LONDON BOROUGH OF WALTHAM FOREST

LOCAL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

Executive Summary

CHILD Z

07.10.09

CONTENTS

1 INTRODUCTION

1.1 BACKGROUND TO SERIOUS CASE REVIEW

1.1.1 Child Z (a two and a half year old girl) was of white British heritage and the only child of her mother Ms Y and father Mr X. The family lived in Waltham Forest and were without the support of any nearby extended family as both parents originated from elsewhere in the United Kingdom.

1.1.2 Child Z was disabled, and had a presumed genetic condition resulting in global developmental delay. She required a high level of care.

1.1.3 Child Z's mother is a health professional though appears not to have worked during the period of this review having experienced difficulties reconciling her work and care of a disabled child. Child Z's father also experienced some difficulties reconciling his employment with the need to support Ms Y and child Z.

1.1.4 Ms Y reported that in May 2009 she left child Z alone in the bath for a minute or two; she heard a cry and returned to find her under the water and not breathing. Ms Y reportedly initiated resuscitation of her daughter, dialled emergency services and following further on site treatment from road and air based paramedics, child Z was admitted to hospital.

1.1.5 Child Z was later transferred to the intensive care unit and remained on a ventilator until four days later, when life support was withdrawn, with parental agreement, and life pronounced as extinct.

1.1.6 Prior to her death, child Z and her family had been in receipt of a range of universal and targeted specialist health and welfare related services.

1.2 REPORT CONTRUCTION

1.2.1 The remainder of this document contains:

- An explanation of the review process
- An overview of agencies' involvement during the period of this review
- A summary of findings arising from the detailed analysis provided to Waltham Forest's Safeguarding Children Board in the full overview report and of lessons learnt
- Recommendations for action within prescribed time limits by Waltham Forest's Safeguarding Children Board and its member agencies

2 REVIEW PROCESS

2.1 INITIATION OF SERIOUS CASE REVIEW

2.1.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake reviews of serious cases in accordance with procedures set out in chapter 8 of government's statutory guidance '*Working Together to Safeguard Children*'[1].

2.1.2 A serious case review should be initiated if a child has died and abuse or neglect is known or suspected to be a factor in that death. Its purpose is to:

- 'Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result and
- As a consequence, improved inter-agency working and better safeguard and promote the welfare of children'

2.1.3 Serious case reviews are not inquiries into how a child dies or who is to blame. These are matters for Coroners and for criminal courts. At the time of writing (05.10.09), the outcome of a Police investigation is not known and the circumstances of this tragedy have yet to be fully clarified.

2.1.4 The day after the reported death of child Z, the chair of Waltham Forest's Safeguarding Children Board decided to convene the Board's serious case review panel so as to consider the case. In June 2009 the panel determined that the criteria set out in '*Working Together to Safeguard Children'* 2006 were satisfied and recommended that a serious case review be completed. This recommendation was agreed later that day by the chair of the Board.

2.2 INVOLVEMENT OF LOCAL AGENCIES

2.2.1 The serious case review panel identified the following agencies as having potential information and opinions of relevance to the review:

- Primary Health Care: NHS Waltham Forest & Outer North East London Community Services (ONEL) – commissioning GP and providing health visiting services
- Secondary Health Care: London Ambulance Service (LAS), local Hospital, Child Development Centre (CDC) and a Parent Infant Mental Health Service of the North East London Foundation Trust – (PIMHS) respectively providing emergency medical aid and transport, emergency medical treatment, multi professional expertise on child development, and psychological / psychiatric parental support

[1] *Working Together to Safeguard Children* HM Government (2006) London: The Stationery Office

- Waltham Forest Council Children and Young People's Services (CYPS) (providing children and families', special education and Portage services)
- Metropolitan Police Service (MPS) (completing investigative and protection-related responses)
- A Barnardo's Project which provided a 'sitting' service in the family home
- A National Specialist Hospital additionally had potentially relevant information

2.3 INDEPENDENCE

2.3.1 The need for sufficient independence of panel membership to enable debate and challenge was recognised and the following arrangements made.

