

**LONDON BOROUGH OF WALTHAM
FOREST SAFEGUARDING
CHILDREN BOARD**

SERIOUS CASE REVIEW

Executive Summary

CHILD W

20.10.11

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PREFACE

The serious case review was completed on 23.03.11, approved by the Waltham Forest Safeguarding Children Board (WFSCB) on 13.04.11 and submitted to Ofsted for evaluation on 28th April. Ofsted informed the Board on 23.08.11 that the overall evaluation for the SCR was good.

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 this serious case review the outcome of these processes was not known, but it was agreed that the report would be reviewed in the light of information available following the end of the criminal trial, so as to ensure all learning from the case is included.

The outcome of the criminal proceedings was that on 12th October 2011, the mother was convicted of 'allowing or causing the death' and the father was acquitted.

This executive summary was written in April 2011. Subsequent changes have been made so as to better protect the confidentiality of other children in the family. WFSCB will consider if any further learning has emerged from the criminal trial itself. If further lessons are identified, appropriate recommendations will be agreed and implemented.

1 INTRODUCTION

1.1 BACKGROUND

- 1.1.1 Child W was a ten month old female and the youngest child of the family. Her parents moved to the UK approximately nine years ago and English is their second language.
- 1.1.2 Some children of the family had a history of previous referrals to health care professionals for feeding difficulties and an elder sibling had in 2009 been the subject of a formal child protection investigation (involving Police and Children's Social Care) in relation to injuries inflicted by force feeding.

Circumstances of death

- 1.1.3 According to her parents, Child W had been suffering some 24 hours before her death in March 2010 with a loss of appetite, a history of fever, heavy breathing and vomiting. The family took the child to the GP the day before Child W died. That evening she slept, woke at about 22.00, was fed but remained unsettled.
- 1.1.4 At 01.30 the next day she was found to have vomited and been unresponsive. At the Accident & Emergency (A & E) Department Child W was assessed as not breathing with no palpable pulse. The baby was intubated to assist artificial ventilation and cardio-pulmonary resuscitation commenced immediately. Efforts to revive Child W were discontinued at 04.40 with the full agreement of the resuscitation team and Child W was pronounced dead.
- 1.1.5 The police and Coroner's office were informed of the death which was regarded as unexpected. An initial post mortem was inconclusive, histology and toxicology tests were undertaken and the cause of death was declared to be pneumonia with further causations being the chronic aspiration of gastric content. There was aspiration of food material in the airways with a surrounding acute inflammation. Evidence of previous aspiration was also seen by the presence of multiple areas of acute inflammatory response. These were identified as food from recent and old feeds suggesting possible abuse by 'force feeding'.
- 1.1.6 In April 2010 an inquest was opened and adjourned pending Metropolitan Police Service investigations. In December 2010 both parents were charged with causing or allowing the death of Child W.
- 1.1.7 A serious case review was initiated by Waltham Forest Local Safeguarding Children Board on 24.05.10 and concluded on 13.04.11. In accordance with Working Together to Safeguard Children (2010) the purpose of the review was not to attribute blame but to identify what lessons could be learned to improve multi-agency working in the future. The review covered a seven year period from the birth of the first child in the family to the death of Child W.

Overall conclusion

- 1.1.8 Whilst this serious case review has generated many lessons to be learnt, the panel and independent authors have concluded that the death of child W was not predictable. An expert¹ consulted for the purpose of the review confirmed that the death of a child through force feeding is extremely rare and that she had never heard of a normally developing child who has died from force feeding alone. However, if best practice had been followed, the risk of Child W force fed would have been better recognised and the family would have been offered further support and intervention. This should have reduced the probability of Child W being subject to behaviour that proved in this case to be fatal.

¹ A clinical psychologist and researcher in feeding, force-feeding and child behaviour factors

1.2 SUMMARY OF FINDINGS

- 1.2.1 The mobility of children across authorities, countries and continents provides a challenge for UK universal services in trying to ensure that such children's welfare is safeguarded and promoted.
- 1.2.2 Practitioners were insufficiently sensitive to obtaining an understanding of the significance of cultural and/or individual values with regard to weight, body image and feeding practices. The assessments undertaken did not result in adequate understanding of the family's concerns around their children's feeding.
- 1.2.3 The use of family members as interpreters in situations such as child protection enquiries should be consistently avoided.
- 1.2.4 Communication problems may have arisen in this case due to practitioners' difficulties understanding the father's English, and in such circumstances there is a need for an interpreter.
- 1.2.5 Practitioners in this case were inexperienced in dealing with force feeding. Whilst able to understand the child protection implications of an injury caused through use of excessive force when feeding, they did not derive from the subsequent child protection enquiry all pertinent information so as to be able to assess the risk of future harm to children in the family.
- 1.2.6 The planning and conduct of child protection enquiries by staff from an Islington hospital, Waltham Forest Children's Social Care and the Metropolitan Police Service Child Abuse Investigation Team had significant shortcomings.
- 1.2.7 The weakness of such enquiries stemmed partly from insufficient forensic focus on the investigation and partly because professional concerns were mistakenly diluted when maltreatment within the family was perceived to be motivated primarily by carers' 'concern for a child's welfare'.
- 1.2.8 There was a lack of involvement of children in the assessments undertaken, with little evidence that their wishes and feelings were sought. This was particularly pertinent during the child protection enquiry.
- 1.2.9 When a child protection enquiry concludes that a child has suffered 'significant harm', a decision not to progress to a child protection conference, needs to be authorised by a senior manager able to reflect on the circumstances through not being involved in the day to day decisions of the case.
- 1.2.10 This case raises concern about the role of the GP and her/his ability to provide a holistic assessment which takes account of previous presentations of a child and family members, as opposed to one based purely on the presenting symptoms of each individual.
- 1.2.11 It additionally indicates the need for a co-ordinated response from health practitioners, which includes sharing information, collective analysis and decision making.
- 1.2.12 The lack of a consistent GP reduces the potential for holistic assessment, recognition of concerns, co-ordination and monitoring of health inputs.
- 1.2.13 It is of concern that a doctor did not observe the scars on a child's face in 2009; this is in contrast to the commendable practice of the staff nurse and paediatrician at the hospital a few days later who were alert to the possibility of abuse.

1.2.14 The vulnerability of children not in receipt of 'enhanced' health visiting is increased by the lack of:

- A consistent service, without a named health visitor
- Agency records (as opposed to the Personal Child Health Record) of the child's absolute and relative weight
- Universal eight month developmental checks

1.2.15 When Children's Social Care closes cases following substantiated child protection enquiries, future plans should be clear about the roles of universal services and this is best facilitated through use of a 'child in need' meeting.

