for GPs and health visitors was commendable. Perhaps if, aside from sib.1's weight, the wider variety of concerns had been shared more explicitly with the GP Practice, medical staff might have felt encouraged to think in a more 'whole family' manner e.g. information known to the GP Practice (and Probation) records suggested a more full-time and ongoing parental relationship than was offered by parents to either health visitors or social workers.

5.1.8 The most substantive communication difficulty was that there remained an unawareness of father's serious and extensive criminal record (in particular licenced prison release) from mid-2014 until January 2016 when PO1 contacted Children's Social Care.

5.1.9 It appears that the reasons for the above difficulty are that the original Children's Social Care assessment did not include Police checks on the then unidentified father. The extremely comprehensive material supplied by the MPS for the protection conference in November 2015 *did* include references to lengthy periods of imprisonment. This, an apparently early release and the fact that he remained on license were not extracted from the large volume of material provided, recognised as significant and discussed.

5.1.10 Communication of relevant facts would have been more efficient and decision-making better informed, if Probation had been invited to contribute to the child protection conferences and share relevant information with the safeguarding network.

- 5.1.11 Whilst the GPs' 'flagging' of vulnerability and incorporation of conference records into medical records were helpful practices, the local practice of setting up individual records of new-borns at the time of their 6 week 'baby checks' is not helpful. It runs the risk of overlooking an A&E attendance of a neonate.
- 5.1.12 During child M's second hospital admission, the documented opinion of the paediatric consultant was insufficiently clear with respect to whether the injuries should be regarded as 'accidental', 'non-accidental' or 'unexplained'. At child M's discharge the record suggests 'accidental while the discharge summary sent to the GP suggests 'unexplained'.
- 5.1.13 With respect to child M's latter presentation to A&E, SW3 should have alerted the hospital to the anticipated arrival of the child.

***Understanding: was there an agreed and complete understanding of risk across involved agencies?***

- 5.1.14 The feeling of discomfort / threat felt by the GP at a consultation by mother and child M's father in February 2015 should have triggered a concern about the lived experience of sib.1 and child M as highlighted in Ofsted's 2011 publication<sup>9</sup>.
- 5.1.15 The risk associated with childhood obesity (as well as exposure to domestic abuse) was recognised by the health visitor allocated in 2014.
- 5.1.16 The probation officer (who qualified in April 2016) has reported he cannot recall receipt of safeguarding children training which is surprising and of concern.

***Practice: was practice and intervention within and across agencies appropriate and proportionate to identified concerns ?***

- 5.1.17 Whilst other biographical detail was captured, most agencies seems to have omitted to confirm any religious affiliation or preferred languages.
- 5.1.18 The initial decision within Children's Social Care in Autumn 2014 to complete an assessment was prompt and appropriate (though under-informed because the referring health visitor had not noted and probably not known father's name). At child M's 2<sup>nd</sup> A&E presentation in Autumn 2015 the required strategy discussion was belated and non-compliant with London's Child Protection Procedures.
- 5.1.19 The response to father by Housing and Children's Social Care in Summer 2015 may not have taken sufficient account of 'parental responsibility' (records provided are unclear with respect to whether father was named on child M's birth certificate and thus enjoyed parental responsibility).

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<sup>9</sup> Report summary: The voice of the child: learning lessons from serious case reviews – a thematic report of Ofsted's evaluation of serious case reviews from 1 April to 30 September 2010

- 5.1.20 The decision to make both children subject of child protection plans (though done without key information held by Probation) was sufficiently well-informed, prudent and proportionate to the known circumstances. The subsequent plan was based though upon a mistaken presumption that non-accidental injury had been ruled out as a potential risk.
- 5.1.21 The probation officer was at risk of under-estimating the risk to mother and children when he did not seek from Police further information to enable completion of a 'Spousal Assault Risk Assessment' (SARA).
- 5.1.22 The knowledge gained in 2016 that Probation was involved with father should have triggered further exploration by Children's Social Care.
- 5.1.23 Provision of 'parenting support' was justified and reported to have improved parenting skills, but could not of itself, prevent abuse.

## 6 RECOMMENDATIONS

### CITY & HACKNEY SAFEGUARDING CHILDREN BOARD (CHSCB)

- 6.1.1 CHSCB should seek reassurances with respect to the responses of non-statutory services in dealing with poor or non-engagement following case closure by Children's Social Care (by 30.09.17).
- 6.1.2 CHSCB should also seek reassurances from member agencies that there exists, or is being developed sufficient:
- Clarity and confidence about the circumstances in which 'personal data' may lawfully be sought from other sources with and without consent (by 30.09.17)
  - Appreciation of the role and working practices of Probation Service Providers (by 30.09.17)
- 6.1.3 CHSCB should develop and disseminate best practice guidance to:
- Support practitioners working with avoidant families, frequently fluctuating circumstance and disguised compliance
  - Enhance confidence within professional networks in the context of 'respectful uncertainty'<sup>10</sup> / 'cognitive dissonance'<sup>11</sup>, to develop plans and interventions which respond to the possibility of deliberate harm even in the absence of conclusive evidence
  - Remind practitioners of the need to remain aware of the significance of bruising in pre-mobile children (as per section 3.9 London Child Protection Procedures 5<sup>th</sup> ed. 2016) (by 30.09.17)
- 6.1.4 The CHSCB should also seek reassurance that network checks are comprehensive and engage all key partners at the point of a referral to FAST [by 31.07.17]