PANEL MEMBERSHIP

2.3.2 Members of the serious case review panel, none of whom had had any involvement with child Z or her family were determined as follows:

- Independent Chair: Deputy Director Children & Young People's Service (London Borough of Hackney)
- Group Manager Protection Partnership & Plans LBWF
- Head of Education for Communities LBWF
- Designated Doctor ONEL Community Services
- Acting Detective Inspector (Metropolitan Police Service) until end of August 2009
- Detective Inspector (Metropolitan Police Service) from September 2009
- Legal Department LBWF
- Interim Designated Nurse Child Protection NHS WF until end July 2009
- (Designated Nurse Safeguarding NHS WF from August 2009

2.3.3 The LSCB manager and administrator supported the review process.

INDIVIDUAL MANAGEMENT REVIEWS

2.3.4 Local managers who had had no direct responsibility for child Z or her mother were identified and completed 'individual management reviews' of the involvement of their respective agencies, consisting of a chronology and report. The Metropolitan Police Service's (MPS) management review was authored by one of the MPS Specialist Crime Review Group.

OVERVIEW AUTHORSHIP

2.3.5 CAE Ltd (Edina Carmi and Fergus Smith) was commissioned to complete a critical overview of all these individual agency reviews for approval by the panel and subsequent ratification by the Safeguarding Board.

2.4 SCOPE

2.4.1 It was agreed that the review was to cover the period from the point of the confirmed pregnancy of child Z's mother's to the day of her child's admission to hospital.

2.5 FAMILY INVOLVEMENT

2.5.1 On advice from Police and Crown Prosecution, it was determined that, although enquiries by the Coroner and Police were proceeding, it would not interfere with these parallel processes if the parents of child Z contributed directly to this serious case review.

2.5.2 Accordingly, the overview authors met Ms Y and Mr X at their home and their experiences are reflected in the larger report and in this executive summary.

2.6 STAFF INVOLVEMENT

2.6.1 Most individual management review authors undertook interviews with relevant staff involved with the family so as to be able to obtain a clearer account of what involvement there had been and why actions and decisions were or were not taken.

2.7 RECOMMENDATIONS & ACTION PLANS

2.7.1 Each agency individual management review agreed recommendations for improving its service delivery and developed action plans for implementation of those recommendations. Most have already been at least partially completed and all recommendations from the individual management reviews scheduled for full implementation [at the latest] by July 2010.

2.7.2 The overview report, agreed by the Panel on 21.09.09 and the LSCB on 01.10.09, introduced some new recommendations and amendments to those within individual management reviews. The amendments:

- Changed individual management review recommendations to make them more specific or effective
- Placed recommendations in the Safeguarding Board section when relevant to more than 1 agency
- Omitted a few individual management review recommendations on the grounds that the action did not emerge from the findings of this case review

2.7.3 An integrated action plan has been produced which details how each recommendation from the overview report has or will be implemented, identifying the responsible person, the progress made and the timescale for its achievement.

2.7.4 All recommendations have already been initiated and nearly all are partially or fully implemented. Recommendations are to be completed at varying dates, but at the latest, by April 2010.

2.8 PUBLICATION ARRANGEMENTS

2.8.1 This executive summary will, subject to advice from the Crown Prosecution Service, be published on Waltham Forest's Safeguarding Children Board website.

3 SUMMARY OF AGENCY INVOLVEMENT

3.1 PREGNANCY & FIRST 3 MONTHS

3.1.1 For much of her pregnancy with child Z her mother, Ms Y felt unwell and unable to work. She had no other children, although had previously had a termination of pregnancy and two miscarriages. It is understood that child Z's father Mr Y was supportive. Little was known of the family as their previous agency contact was limited to the GP surgery.

3.1.2 Child Z was born by emergency Caesarean section following an induction of labour. Mother and daughter were discharged home two days later with no reported problems.

3.1.3 During the post natal period there were no significant concerns about child Z's health or development.

3.2 AGE 3 MONTHS – 6 MONTHS

3.2.1 By the time child Z was aged three months her mother was diagnosed with postnatal depression. She had told her midwife and health visitor that she had previously suffered with depression.