1.2.16 When families move, especially between local authority areas, there is a need for effective and timely information transmission between agencies, reinforced by verbal communication to highlight any particular concerns.

1.2.17 There were weaknesses in several agencies' recording systems including:

- The lack of 'alert' systems and case summary in the GP records
- Shortcomings due to transfer to electronic records
- An inability to provide lists of school starters / leavers for the school nursing service
- A worrying loss of records in three agencies in Islington
- A lack of recording within health of the adults accompanying a child
- An absence of names used to identify those thought to be 'father', including those in attendance at birth
- A lack of any strategy discussion records, despite three meetings being held

1.2.18 Although not affecting the tragic outcome in this case, there is an urgent need to improve the signage at the local A&E and strengthen the out of hours reception arrangements.

1.3 REPORT CONSTRUCTION

1.3.1 This executive summary contains:

- An explanation of the review process
- A summary of the events and the agencies involvement
- An overview of the key issues arising from the case
- Priorities for learning and change
- Recommendations for action

2 SERIOUS CASE REVIEW PROCESS

2.1 INITIATION OF SERIOUS CASE REVIEW

- 2.1.1 In accordance with chapter 8 of Working Together to Safeguard Children (HM Government 2010), a serious case review (SCR) should be initiated when a child has died and abuse or neglect is known or suspected to be a factor in that death. Its purpose is to:
- 'Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
 - Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result and
 - Improve inter-agency working and better safeguard and promote the welfare of children'
- 2.1.2 The independent chair of the LSCB (Mark Benbow) decided on 06.05.10 to convene a serious case review panel to consider the case. On 18.05.10 the panel was convened and determined the criteria in *Working Together* 2010 were satisfied i.e. 'a child dies and abuse or neglect is known or suspected to be a factor in the death'.
- 2.1.3 The panel's recommendation was accepted by the LSCB on 24.05.10 and the Government Office for London (GOL) and Ofsted were notified on 26.05.10 that a serious case review would be completed by 22.11.10.
- 2.1.4 The timescale was subsequently extended due to the need for further investigation and reports following the family's input and a new police investigation in December 2010, which had potential implications for the review.

2.2 TERMS OF REFERENCE

- 2.2.1 The serious case review panel agreed terms of reference which, in addition to the issues itemised in 8.3.9 of Working Together to Safeguard Children (2010)² asked for comment on:
- The extent to which practitioners were sensitive to the needs of the child in their work, knowledgeable about potential indicators of abuse or neglect, especially in relation to force feeding, and about what to do if they had concerns about a child
 - Whether the organisation had in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare
 - The key points / opportunities for assessment and decision making in the case
 - The extent to which assessments and decisions have been reached in an informed professional way, adhering to procedures
 - The coherence of actions and decisions within assessments, whether appropriate services were offered / provided, or relevant enquiries made, in the light of assessments
 - Where relevant, whether appropriate plans were in place, and child protection processes complied with
 - The extent to which practice was sensitive to the racial, cultural, linguistic, and religious identity of the child and family and how these were met
 - The involvement of senior managers or other organisations and professionals at points where this was indicated as appropriate

² http://www.workingtogetheronline.co.uk/chapter_eight.html#individual

- Whether the work in the case was consistent with each organisation's, and the WFSCB's, policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards
- The extent to which decision making was affected by other organisational considerations for example workload pressures or organisational change

2.3 INVOLVEMENT OF LOCAL AGENCIES

- 2.3.1 The following agencies were asked to provide an individual management review (IMR) or brief report of their agencies involvement with the family:

Waltham Forest

- Waltham Forest Children & Young Peoples Services
- Waltham Forest Schools
- Outer North East London Community Services (ONEL)
- NHS Waltham Forest
- Waltham Forest Hospital
- Metropolitan Police Service (MPS)

Islington

- Hospital
- NHS Islington
- Islington Children's Social Care
- Early Years

Camden

- Specialist Hospital

2.4 INDEPENDENCE

- 2.4.1 The need for sufficient independence to enable objective debate and challenge was recognised and it was ensured that:
- Panel members and IMR authors had no prior involvement with or immediate line management responsibility for Child W and her family
 - The panel was chaired by an experienced independent person
 - Overview authors were wholly independent
- 2.4.2 The SCR panel chair was Alastair Pettigrew, a recently retired Director of Children's Social Care who has over thirty five years of relevant service experience including experience of SCR's.
- 2.4.3 Edi Carmi and Fergus Smith were commissioned to provide an overview report of all the agencies involvement with the family. They are independent and have extensive experience as SCR overview and individual management review authors and panel chairs.

SCR panel membership

- 2.4.4 Membership of the serious case review panel was as follows:
- Alastair Pettigrew (Independent Chair)
 - Deputy Director Children & Young Peoples Service London Borough of Waltham Forest LBWF
 - Interim Group Manager Protection, Partnership & Plans Children & Young Peoples Service LBWF

- Detective Inspector initially, replaced by Acting Detective Superintendent of the Metropolitan Police Service MPS
- Designated Doctor Child Protection ONEL
- Independent Health Overview Author NHS Waltham Forest
- Principal Lawyer LBWF
- Designated Nurse Child Protection NHS WF
- Head of Education for Communities London Borough of Waltham Forest LBWF

2.4.5 The work of the SCR panel was supported by the LSCB manager and administrators.

2.5 EXPERT OPINIONS

- 2.5.1 Consideration was given at the beginning of the process to identification of sources of expert advice and a clinical psychologist and researcher in feeding, force-feeding and child behaviour factors that can cause force-feeding was consulted at the outset of the review.
- 2.5.2 An expert from London University was consulted in relation to the feeding issues in the context of the family's culture.
- 2.5.3 In addition to the IMRs, the authors and panel requested medical opinion regarding the role of the GPs generally and in this case with regard to the recognition and responses to weight and feeding problems in young children.

2.6 INVOLVEMENT OF FAMILY

- 2.6.1 Offers were made to meet with the parents at the start of the SCR process and in November the parents met with the overview authors. Their contribution raised issues relating to the Accident & Emergency arrangements at the local hospital during the night and led to further reports and recommendations.

2.7 INVOLVEMENT OF STAFF

- 2.7.1 Key staff were interviewed and fully involved in the process of exploring and arriving at a clearer understanding of practice and decisions made. The Safeguarding Board held a series of meetings for staff involved in the case to come together and be provided with information on the process and learning from the review.

3 SUMMARY OF AGENCY INVOLVEMENT

3.1 INTRODUCTION

- 3.1.1 This section provides a narrative account of the events known by agencies in the UK over an eight year period, since 2002. Earlier history is provided to give contextual information.