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<sup>10</sup> Respectful uncertainty = In his 2003 inquiry report into the death of Victoria Climbié, Lord Laming used the phrase 'respectful uncertainty' to describe the attitude social workers need to strike in trying to spot an abuser (viz: maintaining some scepticism and mistrust about what might really be happening behind closed doors). (John Dewey explained the respectful uncertainty principle well much earlier (1910)... 'genuine ignorance is profitable' ... 'because it is likely to be accompanied by humility, curiosity, and open mindedness'.

<sup>11</sup> Cognitive dissonance = the mental stress (discomfort) experienced by a person who simultaneously holds two or more contradictory beliefs, ideas, or values; when performing an action that contradicts existing beliefs, ideas, or values; or when confronted with new information that contradicts existing beliefs, ideas, and values

## **CITY & HACKNEY CLINICAL COMMISSIONING GROUP (CCG)**

6.1.5 The CCG should ask GP Practices to:

- Separate maternal and baby records at birth (a temporary file for the baby should be set up on the system) and triangulate them at the joint mother and baby post-natal checks (by 30.09.17).
- Establish and maintain a summary of safeguarding concerns within GP EMIS records (by 30.06.17)
- Ensure that 'child in need' 'Read codes' are placed in records (by 30.09.17)

6.1.6 The CCG should re-issue the 2016 'Safeguarding Children & Young People Resource Pack (2016) (by 31.07.17).

## **HOMERTON UNIVERSITY FOUNDATION TRUST**

6.1.7 Child protection documentation relating to acute services should be strengthened by requiring full completion of child protection medical reports regardless of the conclusions of the associated enquiries (by 31.07.17).

6.1.8 A protocol should be developed with relevant hospitals so as to make explicit the expectation of a written medical discharge summary if a child presents with a suspected non-accidental injury (by 31.07.17).

## **NATIONAL PROBATION SERVICE**

6.1.9 The 'Head of Cluster' should confirm that all relevant staff have completed / are scheduled to complete safeguarding training required by current policy (by 30.09.17) and initiate any required response

6.1.10 Guidance on the criteria for reviewing OASys risk assessments should be re-issued and a sample of relevant cases audited (by 31.07.17) and any further required steps taken (by 30.09.17).

## **HACKNEY CHILDREN'S SOCIAL CARE**

6.1.11 In accordance with *Working Together to Safeguard Children 2015* and London Child Protection Procedures, Children's Social Care should take steps to ensure the involvement of relevant professionals e.g. paediatricians / relevant other health professionals in strategy discussions about suspected non-accidental injury (by 31.07.17).

## **HACKNEY CHILDREN'S SOCIAL CARE & NATIONAL PROBATION SERVICE**

6.1.12 In the context of the current wider review of information sharing process across London, these agencies need to jointly achieve clear operational arrangements for information exchange [by 30.09.17]

## 7 BIBLIOGRAPHY

- Improving safeguarding practice, Study of Serious Case Reviews, 2001-2003 Wendy Rose & Julia Barnes DCSF 2008
- Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial study of serious case reviews 2003-2005 Marian Brandon, Pippa Belderson, Catherine Warren. David Howe, Ruth Gardner, Jane Dodsworth, Jane Black, DCSF 2008
- Learning Lessons, Taking Action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008 Published December 2008
- The Child's World Jan Horwarth Jessica Kingsley 2008
- Learning Together to Safeguard Children: A 'Systems' Model for Case Reviews March 2009 SCIE
- Healthy Child Programme DH 2009
- A Study of Recommendations Arising from Serious Case Reviews 2009-2010 M Brandon, P Sidebotham, S Bailey, P Belderson University of East Anglia & University of Warwick
- Understanding Serious Case Reviews and their Impact a Biennial Analysis of Serious Case Reviews 2005-07 Brandon, Bailey, Belderson, Gardner, Sidebotham, Dodsworth, Warren & Black DCSF 2009
- Building on the learning from serious case reviews: A two-year analysis of child protection database notifications DfE – RR040 ISBN 978-1-84775-802-6 2007-2009
- Working Together to Safeguard Children, HM Government 2010, 2013 & 2015
- Ages of Concern: learning lessons from serious case reviews: a thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011
- Munro Review of Child Protection: A Child-Centred System TSO [www.tsoshop.co.uk](http://www.tsoshop.co.uk) Professor Munro 2011
- Learning together to safeguard children: a systems model for case reviews SCIE January 2012
- New learning from serious case reviews: Marian Brandon et al RR226 DfE 2012
- Improving the Quality of Children's Serious Case Reviews Through Support & Training@ NSPCC, Sequili, Action for Children; DfE 2013 (revised Feb. 2014)
- Multi-Agency Working and Information Sharing Project HOME OFFICE Final report July 2014
- JUDICIAL REVIEW; (R (AB and CD) v Haringey London Borough Council (2013) EWHC 416 (Admin)
- Festinger, L. (1962). 'Cognitive dissonance'. Scientific American. 207 (4): 93–107. doi:10.1038/scientificamerican1062-93 .