3.2.2 A week later child Z's mother saw her GP again and it was confirmed she was pregnant again.

3.2.3 Around the same time, maternal concerns about child Z's development led to the health visitor's referral to the Child Development Centre. A referral was also made to a Parent-Infant Mental Health Service (PIMHS) following the mother's recognition that she was struggling to cope emotionally with some aspects of parenting a child who had unexplained developmental delays.

3.2.4 When child Z was six months old her mother suffered a miscarriage and continued to feel 'very low'.

3.3 AGE 6 – 18 MONTHS

3.3.1 When child Z was aged 6 months her mother with child Z began attending regular sessions at PIMHS and both mother and health visitor noticed an improvement in the parent –child relationship. All subsequent professional observations of the parenting of child Z were positive, with good interaction noted between mother and baby.

3.3.2 When child Z was aged 7 months the family attended an assessment at the Child Development Centre. This led to extensive medical investigations which established the nature and extent of child Z's disabilities and was continuing attempts to identify specific causes for her developmental delay.

3.3.3 Assessment and support was additionally provided from a variety of allied disciplines to provide occupational therapy aids, to facilitate child Z's development via speech and language therapy and physiotherapy and to provide advice about child Z's feeding difficulties.

3.3.4 By the time child Z was aged 9 months, her mother seemed to have become more optimistic about her daughter's development and child Z was making progress developmentally. This positive perception continued with the health visitor noting child Z was 'doing beautifully' at age 15 months.

3.3.5 Child Z was referred to a specialist educational service which made contact with the family when child Z was a year old and mother and daughter attended a couple of sessions of the support group.

3.3.6 From the age of 14 months, child Z, according to her mother's reports, suffered with 'fits', usually when she had a cold. She attended the local Urgent Care Centre and Accident & Emergency (A & E) in connection with these concerns.

3.3.7 However, throughout this period child Z's mother continued to see her GP for post natal depression and experienced distress when obtaining medical confirmation of the extent of her daughter's disabilities. She also spoke of her exhaustion at attending the numerous appointments for child Z and did not attend those arranged for her own psychological needs.

3.3.8 By the end of this period, child Z's mother was still feeling 'down', reporting to the health visitor that there was no respite and that child Z's father was experiencing difficulties at work.

3.4 OVER 18 MONTHS

3.4.1 During this period the medical investigations into child Z's condition continued, with geneticists undertaking further tests to establish whether child Z had a recognisable syndrome. Child Z's mother reported that her daughter continued to have occasional fits and a chest infection. She was admitted to hospital on one occasion with gastro-enteritis.

3.4.2 Feeding difficulties continued and on at least one occasion child Z's mother reported to the health visitor that she had been 'at the end of her tether' one day the previous week, when child Z would not settle.

3.4.3 The health visitor made referrals for services to provide child Z's parents with respite due to their relative isolation and lack of family support.

3.4.4 Barnardo's service responded promptly and quickly provided an experienced 'sitter' to look after child Z within the family home. This service was provided over the next year and was much appreciated by the family. Like the professionals involved with the family, the experienced 'sitter' who spent considerable periods in the home, had no concerns about child Z's care.

3.4.5 The Disabled Children's Team (DCT) of the local authority after some delay in assessing child Z's needs and those of her parents provided some childminding support until child Z commenced nursery school a few weeks prior to her death.

3.4.6 Child Z was described by the health visitor as making a developmental leap, around the age of 2 years and parents seemed more optimistic. An assessment of her special educational needs was initiated and child Z began visits to a specialist nursery school, linked with the specialist education service. A formal statement of her educational needs was concluded by the end of the Spring term 2009 and child Z commenced nursery school the next term, aged 2.5 years.

3.4.7 Child Z attended school for 5 weeks and was observed to have a 'sunny disposition' and 'quickly form bonds with the staff who worked with her'.