3.2 PARENTAL BACKGROUND

- 3.2.1 Ms M, the children's mother, lived with her parents and at times her grandmother, during her childhood. She came to the UK in 2000 for educational purposes and following her qualification as a health professional she worked full time in London. Mr F, the man understood to be the children's father comes from the same country as his partner and from the same cultural group. He has worked in several capacities in London.
- 3.2.2 Both parents speak English fluently, although it is not their first language and professionals may experience some difficulty understanding the father.

3.3 PARENTING

- 3.3.1 Child W's elder siblings were all born in the UK, but left the country to live with maternal grandparents for varying periods, before returning to live with their parents and commence their education. Generally the only concerns about the children's welfare were some indications of feeding difficulties in relation to two siblings. At school children were well presented, happy and friendly.

3.4 FEEDING DIFFICULTIES & CHILD PROTECTION ENQUIRY

- 3.4.1 One of child W's siblings at age three weeks was diagnosed as suffering from aspiration³ and subsequently experienced minor feeding difficulties and respiratory complaints in the early months of life. Mother had concerns about this child's poor feeding and loss of weight some years later when the child returned to the UK from grandparents care.
- 3.4.2 The mother had concerns that a second child in the family was underweight and refused food and spoke to health practitioners in 2006 of force feeding. Mother was provided with information and advice from community staff, although she did not attend all appointments provided. However, staff understood that mother's concerns were decreased, that she understood the risks of force feeding and did not want any further help. Further monitoring was not possible as the child left the country to live with maternal grandparents.
- 3.4.3 This child returned to the family was shortly before the birth of Child W in 2009. Following this child's presentation at hospital with viral gastritis, a child protection enquiry was initiated due to a facial injury (which subsequently required follow-up plastic surgery). There was some confusion with regard to the explanations of the injury but mother explained that the child had lived abroad with maternal grandparents and due to the difficulty feeding, was force fed by grandmother and aunt. The plastic cup that was used caused erosion at both corners of a sibling's mouth. The paediatric registrar spoke to the GP and the health visiting service, establishing from the latter a history of feeding problems but no child protection concerns.
- 3.4.4 The family had recently moved to Waltham Forest, so a referral was made to that area and a strategy meeting was undertaken at the hospital, attended by staff from the hospital, from Waltham Forest Children's Social Care and from the Police.

³ Aspiration is defined as the inhalation of either oropharyngeal or gastric contents into the lower airways. It can lead to pneumonia

- 3.4.5 The child protection medical report concludes injuries were compatible with the explanation of force feeding and suggests that conflicting accounts could be due to communication barriers as family 'speaks little English'. Maternal grandmother explained, using an interpreter, that the injuries took place when the child was so weak from not eating. This explanation was subsequently repeated to police in a joint visit to the home
- 3.4.6 At the first review strategy meeting, attended by Children's Social Care and the police, the consensus was that the injuries were not inflicted intentionally, but recognised the possibility of risk for Child W if she had feeding issues or if she went home with maternal grandmother at the age of six months, as was the custom in the family.
- 3.4.7 The child protection enquiry was concluded in June 2009. The concerns were substantiated but the child was not judged to be at continuing risk of harm. The risk to Child W was perceived to be if she were to live with her grandmother. No continuing role was identified for Children's Social Care.
- 3.4.8 The health visiting records from Islington were received in Waltham Forest in June 2009, after a seven week delay and after the child protection enquiry. These records contained information on the previous concerns about force feeding and that mother had been involved.

3.4.9 SUBSEQUENT PROFESSIONAL CONTACTS

- 3.4.10 The eldest children settled well in their new school in Waltham Forest and were popular with peers and the child subject to the child protection enquiry underwent plastic surgery, made good progress and was described as putting on weight and feeding well by the social worker.
- 3.4.11 Child W was seen at the GP surgery ten times between June 2009 and early March 2010. All but one presentation concerned either respiratory or gastric problems.
- 3.4.12 The mother first expressed concerns about Child W's feeding when she was aged eight weeks and attended the clinic. Reassurance was provided that her daughter was gaining weight. Her mother also mentioned her concerns that Child W was refusing to take a bottle a week later to the social worker, when she confirmed that Child W would not go home with maternal grandmother now. That decision was perceived as positive by the social worker as the risk was to the baby's safety was understood to exist if Child W went with her grandmother.
- 3.4.13 When Child W was seen at thirteen weeks old in the clinic (August 2009), her weight trajectory had fallen to the 25th centile. At sixteen weeks she was seen again at the clinic, when it was *incorrectly* written in the Personal Held Child Record that her weight (as opposed to her weight trajectory) had fallen. She was at that point below the 25th centile, having been born on the 50th, and in June was 'below the 75th centile'.
- 3.4.14 Mother mentioned to the health visitor in December 2009, that Child W displayed the same feeding problems as her sibling and that she was concerned as Child W had lost weight. The health visitor provided advice, but did not perceive a risk, as she considered mother to be experienced in managing a child with a feeding problem. Child W was to attend the clinic that week and be offered an eight month developmental review.
- 3.4.15 Child W was not brought to the clinic that week and the appointment was not provided for a developmental review. Child W was subsequently seen by her GP twice in 2010 (cough and skin complaint), but no follow up to the conversation with the health visitor occurred.
- 3.4.16 Child W's next contact with professionals was when her father brought her to A & E on the date she died, reporting she wasn't breathing. She was pronounced dead following efforts to revive her.