# TERMS OF REFERENCE

## INTRODUCTION

The trigger event, process of initiating the SCR, membership of the nominated review group and the scope of the review are described in section 1 of this overview.

The remaining text describes the required approach and methodology.

## APPROACH TO THE REVIEW

Building on learning from previous cases, the objective of this review is to consolidate learning about what is working well and what presents challenges to organisations both child and adult-facing. We will do this in line with the principles for learning and improvement in *Working Together 2015 (para.4:11)* as outlined below.

SCRs and other case reviews should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight
- Is transparent about the way data is collected and analysed and
- Makes use of relevant research and case evidence to inform the findings

Agencies will be asked to comment specifically on:

- Communication – Was communication clear within and across involved agencies?
- Understanding - Was there an agreed and complete understanding of risk across involved partner agencies?
- Practice - Was practice and intervention within and across agencies appropriate and proportionate to the identified concerns?

Contributing agencies should have regard, where applicable, to the following issues:

1. Were practitioners aware of and sensitive to the needs of the child in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
2. When, and in what way, were the child's experiences ascertained and taken account of when making decisions about the provision of services? Was this information recorded?
3. What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way? Did you agency liaise/engage appropriately with other agencies?
4. Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments and was the family signposted to appropriate support?
5. Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
6. Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?
7. Were senior managers or other organisations and professionals involved at points in the case where they should have been?
8. Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
9. Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
10. Was there sufficient management accountability for decision making?



## METHODOLOGY

The review will take a forensic, evidence-based approach. The reviewer will draw on agencies' written reports, the integrated chronology and key documents from case files. Drawing on information submitted, the agency lead and review group members will meet with practitioners both individually and as a group in order to better understand why decisions were made.

From the pooling of this intelligence, the reviewer will identify areas of good practice and areas of actual or latent vulnerability within our systems.

## TIMESCALES

<b>Milestone</b>	<b>Date/deadline date</b>
SCR agreement date	06 <sup>th</sup> September 2016
Scoping Meeting (+ chronologies produced)	12 <sup>th</sup> September 2016
First Review Panel Meeting	13 <sup>th</sup> October 2016
Submission of first draft agency IMRs	18 <sup>th</sup> November 2016
First Practitioners Focus Group	22 <sup>nd</sup> November 2016
Submission of final agency IMRs	09 <sup>th</sup> December 2016
Second Review Panel Meeting (+ IMR authors)	06 <sup>th</sup> January 2016
Submission of first draft overview report	13 <sup>th</sup> January 2017
Third Review Panel Meeting (+ IMR authors)	26 <sup>th</sup> January 2016
Submission of second draft report	31 <sup>st</sup> January 2017
Second Practitioners Focus Group	02 <sup>nd</sup> March 2017
Submission of third or final draft report	13 <sup>th</sup> March 2017
Fourth (final) Review Panel Meeting	29 <sup>th</sup> March 2017

## FAMILY INVOLVEMENT

Family members will be notified and provided with the opportunity to contribute to the review insofar as it does not impact on any ongoing legal proceedings.

## QUALITY ASSURANCE PROCESS

Chronology work and agency IMRs will be shared with members of the Review Panel. The final report will be quality-assured on behalf of the CHSCB by the SCR Sub-committee and signed off by the Executive Group and the Independent Chair on behalf of the CHSCB who have agreed to delegate this action.

## **ACTION PLANS**

As necessary, agencies will be required to submit an action plan detailing recommendations for improvement. Action Plans are monitored by the SCR Sub-Committee until all recommendations are implemented and then reviewed annually to ensure still in place.

Where lessons are able to be identified during the process they will be acted upon as quickly as possible without waiting for the review to be completed.

## **DISSEMINATION OF LESSONS LEARNED**

The findings from this review will be considered alongside learning from previous reviews undertaken by the CHSCB and findings from relevant research. The following arrangements are proposed for the dissemination of lessons learned from this review:

- A series of multi-agency briefing sessions
  - Development and circulation of training materials
  - Key themes circulated via social media and monthly 'Things You Should Know' (TUSK) briefings and
  - Further arrangements to be made during the process of the review
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