3.4.8 Child Z's mother had continued to feel low during this period, sought help from the GP and was referred for psychological support for herself, although appears not to have taken up the offer. The family were experiencing stress with child Z's father threatened with the loss of his job as he had taken time off work to support his partner and care for child Z.

3.4.9 The first 3 months of 2009 were an extremely difficult period for the family, with child Z's mother experiencing the death of her 3 closest relatives. Child Z's father had eventually lost his job, but was working in these months in a temporary post so unable to provide additional support whilst his partner was visiting unwell members of the family and arranging and attending funerals - all at a considerable distance from the family home.

3.4.10 During these last months must child Z's mother requested additional childminding support, but did not seek help via her GP for depression.

3.4.11 Finally at the point when things may have appeared more settled with child Z at full time nursery, her mother told the health visitor that she was feeling very low, that child Z's father's job was coming to an end that day and she was very concerned about their financial position.

3.4.12 2 days later child Z's mother dialled 999 to report that she had found her daughter under the water in the bath and not breathing.

4 SUMMARY OF FINDINGS

4.1.1 A high level summary of the evidence emerging from this serious case review indicates that child Z's tragic death could not have been predicted by any of those agencies or individuals providing services.

4.1.2 Though there had been no evidence of child protection concerns, there were early indications of potential safeguarding issues with respect to the developing relationship between mother and daughter, possibly arising from maternal depression and the challenge of coming to terms with her daughter's developmental problems

4.1.3 Following prompt intervention to address the relationship difficulties, subsequent observations of child Z and of her care were all positive, with some limited concern arising from the number of cats in the home.

4.1.4 The family was in receipt of a significant level of services from the statutory health, welfare and voluntary sectors, with several examples of excellent practice which were and remain valued by the parents.

4.1.5 There are a number of lessons emerging from this case which would lead to improvements in services to families in these circumstances.

4.1.6 In this case such changes would have led to a better understanding of the parental relationship, parental resilience in the face of accumulating stress and bereavement, mother's mental health and the impact of these factors on the care of child Z. Such improvements might have led to child Z's mother accepting treatment for her depression.

4.1.7 The GP practice worked in isolation from other professionals and repeatedly failed to communicate significant information about Ms Y's history of depression and current post natal depression.

4.1.8 The assessment and delivery of services within the Disabled Children Team (DCT) of CYPS was inadequate, with management weaknesses, partially related to resource constraints.

4.1.9 There was scope across local agencies for enhanced recognition of the combined impact of child disability and parental depression, bereavement and financial stress.

4.1.10 There was scope across local agencies for a more holistic and better co-ordinated assessment and service provision.

4.1.11 As the Police investigation is incomplete and the circumstances of 24.05.09 remain unclear, it is not possible to conclude whether these improvements would have made a significant difference in this case.

5 SUMMARY OF LESSONS LEARNT

5.1 GENERAL / MORE THAN ONE AGENCY

5.1.1 Current research on the impact of postnatal depression and attachment difficulties needs to be routinely used by staff. Whilst there is no evidence of abuse in this family, research demonstrates that depressed parents may neglect important areas of their child's care and the early identification and appropriate input can help a parent to meet parenting responsibilities.

5.1.2 Early identification of disabled children is of critical importance in assisting the child to gain optimum health and development and to provide her/his parents with the appropriate support. This early identification is associated with universal provision of regular input from health visitors.

5.1.3 Once a developmental concern has been identified it is important babies and children are provided with a rapid response via:

- Completion of a Common Assessment Framework[2] (CAF) to provide a holistic understanding of the family history and current circumstances
- Referral to a child development centre
- A multi-agency assessment to facilitate an *early* diagnosis, ensuring that child and her/his carers are provided promptly with appropriate services

5.1.4 The child development centre offers a good multi-disciplinary service but could be further improved through:

- Development of a priority weighting for its assessments, giving priority to identified concerns e.g. parental depression or attachment difficulties
- Routine involvement of social work and education (for children over 2) at developmental assessments and reviews of children with developmental delay, disabilities and/or when there are identified concerns
- Involvement of other involved disciplines / agencies as appropriate
- Appointment of a key worker or lead professional to assist in identifying and co-ordinating all the services for the child

5.1.5 There is a need for GPs to be involved within the professional network, to share relevant information about parental issues and to consider not only the welfare of the adult patients, but the implications of such issues as maternal depression on the child.