4 KEY ISSUES ARISING FROM THE CASE

4.1 ASSESSMENT

- 4.1.1 The key issues arising from this case centre mainly around assessment processes, due to the needs of the family not being perceived to require ongoing service delivery by targeted services. The focus of intervention was judged to be one which concentrated on meeting the process driven management requirements, as opposed to giving sufficient weight to professional expertise, including the development of relationships with the children.
- 4.1.2 There were several key opportunities for assessment and decision making, but these opportunities were not fully utilised due to shortcomings in the assessments undertaken:
- In 2002: following a sibling's hospital admission diagnosed as aspiration and subsequent failed follow-up hospital appointments, rapid weight increase followed by apparent dramatic weight loss
 - Following the discovery that mother and maternal grandmother were force feeding a sibling in 2006
 - During the child protection enquiry and core assessment in 2009
 - Each contact with health practitioners (including GPs) when Child W presented with respiratory type illnesses and/or mother was concerned about her poor feeding
- 4.1.3 Practitioners were insufficiently sensitive to obtaining an understanding of the significance of cultural and/or individual values with regard to weight, body image and feeding practices. The assessments undertaken did not result in adequate understanding of the family's concerns around their children's feeding.
- 4.1.4 Practitioners in this case were inexperienced in dealing with force feeding. Whilst able to understand the child protection implications of an injury caused through use of excessive force when feeding, they did not derive from the subsequent child protection investigation all pertinent information to be able to assess the risk of future harm to children in the family.
- 4.1.5 Given practitioners inexperience of intervention in cases of force feeding and aspiration, it is noteworthy that none sought advice or consultation from named / designated professionals / advisors.
- 4.1.6 The planning and conduct of child protection enquiries by staff from an Islington hospital, Waltham Forest Children's Social Care and the Metropolitan Police Service Child Abuse Investigation Team had significant shortcomings:
- Insufficient forensic focus on the investigation because professional concerns were mistakenly diluted when maltreatment within the family was perceived to be motivated primarily by carers' 'concern for a child's welfare'.
 - Not obtaining full agency checks
 - Insufficient involvement of children in the assessments undertaken, with little evidence that their wishes and feelings were sought: particularly pertinent during the child protection enquiry, when there is no evidence that the eldest siblings were spoken to individually
- 4.1.7 It is likely that mother's professional status encouraged 'the rule of optimism' and an accompanying confidence in her ability to cope with a child with feeding difficulties and her ability to learn from the experience with her elder child.

- 4.1.8 It may be that the lack of adequate risk assessment is a systemic problem arising partly from the way the Assessment Framework has been implemented nationally. It provides a positive focus on the need to consider all the domains of the child's life, and to avoid making decisions based on isolated instances. However, since its introduction, there has been a tendency for child protection enquiries to be subsumed as part of a core assessment, without adequate investigation and risk assessment taking place.
- 4.1.9 When a child protection enquiry concludes that a child has suffered 'significant harm', a decision *not* to progress to a child protection conference, needs to be authorised by a senior manager who is able to reflect on the circumstances by not having been involved in the day to day decisions of the case.
- 4.1.10 It is of concern that a doctor who saw a sibling in April 2009 did not observe the scars on her/his face; this is in contrast to the commendable practice of the staff nurse and paediatrician at the hospital who were alert to the possibility of abuse.

4.2 CO-ORDINATION & MONITORING OF HEALTH

- 4.2.1 One of the features of this case was the lack of co-ordination and monitoring of the health of the children. Within health this responsibility lies with the GP, although there is doubt about the ability of a GP, within the current structures and systems, to provide a holistic assessment which takes account of previous health concerns and presentations of a child and family members, as opposed to one based purely on the presenting symptoms of each individual.
- 4.2.2 When asked 'What symptoms would you notice if a child is being force-fed?', the expert consulted as part of this review replied:
- '... I would expect repeated chest infections where a child is aspirating food. Also, if a child were force-fed you would notice signs of progressive aversion e.g. they will shy away from the food at meal times, but are OK at snack time, e.g. eating a biscuit when out in the buggy.'*
- 4.2.3 Some of the children in the family suffered repeated chest infections. Whilst the GPs responded to each individual presentation, what might have made the presentations significant for Child W was the knowledge of a sibling's force feeding and that mother had told health visitors of concerns that her baby daughter also had feeding problems. Worryingly the GPs did not have knowledge of this background, which might have led to them making a referral for further investigations.
- 4.2.4 The lack of a consistent GP further reduces the potential for such holistic assessment, recognition of concerns, co-ordination and monitoring of health inputs.
- 4.2.5 This indicates the need for a co-ordinated response from health practitioners, which includes sharing information, collective analysis and decision making.
- 4.2.6 Kennedy⁴ refers to the 'complexity of the NHS....is a major barrier to offering the services that children and young people deserve'. He suggests that general practice must take on a more positive role, as the 'hub of a network of services' and the 'single point of access' at 'which the child....is assessed and routed to the most appropriate professional...' and his recommendation 16, for collection and consolidation of information at the GP surgery would be helpful.

⁴ Getting it right for children and young people, Overcoming the cultural barriers in the NHS so as to meet their needs, Sir Ian Kennedy, September 2010

4.3 SENSITIVITY TO RACIAL, CULTURAL, LINGUISTIC & RELIGIOUS IDENTITY

- 4.3.1 Communication problems may have arisen in this case due to practitioners' difficulties understanding the father's English, and in such circumstances there is a need for an interpreter. The use of family members as interpreters in situations such as child protection enquiries should be consistently avoided.
- 4.3.2 Current professional practice relies on basic biographical information being provided openly and honestly and practitioners are not expected to request legal proof of identity when working with families. However, the possibility of families being less transparent about family relationships as a result of complexities arising from immigration status, needs to be borne in mind during formal assessment processes.

4.4 MOBILITY OF CHILDREN

- 4.4.1 The mobility of children across authorities, countries and continents provides a challenge for universal services in trying to ensure that such children's welfare is safeguarded and promoted.
- 4.4.2 When families move, especially between local authority areas, there is a need for effective and timely information transmission between agencies, reinforced by verbal communication to highlight any particular concerns.

4.5 PLANNING

- 4.5.1 When Children's Social Care close cases following substantiated child protection enquiries, there is a need for clarity about the future plans and roles of universal services. Such plans are best facilitated through the use of a 'child in need' meeting.

4.6 RECORDING & ADMINISTRATION SYSTEMS

- 4.6.1 There were weaknesses in the recording systems in several agencies including:
 - The lack of 'alert' systems and case summary in the GP records
 - Shortcomings due to transfer to electronic records
 - The inability to provide lists of school starters / leavers for the school nursing service
 - A worrying loss of records in three agencies in Islington
 - A lack of recording within health of the adults accompanying a child
 - The lack of names used to identify those thought to be 'fathers', including those in attendance at birth
 - The lack of any strategy discussion records, despite three meetings being held

4.7 ORGANISATION OF A&E PROVISION DURING THE NIGHT

- 4.7.1 Although not affecting the tragic outcome in this case, there is an urgent need to improve the signage at the local A&E and strengthen the out of hours reception arrangements.