5.1.6 Midwives and health visitors need to recognise the lack of communication by GPs of such issues as maternal depression as problematic and report it to the Designated Nurse for Child Protection within their Trust.

[2] *The Common Assessment Framework for children and young people*, Children's Workforce Development Council, 2009

5.1.7 Regular reflective supervision, especially for the health visitor and DCT staff, would have assisted in highlighting the complexity of this case, potential risk factors and the need for a holistic assessment: a CAF and then subsequently a core assessment[3].

5.2 OUTER NORTH EAST LONDON COMMUNITY SERVICES

5.2.1 The Health Promotion Guidelines do not provide sufficient guidance on:

- When a 'centile chart' should be drawn up (additional to that in the parent held Child Health Book)
- Behaviour management issues such as feeding and sleeping problems
- The need for accident prevention / safety advice based on research and a child's developmental stages

5.2.2 The health visitor needs to persevere in communicating with the GP practice, even in the face of a lack of response.

5.2.3 The health visiting records do not help professionals to gain psycho-social information: the document should be formulated in such a manner consistent with the Assessment Framework[4] so aspects of the child's development, parenting capacity and wider social/ environmental details are gathered.

5.2.4 The absence of supporting documentation such as a Centile Chart, genogram and significant events sheet reinforced difficulties in identifying key issues for child Z and her family.

5.2.5 The health visitor should have undertaken a CAF once concerns emerged and used as part of the referral to the child development centre and to the DCT.

5.2.6 There is no documentation to keep a record of the health visitor referrals that were being made and the referral form to the child development centre has inadequate space for the referrer to give all the information on a child.

5.3 CHILDREN & YOUNG PEOPLE'S SERVICES

5.3.1 The DCT duty system needs to be more robust in its response to referrals by requiring completed CAFs for appropriate cases and using the information to guide the next steps.

5.3.2 Because completion of the DCT initial assessment took 3 months to complete, a core assessment was not started and that decisions taken in supervision were repeatedly not implemented, there was an ineffective response to this family's needs. These failures indicate the need for enhanced monitoring, more effective supervision and, most critically, a robust performance management process.

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[3] *Framework for the Assessment of Children in Need and their Families*, Department of Health, 2000
[4] *Ibid*

5.3.3 In addition to the standard practice of all social work services, the DCT should explore the family's view of the child's disability, the meaning that *this* child has in the family, how parents deal with the loss of their hope for a child without disabilities, what supports parents have that help them to be more resilient and which factors might make it even harder for parents to manage an already difficult situation.

5.3.4 The EDT service needs to recognise when they are being given a child protection referral and understand the immediate tasks involved, in this case immediate liaison with Police and a strategy discussion with Police and A&E staff to ensure the safety of the child.

5.4 NORTH EAST LONDON FOUNDATION TRUST (NELFT)

5.4.1 NELFT needs to ensure the good practice in this case is generalised and consolidated across services in the Trust, when appropriate using the Care Programme Approach (CPA) and Common Assessment Framework (CAF).

5.4.2 NELFT was not formally notified of child Z' death which created initial problems about instigation of 'serious untoward incident' procedures and to delays to NELFT contributing to the serious case review process. NELFT needs to be a partner in the established child death overview panel and informed via that system, of all child deaths in the borough.

5.5 LOCAL HOSPITAL

5.5.1 Midwives need to explore a history of miscarriages with pregnant women to help inform ongoing assessment of emotional well-being and adaptation to parenthood.

5.5.2 Police should be informed of near-fatalities in children as soon as it is practicable following their attendance at the hospital; reliance must not be placed on another agency to inform the Police of such incidents.

5.6 NATIONAL SPECIALIST HOSPITAL

5.6.1 Service provision was consistent with contemporary standards of good practice, although there was a delay in providing a letter describing child Z's 1st attendance at the North East Thames Regional Generics Service. This does not need a recommendation as it is picked up through regular review of service compliance with the Trust's communications policy and procedures.

5.7 BARNARDO'S PROJECT

5.7.1 Visits and supervision were reliably recorded but there is a remaining unmet need for records, even in cases with no safeguarding concerns, to:

- Enable the sitter to make records themselves
- Include analytical consideration of the case

- Chart progress and developments
- Ensure information transfer is fluid and coherent
- Demonstrate evidence based decision making
- Provide detailed records of supervision sessions

5.7.2 There is a need for the service and the sitter to be more fully included in the 'team around the child', as they are in the unique position of having informal and relatively intimate access to the child.

6 RECOMMENDATIONS

6.1 INTRODUCTION

6.1.1 Recommendations to Waltham Forest's Safeguarding Children Board emerging from this serious case review have been divided into those requiring action by:

- The LSCB
- Individual member agencies

6.1.2 There are no specific recommendations arising from this serious case review for the specialist hospital, the Metropolitan Police Service or the School and Educational Service.

6.1.3 All recommendations have already been initiated and nearly all are partially or fully implemented. The dates provided (in italics) give the completion date for each recommendation, which includes any planned audits to ensure compliance.

6.2 LSCB RECOMMENDATIONS

6.2.1 The LSCB should ensure that the current good service of the child development centre is enhanced by:

- Use of a CAF by referrers if there is a need for the involvement of more than 1 discipline or any concerns about parenting [*by December 2009*]
- The child development centre to request a CAF in relevant cases (if not already provided) [*by December 2009*]
- Development of a priority weighting for child development centre assessments, which gives priority to babies and children with identified concerns e.g. parental depression, attachment difficulties [*by December 2009*]
- Routine social work involvement at child development centre assessments and reviews of children with developmental delay, disabilities and/or where there are any identified concerns [*by January 2010*]
- Routine involvement of education at child development centre assessments and reviews for children aged 2 and over [*by January 2010*]
- Involvement of other disciplines / agencies as appropriate, including mental health therapists, if there are issues around parental mental health / post natal depression [*by January 2010*]
- Appointment of a key worker or lead professional to assist in identifying and co-ordinating all the services for children [*by January 2010*]
- There should be a review of the databases and electronic systems used within the Specialist Children's Services so as to provide only one health record for each child and staff able to access relevant information

according to the needs of their role, rather that dependent on the identity of their employer. [*by February 2010*]

6.2.2 The LSCB should provide [*by October 2009*] multi-agency training on safeguarding disabled children incorporating:

- The need for early identification
- The vulnerability of the disabled child
- Association between parental depression, disabled children and attachment difficulties
- Issues of loss within family
- The issues arising when parents are professionals, including potential underestimation of concerns and overestimation of resilience
- The need for practical, safety advice to parents of developmentally delayed children (regardless of their professional background)
- The need for holistic assessments, based on the use of the Assessment Framework, including the Common Assessment Framework, initial and core assessments
- The need for a lead professional / key worker to co-ordinate the multi-agency work
- The need to share information and the need to challenge professionals who do not do this, including reporting to designated staff / managers

6.2.3 In order to establish if the practice of EDT in this case is typical an independent audit to be undertaken [*by December 2009*] into the EDT responses to child protection referrals from hospital 1with:

- The sample to be taken from hospital records
- Inclusion of hospital, EDT and police records
- Interviews with staff to establish the cause of any identified lack of appropriate response

6.3 INDIVIDUAL AGENCIES' RECOMMENDATIONS

OUTER NORTH EAST LONDON COMMUNITY SERVICES (ONEL)

6.3.1 The first health visitor contact should be offered to families between 10-14 days after the birth with a second visit between 4 to 6 weeks. [*by November 2009*]

6.3.2 The Health Promotion Guidelines should be reviewed and updated [*by March 2010*] to ensure:

- Examinations and actions for babies and children are clear and unambiguous
- They contain information on the management of behavioural problems such as feeding and sleeping problems

- They contain information on accident prevention based on research evidence, including the supervision of children.