4.8 ORGANISATIONAL ISSUES

- 4.8.1 The vulnerability of children not in receipt of 'enhanced' health visiting is increased by the lack of:
 - A consistent service, without a named health visitor
 - Agency records (as opposed to the Personal Child Health Record) of the child's absolute and relative weight
 - Universal provision of the eight month developmental check

- 4.8.2 There has been an ongoing issue regarding health visiting capacity in Waltham Forest, which has involved the use of corporate caseloads and does not provide universal eight month developmental checks. The provider reported to the panel that a review of the service was in progress to ensure it has sufficient resources to meet operational requirements, including the universal provision of the eight month developmental check.
- 4.8.3 The school nursing service was unaware the children were in the borough due to both lapses in communication, but more critically the lack of any system to ensure the service is informed automatically of new school starters / changes / leavers.
- 4.8.4 The transitional arrangements in place during a change over of IT systems in the GP surgery in 2009/2010 impacted on the summarising of records and cross referencing of family records.
- 4.8.5 Children's Social Care's decision-making appeared to have been affected by organisational considerations for a speedy transfer between teams, in which there was apparent confusion regarding whose responsibility it was to commence referrals on the siblings, and a consequent lack of assessment of their needs.
- 4.8.6 The Social Care file did not contain a chronology, in accordance with Lord Laming's recommendation (2003)⁵. Discussion in panel confirmed this is a systemic issue as opposed to one of individual failure, since the introduction of the Integrated Children's System.

4.9 COMMUNICATION

- 4.9.1 There were examples of good communication as well as of communication lapses. The main problems relating to communication were due to changes in responsibility between services following family moves with delays in sending records and lack of verbal communication between practitioners. This was particularly relevant in health between GP practices and health visiting services.
- 4.9.2 A further general area of poor communication is between primary health practitioners, especially GPs and health visitors.

4.10 SUPERVISION

- 4.10.1 Eileen Munro⁶ refers to the traditional guard against 'the rule of optimism' as reflective supervision, where the 'supervisor helps the worker notice what is happening and revise their reasoning. Failure to give attention to errors in reasoning 'will increase the chances of erroneous assessments being made and kept'. Had the fact of mother's involvement in force feeding in 2006/7 or her reported experience in feeding problems with Child W been discussed in supervision by practitioners, it is possible that this may have led to a re-evaluation of risk.
- 4.10.2 Within social care there is limited evidence of supervision taking place and staff interviewed confirmed this. The individual management review indicates this may have been associated with the recent restructure and workload pressures, but since July 2010 is being monitored.
- 4.10.3 The ONEL individual management review highlights weaknesses in the supervision provided and refers to changes in child protection supervision structure since November 2009, following two previous case reviews, with a new procedure implemented that better facilitates the identification of risk, the reflection on practice and the development of a plan to meet identified needs. The effectiveness of the policy needs to be audited to ensure that children are effectively safeguarded and that practitioners are receiving the specialist support and that it is not enmeshed within managerial and caseload responsibility.

⁵ The Victoria Climbié Inquiry report of an inquiry by Lord Laming, 2003

⁶ The Munro Review of Child Protection – Part One: A Systems Analysis (2010)

5 PRIORITIES FOR LEARNING & CHANGE

5.1 GENERAL / MORE THAN ONE AGENCY

- 5.1.1 There is a need for greater professional and public health awareness of the risks relating to force feeding.
- 5.1.2 When staff encounter unusual circumstances which suggest a need for a safeguarding response, there is a need to proactively seek consultation from within their agency and/or from Children's Social Care and/or external sources of expertise.
- 5.1.3 The *Assessment Framework* provides a positive focus on the need to consider all the domains of the child's life, and to avoid making decisions based on isolated instances. Since its introduction however, there has been a tendency for child protection enquiries to be subsumed as part of a core assessment, without adequate investigation and risk assessment taking place.
- 5.1.4 In order to better understand family functioning, the existence or lack of supportive family networks, and in order to better inform holistic assessment of family needs, it is essential that **all** services as far as is possible:
- Engage with fathers (or prospective fathers) and gather relevant information on them
 - Capture information about the carers of children and the role of extended family members
 - Obtain an understanding of the pressures on the family arising from parental employment or unemployment
- 5.1.5 All staff working with children and families need to understand the importance of:
- 'Professional curiosity' e.g. for a GP to ask why a twelve month old was referred to a psychologist
 - 'Respectful uncertainty'
 - The need to have knowledge of the family history, from the family and agency records
 - The relevance of sharing information with other agencies
 - Continual challenge with family, within and between agencies, leading to continual re-assessment
 - The role of supervision to provide reflective practice and continual challenge
 - Avoiding assumptions about parental understanding and compliance, especially when working with parents from 'caring' professions
- 5.1.6 Practitioners completing assessments need to sensitively consider the culture of a family and their immigrant status, where relevant, and consider ways of ensuring that their needs are met. This includes understanding the:
- Reasons for parenting practices and the impact on the child
 - Potential for change should it be judged that behaviour is potentially harmful
 - Need to avoid use of family members as interpreters during sensitive assessments and investigations
- 5.1.7 Practitioners must keep the child at the centre of their work at all times. In order to do so it is essential that they engage effectively with the child and gather together a full picture of their experience and what day-to-day life is like.
- 5.1.8 There is a need for standards of record and file keeping to be reinforced in all agencies.

5.2 HEALTH AGENCIES

- 5.2.1 There is a need for health to provide a co-ordinated service which ensures that there is an effective and consistent lead health professional able to access and monitor comprehensive health information about a child and have responsibility to take decisions based on such information, including referrals for specialist services or to social care. It is not clear how within current structures this can be achieved, but is in line with the thinking from the Kennedy Report ⁷ and will need to be addressed nationally.
- 5.2.2 To be better able to protect vulnerable children, relevant health practitioners need to be able to access the information currently only available in the parents' Personal Child Health Record. This includes:
- Antenatal appointment information
 - Weight of children
 - Weight trajectory of children
- 5.2.3 This case highlights the need for the hospital providing the postnatal care to keep a copy of all visits prior to returning the records to hospital of delivery. A review of this practice within the local hospital is currently taking place.
- 5.2.4 Midwives need to be aware of the importance of clarifying and recording the identity and relationship of those individuals accompanying women to appointments and present at the birth. Wherever possible the identity of the (potential) father should be established.
- 5.2.5 In order to ensure timely notification of new births and facilitate communication between midwifery and health visiting, midwives need to complete the health visitor liaison form following the first visit to a mother and baby born out of area.
- 5.2.6 Staff in health settings should be aware of the importance of clarifying and recording the name, relationship and contact details of any adult who accompanies a child to appointments and hospital presentations.
- 5.2.7 Healthcare professionals need to explore feeding habits and undertake a holistic assessment whenever there is falling growth velocity. Such an assessment must involve understanding the extent and cause of any parental concern.
- 5.2.8 There has been the introduction of skill mix in health visiting teams which has provided capacity. However, there needs to be clear guidelines and the opportunity for supervision for those working with families whose infants are experiencing feeding difficulties to ensure that they have the appropriate skills and knowledge to deal with them.
- 5.2.9 There is a need to ensure that the transfer of patients between health agencies within and between different areas does not result in any:
- Loss of records
 - Delay in records reaching the new service (GPs and health visitors)
 - Lack of direct communication at transfer of responsibilities and the highlighting of significant information e.g. the fact of a current child protection enquiry

⁷ *Getting it right for children and young people, Overcoming the cultural barriers in the NHS so as to meet their needs*, Sir Ian Kennedy, September 2010

NHS Islington

5.2.10 Learning specifically related to NHS Islington identified a need for adequate:

- Supervision (during 2009, NHS Islington Provider Services contributed an IMR for a serious case review⁸, which provided a recommendation that covers this, which has been implemented and subject to audit, so a recommendation does therefore not need to be repeated in this case)
- Recording of supervision and subsequent maintenance of such records by the Community Child Psychology Service
- Communication between all health professionals and in particular between GPs and health visitors, with regular meetings held between GP practices and their allocated health visitor
- Involvement of fathers and extended family members as part of holistic assessment of family needs

ONEL

5.2.11 The risk assessment undertaken did not systematically analyse information in the context of previous history to obtain an understanding of the needs of the children in this family and plan appropriate care. This should have involved the use of an enhanced health visiting service, until it was clear that the concerns and difficulties around feeding had not re-presented for the baby.

5.2.12 Health visiting capacity was judged to have had an impact on professional practice in this case. This has highlighted concerns regarding a lack of policy and procedure around supervision and the best utilisation of the skill mix team within the health visiting service,. This is particularly significant around the role of the community nursery nurse.

5.2.13 The move to the electronic based record keeping system (RIO) did not facilitate the recording of clinical information on patients' records. There is though the potential for clinical information to be accessed by all practitioners involved with a client, but to prevent a response based on just the immediate presenting issue:

- Practitioners who see a family in clinic need to be able to access previous information or history on RIO and
- The health visitors need to be able to access routine contacts in the child health clinic on RIO

5.2.14 There was insufficient professional curiosity and challenge evident in child protection supervision, so risks were not identified from the past history and child protection enquiry and consequently there was not an appropriate proactive plan in place to safeguard the needs of the children.

5.2.15 The older siblings did not receive a service from the school nursing service until after the death of Child W due to:

- An absence of inter-professional liaison and
- Systemic problems within that service regarding the maintenance of school nursing records for all children under its care.

⁸ Child A Serious Case Review, Islington Safeguarding Children Board, 2009

NHS Waltham Forest

5.2.16 The GP recording tools were not used to optimal effect and did not:

- Enable doctors to access summaries and be aware of the family history of feeding difficulties and force feeding, so as to increase the GP's ability to make holistic assessments, beyond individual clinical presentations
- Include recording of the experiences of the child e.g. demeanour, developmental stage and interaction with carer

5.2.17 The circumstances of Child W's arrival at the local A&E department have highlighted the need for NHS Waltham Forest, in commissioning this service, to ensure that there is adequate medical provision to undertake safe screening at reception and to be able to arrange emergency medical responses when required within reception.

Local hospital

5.2.18 The circumstances of this case have alerted the hospital to the need to improve signage to the paediatric A&E department and ensure consistent terminology is used in letters and signage to describe the service.

Islington hospital

5.2.19 The recording of communications between the hospital and other agencies needs to be complete and specific, to include records of strategy meetings and communications with community midwives from other areas.

5.2.20 Staff were not using the name stamps, provided since 2008, due to practical obstacles not previously shared with management. These problems will need to be resolved so as to ensure legible signatures.

5.3 SCHOOLS

Islington

5.3.1 The accidental destruction of a child's records by another child highlights the need for:

- All early years settings to be aware of the importance of storing and managing records safely and securely to ensure that they are available when required
- Children in early years settings to be supervised at all times and not to have access to any professional's office without an adult being present

Waltham Forest

5.3.2 Systems for managing information about children new to the school and those already in attendance needs to be as robust as possible within available resources e.g. exploring family composition and parental responsibility, and specifically in relation to child protection case recording.

5.4 WALTHAM FOREST CHILDREN'S SOCIAL CARE

- 5.4.1 It is commendable that Waltham Forest Children's Social Care has provided child protection enquiry training for staff; however it is important that all social workers and managers that undertake this work have attended the training.
- 5.4.2 The current organisational structure of transferring cases after initial assessment and prior to the child protection enquiry potentially leads to confusion about responsibilities. The planned re-organisation will address this issue, with one service undertaking both functions.
- 5.4.3 It is crucial that all the information, meetings and discussions are clearly recorded so that it is easier to understand how decisions have subsequently been made.
- 5.4.4 The role of supervision in providing reflective practice, continual challenge and management oversight is vital to safe practice. This should include examination of how personal attitudes and values may impact and affect the outcomes of assessments and services provided.
- 5.4.5 The failure to include all the children as subjects of the investigation and assessment, to involve all relevant agencies and to develop a working agreement and agreed care plan were significant. Important issues around feeding remained unexplored and the children were in a position of unidentified potential risk.
- 5.4.6 When child protection concerns are substantiated, but the child is not judged to be at continuing risk of significant harm and a child protection conference is not going to be convened, that decision, and the rationale for making it, would be safer if authorised by a more senior manager and not the manager who chaired the strategy discussions.
- 5.4.7 As a reported consequence of workload pressures upon social workers the case closure tasks were allocated to a social work assistant who had had no prior involvement with the case or family. This led to important aspects of case closure being omitted. Line managers need to ensure that the allocated worker completes the case closure summary and associated closure tasks.
- 5.4.8 The lack of chronologies on children's case records is a national problem since the introduction of the Integrated Children's System (ICS). Whilst awaiting the outcome of the Munro Review and the future of ICS, it is important that a local strategy is implemented to provide chronologies that are 'fit for purpose'.
- 5.4.9 Prior to closure of a case following a child protection enquiry, it is important to ensure clarity around future plans and the role of other professionals, including the possibility of a lead professional. Such planning is best achieved through the use of a child in need meeting with a written output plan.

5.5 METROPOLITAN POLICE SERVICE

- 5.5.1 The joint investigation in this case had shortcomings and there is a need for the CAIT team to ensure that the investigative plans made at strategy meetings are sound.

6 RECOMMENDATIONS

6.1 INTRODUCTION

- 6.1.1 Recommendations emerging from this serious case review include those requiring action by:
- Waltham Forest Safeguarding Children Board (SCB)
 - Individual Waltham Forest SCB member agencies
 - Individual Islington SCB agencies
 - All agencies in both boroughs
- 6.1.2 Waltham Forest SCB will need to ensure that Islington SCB are provided with the recommendations that apply to all agencies and to individual Islington agencies.
- 6.1.3 The following recommendations include those from the individual management reviews (IMR) which emerge from the findings of this overview report. If they are of more general relevance, they have been incorporated into 'LSCB or 'generic' health agencies recommendations. Some IMR recommendations have been amended so as to make them more specific.
- 6.1.4 The overview has added recommendations which are not in the IMRs both for the two LSCBs and for individual agencies.
- 6.1.5 The accompanying action plan provides details of how the recommendations have been / will be implemented and the completion dates. The purposeful delay in the completion of this serious case review did not delay the implementation of the recommendations.