6.3.3 The health visitor should initiate contact with GPs when a child or parent is identified as having complex health needs (e.g. child's developmental delay, parental mental health issues). [*by January 2010*]

6.3.4 ONEL should clarify arrangements for health visitors to escalate concerns regarding GPs (and other professionals) not sharing pertinent information with them, including the involvement of the Named Nurse of the Trust and the relevant Designated professional of the other Trust / agency involved. [*by October 2009*]

6.3.5 The supervision process should be reviewed [*by January 2010*] to:

- Ensure that staff use the National Assessment Framework in discussions about children with disabilities and their families and which supports staff in recognising defence mechanisms used by families with complex problems
- Facilitate the identification of child protection risks and ensures that child protection health plans in place are commensurate with risk
- Ensure that supervisors are trained in undertaking child protection supervision as well as clinical supervision

6.3.6 A review of the child protection service should be undertaken to ensure that the operational and strategic needs including supervision are being met within ONEL (Waltham Forest). [*by January 2010*]

6.3.7 Given that a move to electronic records has been initiated by the ONEL (Waltham Forest), these recording systems should be reviewed [*by March 2010*] to ensure:

- Practitioners are facilitated in the collection, collation and analysis of data relevant to undertaking a comprehensive assessment and which provides early identification of children in need of safeguarding
- A front page that contains the child's date of birth and full information on parents and significant adults as well as racial, cultural, linguistic and religious identities of the parents and child
- It is evident where and when a child was seen and age at that point
- Referral forms for the child development centre provide adequate space for full information provision

6.3.8 A centile chart (in addition to the parent held record), genogram and significant events sheet must always be drawn up for a child when a significant disability is identified. Access to a significant events sheet and genogram should be available for all staff to support their work. [*by January 2010*]

6.3.9 Training must include the importance of taking a comprehensive history of families and the importance of considering previous experience on the ability

of parents to parent effectively. The importance of the father's role should always be emphasised in training. [*by November 2009*]

CHILDREN AND YOUNG PEOPLE'S SERVICES (CYPS)

6.3.10 The Portage service should:

- Review their eligibility criteria to reduce waiting times for the service [*January 2010*]
- Only close a case following formal discussion with the family [*by October 2009*]

6.3.11 The Disabled Children's Team (DCT) needs to have a more robust system for receipt of referrals with an expectation that [*by April 2010*]:

- Copies of CAFs are provided in appropriate cases
- Referral information is adequately explored prior to a decision on its outcome

6.3.12 Further training should be provided to develop more analytical skills as a second stage to basic core assessment training. [*by November 2009 with auditing of assessments by April 2010*]

6.3.13 The DCT should set clear standards and auditing processes to ensure that [*by April 2010*] core assessments involve:

- Allocation to qualified social workers
- Clarity of purpose and requirements by managers
- A focus on the child's needs
- The family's view of the child's disability and the loss experienced through their expectations of a child without disabilities, including the impact on all family members and on the quality of parental care
- History of family members
- Exploration of the significance of parental issues for parenting e.g. depression
- Consideration of available supports to the family that help them be more resilient
- Management monitoring of the progress of assessment and ensuring that the provision of resources, whilst appropriate, does not become the focus of the work
- Completion within timescales

  All already implemented, but audit to be completed by April 2010

6.3.14 Supervision should be undertaken and recorded according to departmental policies taking full account of the particular needs of the supervisee and including the opportunity for reflective practice and full consideration of cases not deemed as child protection. [*by September 2009- already implemented*]

6.3.15 Through reflective practice, supervisors should facilitate social workers' development of professional curiosity and interrogate information provided by other professionals and families. [*by December 2009*]

6.3.16 The DCT should set clear standards, administrative arrangements and auditing processes to ensure that [*by April 2010*] recording practice involves:

- Managers recording their advice and decisions in all cases
- Decision making about resources with reasons given
- The supervision episode accurately reflecting information provided about the child
- Clear management accounting for changes in the intervention plan
- Case closure clearly recorded
- Initial assessments signed off with clear outcomes and recommendations
- Recording all contacts with a family or another professional
- Recording of all complaints with outcomes and timescales
- Recording of referrals and contacts

6.3.17 The DCT should develop a process whereby the provision of basic level resources through direct payments following an assessment becomes an administrative process for seeking and paying for childminders, rather than one using considerable social work resources. [*by October 2009 – already implemented*]

NORTH EAST LONDON FOUNDATION TRUST (NELFT)

6.3.18 If a client disengages from NELFT services, other services need to be informed and concerns raised when appropriate. Service users and other professionals should be advised how to re-engage NELFT services if indicated. [*by January 2010*]

6.3.19 The good practice identified in this review needs to be shared within the NELFT services for children through workshops / team discussion. [*by October 2009*]

6.3.20 NELFT representation on the Waltham Forest Child Death Overview Panel (CDOP) should be negotiated. [*by September 2009 – already implemented*]

LOCAL HOSPITAL

6.3.21 A review should be undertaken into the assessment process carried out by midwives to ensure that emotional / psychological needs are appropriately addressed. [*implemented in August and September 2009, with an audit in December 2009 to ensure compliance*]

6.3.22 A policy should be developed to manage near fatalities in children with particular reference to safeguarding and involvement of Children & Young People's Services and the Metropolitan Police Service. [*by November 2009*]

NHS WALTHAM FOREST

6.3.23 The designated professionals NHS Waltham Forest should [*by November 2009*] interview the GPs concerned in this case and:

- Urgently establish the reasons behind the lack of information sharing and professional isolation demonstrated in this case
- Explain the risks to children arising from such conduct
- Consider whether this is likely to be an issue for this GP practice or for other practices in the area and
- If the latter, refer to the LSCB for further action

6.3.24 The designated professionals NHS Waltham Forest should [*by November 2009*] meet with the senior GP practice professionals to:

- Provide feedback from the findings of this serious case review
- Advise on the need for an immediate training needs analysis of all the practice staff, including the senior staff and all GPs
- Establish the type of training required and the appropriate provider
- Ensure relevant training delivered as a matter of urgency to all GP practice staff

6.3.25 NHS Waltham Forest should develop [*by January 2010*] a strategy to address the isolation of GP practices within the professional network to incorporate:

- The need for GPs to recognise patients as parents and the potential risk to children arising from parental issues, such as depression
- The expectations for information sharing by GPs
- Minimum expectations for attendance on safeguarding courses
- Dissemination of information from serious case reviews in which practice of GPs has been of concern, including this review

6.3.26 Via its contact monitoring arrangements NHS Waltham Forest should ensure compliance with recommendation 7.3.1. [*by October 2009*]

6.3.27 NHS Waltham Forest should ensure professionals in other Trusts / agencies are aware of how to escalate concerns about the performance of its private contractors. [*by December 2009*]

BARNARDO'S PROJECT

6.3.28 The service should introduce improvements to case recording so that:

- Sitters are able to provide written records of their contacts
- Analytical discussions are included
- Progress and developments are recorded
- The evidence base of decision making is transparent

[*This recommendation has already been implemented]*

6.3.29 The practice and recording of supervision should be reviewed. [*This recommendation has already been implemented]*

6.3.30 The project should explore improvements in working together with partner agencies when a service is being provided to a family. [*by October 2009*]

07.10.09

GLOSSARY OF ABBREVIATIONS

BOCU	Borough Operational Command Unit
CAF	Common Assessment Framework
CDC	Child Development Centre
CYPS	Children & Young People Service
CPS	Crown Prosecution Service
DCT	Disabled Children's Team
LSCB	Local Safeguarding Children Board
MPS	Metropolitan Police Service
NELFT	North East London Foundation Trust
ONEL	Outer North East London Community Services
PIMHS	Parent-Infant Mental Health Service
SALT	Speech & Language Therapy
SCS	Specialist Children's Service
SEN	Special Educational Needs