6.2 LSCB RECOMMENDATIONS

- 6.2.1 Waltham Forest SCB should recommend to the London SCB and the DfE that future guidance clarifies the need for independence in the conduct of serious case reviews with panel members having no involvement in a case being reviewed, either as a practitioner, line manager or as a manager of the latter.
- 6.2.2 WF and Islington SCBs should develop a strategy to ensure greater professional and public health awareness of force feeding.
- 6.2.3 Waltham Forest SCB should ensure that all single and multi-agency safeguarding training highlights the:
- Need for 'professional curiosity' and 'respectful uncertainty'
 - Engagement with children as part of any assessment
 - Use of consultation within each agencies and by children's social care, especially when encountering unusual or challenging issues
 - Importance of information sharing
 - Need to understand as part of any assessment the individual family's own history and culture and how this impact's on the care of the children
 - Need to consider each child's developmental stage when evaluating risk
 - Need to engage and gather information about all significant people for the children, including fathers and all carers
 - Need to obtain a holistic understanding of family circumstances, including pressures arising from immigration status, employment arrangements, housing etc
 - Need to be aware of potential 'assumptions' that can be made about compliance, especially when working with parents from 'caring' professions, which may lead to errors in assessment

- Need to constantly re-assess and provide professional challenge to one's colleagues within and between agencies
 - Need for recorded decisions about the use of interpreters (other than family members) when discussing sensitive issues to take account of both the service users comprehension of English and the practitioners ability to understand the service user's English
- 6.2.4 Waltham Forest SCB should write to the Munro Review and the DH about the need for an effective and consistent lead health professional who is able to have full health information about a child and have responsibility to take decisions based on such information, including referrals for specialist services or to social care, so as to provide a co-ordinated health service for children.
- 6.2.5 Waltham Forest SCB should write to the Munro Review about the need for national research into the extent to which child protection enquiries have been subsumed as part of a Core Assessment under the Assessment Framework and the impact this has had on the quality of investigation and risk assessment.

6.3 LONDON BOROUGH OF WALTHAM FOREST

- 6.3.1 LBWF should ensure there is an electronic system which provides ONEL every term with correct details of all school age childrens' names, date of birth, address and school.

6.4 WALTHAM FOREST CHILDREN'S SOCIAL CARE

- 6.4.1 Children's Social Care should offer a rolling programme of s.47⁹ training to all social workers and no social worker should undertake child protection enquiries unless they are trained to do so.
- 6.4.2 To implement the proposal for restructuring Children's Social Care to place the responsibility for responding to referrals and completing the s.47 investigation within the same team.
- 6.4.3 Whenever the use of an interpreter is considered for the purposes of assessing a child's welfare the reason for doing so, or the rationale for not, should be clearly recorded by the social worker or their manager, on the child's file.
- 6.4.4 To improve the quality of case management and recording, all decisions made as a result of informal discussion between practitioners and managers, and the rationale for these, must be clearly recorded in the child's file.
- 6.4.5 To improve the compliance with procedures and the quality of casework, managers in children's social care must undertake audits to review casework and decision-making and ensure it is in line with wider policies and procedures and to seek evidence of an agreed care plan on file.
- 6.4.6 To improve the quality and level of analysis in assessment, and to ensure that social workers are sensitive to the cultural and racial needs of the child and family, managers in children and young people services must offer regular formal supervision to all social care practitioners. Supervision must provide opportunities to improve the quality of assessments and casework through reflective practice.
- 6.4.7 All supervision discussion, decisions made and rationale for those, must be clearly recorded in the child's file.
- 6.4.8 Team and group managers to continue to audit supervision records to ensure supervision standards are maintained.

⁹ S.47 refers to section 47 of the Children Act 1989, Local Authority duty to undertake enquiries. This is commonly called a child protection or s.47 enquiry or investigation

- 6.4.9 To improve performance in child protection enquiries, team managers to undertake observational and recording audits of strategy meetings to ensure high standards of robust multi-agency discussion and decision-making.
- 6.4.10 To improve coherence of actions and decision-making, where the outcome of a child protection investigation is that the concerns are substantiated but the child is not judged to be at continuing risk of significant harm and a child protection conference is not going to be convened, that decision must be approved and recorded by a team manager or principal officer, on the child's file i.e. a manager more senior than the one who chairs the strategy meeting.
- 6.4.11 To improve the quality of case closures, managers must ensure that all case closure tasks are completed by the allocated social worker, including completing the chronology.
- 6.4.12 To improve practitioners' ability to understand and safeguard children where there are complex health and developmental concerns, children's social care should consider inviting experts in all areas of child development to local service meetings.

6.5 GENERIC HEALTH AGENCIES RECOMMENDATIONS

The following recommendations apply to more than one Health Trust. The responsible Trusts are cited in brackets after the recommendation. Provider Trusts are responsible for implementing the recommendations. Commissioning Trusts are responsible for ensuring this is part of the service commissioned and monitoring their implementation.

- 6.5.1 All agencies should review their guidelines for the management of weight in children with particular reference to feeding/eating and faltering growth. In particular this must include the supervision of unregistered staff who play a key role in developmental assessments and the weighing of infants and children. [Applies to ONEL, NHS WF and NHS Islington]
- 6.5.2 Agencies must assure themselves that their assessment processes are thorough and comprehensive. As part of this, documentation/processes should be developed so that information on key events or concerns about the family are readily available for all of those working with the family. [Applies to ONEL, NHS WF, Whipps Cross Hospital and NHS Islington]
- 6.5.3 Agencies should ensure that their child protection supervision policy reviews the quality and frequency of supervision. [Applies to ONEL, NHS WF, and NHS Islington]
- 6.5.4 All children's records (including those compiled by GPs) should identify those adults with parental responsibility for each child. For each contact the practitioner should:
- State how the child/ren have themselves contributed to the assessment (e.g. observation and/or speaking with child)
 - Specifically state who accompanies a child and the person's relationship with the child
- 6.5.5 To improve the communication and liaison process between Waltham Forest GPs and the primary health care team [Applies to ONEL and NHS WF]:
- GP services should when they see a new baby review the personal child health record (PCHR) and record in the GP records the health clinic the baby will attend and the name of the health visitor recorded in the PCHR
 - A revised list of the local health visiting service that is nearest to each GP practice should be distributed urgently, covering details of all the roles that comprise the health visiting team, health visitors, Team Leaders and support staff
 - GPs to be consulted about the review of the health visiting service in Waltham Forest
 - There should be a named health visitor for a group of practices who could meet with the safeguarding lead from a cluster of GPs monthly to discuss pertinent issues

- There should be regular formal documented meetings where appropriate, between the GP and members of the primary health care team to discuss families of concern and share information.

6.6 WALTHAM FOREST NHS

- 6.6.1 General practices should use alert systems for families who may be vulnerable or for whom there may be concerns. These should flag up whenever a family record is accessed, alerting the professional.
- 6.6.2 The GP practice in this review should update the Record Summarising Protocol to make specific reference to the urgent electronic filing on receipt of records that contain information of a history of social services intervention (not just children on a child protection plan).
- 6.6.3 The commissioning organisation to report back to the LSCB how they have ensured that the out of hours and urgent care services at the local hospital delivers safe care involving:
 - Adequate *clinical* screening throughout the night
 - The documenting of all arrivals and
 - Immediate provision of emergency medical attention and/or resuscitation if required.

6.7 ONEL

- 6.7.1 Current health visitors' case loads need to be reviewed so as to provide equity in the number of children and complexities within case loads.
- 6.7.2 To improve the quality of safeguarding supervision so as to enable practitioners to identify risks and ensure health care plans in place that appropriately safeguard children by ensuring:
 - Health visitors have attended the mandatory safeguarding training at levels 1- 3 and
 - All child protection supervisors have attended the annual update for supervisors
- 6.7.3 An audit of child protection supervision to be undertaken within the health visiting service in order to identify the quality and assessment of risk within child protection supervision.
- 6.7.4 An audit of health visitor records for children in receipt of enhanced services to be undertaken to ensure that information sharing is identified as part of the health care plan and that it has taken place.
- 6.7.5 The system to be reinforced to ensure information is shared between the health visiting and school nursing service whenever children have transferred into or out of ONEL.
- 6.7.6 An up to date audit of children to include initial assessments for routine and enhanced service, so as to ensure risks have been identified and actioned within local and national policy and procedure.
- 6.7.7 Health visiting guidelines to be completed and ratified, to include policy and procedure regarding the supervision and support of the skill mix team.
- 6.7.8 The Trust to ensure a system of recording child health clinic attendances on the RIO system by the health visiting team.

6.8 WALTHAM FOREST HOSPITAL

- 6.8.1 The Hospital Trust to review current process for transferring records back to hospital of delivery following discharge from community midwifery services. This will include:
 - Local protocol to ensure record of postnatal contacts is retained prior to return of original records to hospital of delivery

- Review and agree London wide practice of transfer of records with support from London Supervising Authority and Heads of Midwifery
- 6.8.2 The Hospital Trust to review the use of the Health Visitor Liaison form as a method of communication between the Midwifery and Health Visiting services.
- 6.8.3 The Hospital Trust to ensure that:
- Consistent use is made verbally and in written documents of the term Children's A&E' rather than 'Paediatric A&E'
 - New clear signage to be put above the doors leading to various departments
 - The coloured lines used for patients to follow are in good condition and provide adequate signposting
 - These coloured lines are referenced in the department's signage

6.9 SPECIALIST HOSPITAL

- 6.9.1 All staff should be reminded about good record keeping practice through training and supervision. The Trust has a robust record keeping policy and this should be reinforced through training as well as practitioner's own record keeping guidance from their respective governing bodies. This can be assessed by document audit and case review.
- 6.9.2 In cases such as this where the team encounters previous unknown or unusual circumstances which may relate to ongoing child protection concerns, good practice would indicate that the team should not only contact local social care services (which they did) but seek consultation from the hospital social care duty service.
- 6.9.3 Legal Advice to be sought to identify whether the electronic system for patient bookings could be improved to expand current system of only flagging children subject to a child protection plan (in line with current data protection legislation). This may better inform future patient contact with practitioners at the hospital.

6.10 NHS ISLINGTON

- 6.10.1 The Trust should give consideration to the training needs of the practitioner who apparently did not notice the scars on a child's face in 2009.

6.11 ISLINGTON HOSPITAL

- 6.11.1 Review the:
- Use of name stamp so as to ensure signatures are legible
 - Maintenance and storage of records of children who attend the emergency department
- 6.11.2 Ensure:
- Explicit guidance regarding creation of medical records for children who attend the emergency department and consequently non accidental injury is suspected (NICE 2009) when the child is not admitted
 - The concept of authoritative practice and the importance of asking and documenting the names of all the adults accompanying a child or pregnant women is reinforced in training for level 2 training and above
 - A robust system in the maternity department for documenting and filing transfer in and out of postnatal records

6.12 ISLINGTON CHILDREN'S SOCIAL CARE

- 6.12.1 Islington Children's Social Care to ensure that when staff are involved with strategy discussions / meetings with other local authorities, clarity is sought and recorded regarding responsibility for the strategy meeting and any subsequent s.47 enquiry.

6.13 WALTHAM FOREST SCHOOL

- 6.13.1 Appropriate training should be provided to promote new good practice guidance on planning and conducting outreach visits.
- 6.13.2 Opportunities for building relationships between schools and Children's Social Care should be developed across the Children's Partnership to promote proactive communications.
- 6.13.3 The Children's Workforce Strategy local recommendations to be reviewed to consider whether enough clarity is given about the expectations of the various practitioners working in universal services in identifying risk and that these are consistent across the children's workforce and matched with appropriate supervision and skills development.
- 6.13.4 A practice note should be produced to assist in the planning and conducting of outreach visits with clarity about the respective roles of the Outreach Worker and the Midwife.
- 6.13.5 Systems for managing information about children with regards to safeguarding, need to be reviewed to reassure the school that resources are used to best effect.

6.14 LONDON BOROUGH OF ISLINGTON EARLY YEARS SERVICE

- 6.14.1 All early years setting in the London Borough of Islington should:
- Be reminded of the need to manage all paper records in a way which ensures their security and safety
 - Ensure that children are not able to gain access to office areas without supervision.

6.15 METROPOLITAN POLICE SERVICE

- 6.15.1 The CAIT team managers need to ensure that investigative strategies in joint investigations are compliant with operating procedures and include:
- All children in the family
 - Obtaining information from all relevant agencies
 - Provision for individual family members to explain their roles in private, especially where criminal culpability is being attributed to just one person
 - Exploring discrepancies in individual accounts
-